The International Association of Psychosocial Rehabilitation Services (IAPPRS) creates a number of webinars designed to improve psychosocial rehabilitation and recovery based practice around the country. The training director contacted us when she was putting together a set of "exemplary practice" webinars asking what we at MHA-LA do best that we would want to share with other programs and providers. After some internal discussion, and creating a list of credible choices, we decided that what we do best is not any one service but to "integrate services" and that our programs are "exemplary integrated service agencies". Paul Barry, the director of the MHA Village (originally the director of employment services) and I created this webinar together. (IAPRS probably has a recording of it for sale too.)

The Village's full name is the Village integrated Services Agency. We weren't originally established to be a recovery based program. We were supposed to combine a number of exemplary practices (ACT, club house, accessible psychiatric medication, crisis, and hospital services, integrated dual diagnosis treatment, rehabilitation, family inclusion, health care integration, etc.) into a single "one-stop shop". Our success is due in large part to the discovery that recovery is a model that is holistic enough that all services can be adapted into it, but it takes a lot of hard work to stay integrated. This paper describes the nuts-and-bolts of how we manage integrated services.

Integrating Services is What We Do Best (with Paul Barry)

(2009)

Every service that MHA-LA programs provide is probably provided better by some specialized program somewhere else…but people rarely need just one service provided excellently. They usually need a whole array of services to meet their needs and they usually need those services to be integrated in one place to really use them. Many of MHA-LA's programs – the Village, the Wellness center, the Homeless Assistance Program, the Transitional Age Youth Academy, and MHA-Antelope Valley offer integrated services.

"Do whatever it takes" doesn't just mean to go beyond normal service limits, being dedicated, accessible, flexible, and creative. It also means "Do whatever service it takes." Helping people achieve their goals may require a whole array of services from medications to employment to housing to substance abuse to health to community integration to financial to….

"Meet them where they're at" doesn't just mean be good at welcoming, charity, "housing first", and harm reduction. It also means being able to support an array of goals for people at a range of places in their recovery – including people who are unengaged, engaged but poorly self-coordinating, self-responsible, and self-reliant. For example, employment services need to include day labor for unengaged people, supportive employment for engaged but poorly self coordinating people, and job development and job coaching for people who are self-responsible or self-reliant.

Therefore, an Integrated Service Agency must include an array of different kinds of services and a range of different levels of services.

Creating a "system of care" where every service exists somewhere in the system rarely works. Services become fragmented and too difficult to coordinate. Collaborating is elusive between competing agencies with different cultures and missions. Services generally must be integrated into a "one-stop-shop" to be useful.

Even "just" offering every service somewhere in a large agency also often doesn't work without a concerted effort to integrate them. Services become fragmented and too difficult to coordinate. Silos and specialties emerge. True integration is elusive without a unifying culture and mission as common ground.

1) Principles

The "common ground" MHA-LA uses to integrate our programs is our principles. Generally these principles are in line with SAMHSA's 10 fundamental components of recovery: Self-direction, Individualized and person-centered, Empowerment, Holistic, Non-linear, Strengths-based, Peer support, Respect, Responsibility, and Hope, but each program repeatedly reworks our principles to make them come alive for us. Focusing the vague generalities of most value statements into practical principles with impact takes work. Each integrated service agency may emphasize different principles when they update their principles as they evolve.

For example, the Village's principles presently are:

We believe…

1. Hope makes recovery possible; it facilitates healing of the mind, body and spirit.

2. Welcoming people includes creating a culture of acceptance with easily accessible integrated supports and services.

3. Focusing on the whole person includes their strengths and weakness, abilities and barriers, wounds and gifts.

4. Each person creates their path and determines the pace of their recovery.

5. The recovery process is a collaborative journey in support of individuals pursuing their life goals.

6. Relationships are developed through mutual respect and reciprocity, including openness to genuine emotional connections.

7. A solid foundation for recovery is built by helping people to honestly and responsibly deal with their mental illness, substance abuse and emotional difficulties.

8. People thrive, grow and gain the courage to seek change in respectful environments that promote self responsibility.

9. The practical work of recovery takes place in the community.

10. Each person has the right to fair and just treatment in their community ensured through advocacy and social responsibility.

11. Everyone deserves the opportunity to have a place to call home.

12. Promoting natural supports, having fun and a sense of belonging enhances quality of life.

13. Employment and education are powerful means to help people build lives beyond their illness.

14. Program success is based on achieving quality of life and recovery outcomes.

Principles integrate our programs by:

1. **Inspiring us.** Our principles connect us to why our hearts got us into this work in the first place. They reinforce our passion and diminish burnout.
2. **Unifying us**. Our principles create a shared rationale for not just what we do, but also how we do it and most importantly why we do it. Decision making should be made through the filter of our principles.
3. **Creating a shared culture.** Our principles lead to a shared language, rituals, stories, and heroes.
4. **Creating a compass to guide proactive, planful work**. Our principles can help us move away from a crisis focus, the hole into which the best of recovery intentions fall.

2) Practices

If we provide a service simply because funding is available even because it is effective, but it doesn't promote or even compromises our principles, it will only be a matter of time before it becomes divisive and fragments us. Every service needs to be framed in a way that it relates to our principles. Questions to apply to any service are A) Is there an integrating principle that gives it meaning and value? And B) What services are missing that would further our principles?

For example, years ago we tried to convince a nearby clinically based CMHC to have us provide employment services for their clients, a specialty service they had little experience or inherent investment in.. Our presentation focused on the efficacy of the services in getting people jobs and that it was at no cost to them. We didn't focus on how employment services might promote the principles they already valued, for example, helping their clients "live" and not just "exist," and they didn't integrate employment into their services. Both meaning and efficacy are crucial to integrate a new service.

1. Meaning. To integrate a service into our program it must be embedded in our principles, or else it risks becoming an isolated silo. It must justify why it is important by forwarding our principles. On the other hand, stretching an agency to integrate a new service, may require altering some emphasis in the principles so that *everyone in the program* embraces the "new" service instead of having it become an add-on on the side of the agency never really integrated into the agency.

For example, employment services rest on the principles "People thrive, grow and gain the courage to seek change in respectful environments that promote self responsibility" and "Employment and education are powerful means to help people build lives beyond their illness." To do that, employment services have to 1) Be "real work" with "real responsibilities" and a "real chance of getting respectfully fired" and not just "make work" to "keep them busy" supervised with low expectations because they

have mental illnesses, 2) Focus on moving beyond illnesses rather than the therapeutic nature of work, 3) Focus on community based employment. As a result, a potentially effective form of employment services - community based, protected group enclave placement with disclosure of mental illnesses – is difficult to integrate into the our agency. It just doesn't mean as much to us as supported employment does. On the other hand, the entire agency has to believe that people with serious mental illnesses can do meaningful work and be ready to offer them the support needed to do so – "The practical work of recovery takes place in the community" for supported employment to succeed. The psychiatrist can't be saying that some people aren't ready to work while other staff are trying to find them a job and support them in keeping it. If everyone isn't on board, employment services risk becoming an add-on service, not relevant to the entirety of the agency.

Harm reduction and motivational interviewing rest on the principles of "Welcoming people includes creating a culture of acceptance with easily accessible integrated supports and services" and "Each person creates their path and determines the pace of their recovery." To do that with people abusing substances we can't have "sobriety standards" to access services, though we can have "behavioral standards." We have to be non-judgmental and work to help people "raise their bottoms" as a priority rather than wait for them to "hit bottom." Programs with different principles might have more problems integrating harm reduction and motivational interviewing into their programs. On the other hand, our court advocacy doesn't help people "get off" of drug charges by writing a letter saying they have a mental illness, because that would undermine the "social responsibility" part of " Each person has the right to fair and just treatment in their community ensured through advocacy and social responsibility."

Even medication services, which are often very important, must adapt to meet principles like "The recovery process is a collaborative journey in support of individuals achieving their life goals" and "A solid foundation for recovery is built by helping people to honestly and responsibly deal with their mental illness, substance abuse and emotional difficulties" To do that, medication services must rely on collaboration, empowerment, client-driven and goal oriented, rather than on compliance, care taking, professional-driven and symptom relief oriented and the entire program has to believe that medications can be used productively and aren't just a way of sedating and controlling people, that some people do have biochemical mental illnesses, and that recovery doesn't require "getting off your medications."

Integrating practices effective practices of all sorts, whether they evolve from within or are adopted from elsewhere, into our principles is hard work requiring lots of collaboration and adaptation.

1. Efficacy. To integrate a service into our program it must be effective. Each service must be able to demonstrate that it contributes to people growing, recovering, and improving their quality of life. Each service should also be synergistic with the others making everyone else more effective too.

Since everyone cannot be an expert, or even competent or licensed, to do everything, an integrated services agency must include "specialists" that have substantial expertise in particular services – for example housing development, CBT, medications, financial planning, literacy, but it also must avoid the specialists becoming fragmented from the "generalists" and from each other. Specialists will often need ongoing specialty education and training. On some level, however, all specialists must also be

"generalists" able to 1) create trust and relationships with people with mental illnesses, 2) help form a shared story of how they got in trouble and how they'll recover – from a "menu" of perspectives, and 3) understand how their mental illness creates barriers to achieving their goals and how to overcome them.

Collecting outcome data that is shared with everyone can be a powerful tool to demonstrate and improve effectiveness in specific goal areas. Rituals that emphasize success, for example, awards ceremonies, accomplishment walls, sharing success stories in team meetings can also be powerful. Without demonstrated efficacy other staff will tend not to expend the effort to integrate a service and its specialist.

Each staff is more likely to embrace new staff and services when they can see a synergistic impact on their own work. For example, a psychiatrist is more likely to accept a job developer when he sees that working doesn't have to stress people out and lead to crisis and relapses, work often actually increases people's motivation to take medications and their resiliency and decreases their focusing on unpleasant symptoms and a job developer is more likely to accept a psychiatrist when he sees that medications don't have to be oversedating and they can dramatically improve functioning to make it easier to work.

3. Structures

It is much easier to create and manage a program that does one thing, or a few things, well than an integrated services agency. Here is a list of common challenges and strategies to overcome them:

1. Economy of scale. Many programs are too small to support enough specialists to provide an array of services. They have inadequate "critical mass" and expansion isn't always possible. Especially when we have tried to create a "focused" integrated service agency (for example our TAY Academy serves 18 to 25 year olds and our Wellness Center serves only people who are self-responsible or self-reliant focusing on self help and community integration are both in separate sites form the Village) we have had serious problems with critical mass. Staff may have to take on several roles and staff from other programs may have to be included part time.

2. Funding. Funding sources tend to be focused on a particular service rather than on holistic service or an array of services. To financially support an array of services we have often had to incorporate a variety of funding sources – for example, MediCaid, HUD, and Dept of Voc Rehab – into one program. Although this creates a variety of cumbersome requirements, audits, and paperwork that can be overwhelming, it can also fill in gaps in the program. New funding sources must be strategically evaluated to see if they actually add to the integrated services before they are pursued. We've also advocated for holistic contracts, like Full Service Partnerships and flexible "Client Support Services" funds that can be used directly by line staff to support people, for example with apartment security deposits, school books, interview clothes, and medical medications.

3. Combining licensed professional, unlicensed, and consumer staff. Creating a highly diverse staff enriches our ability to connect with people and to use our experiences to help guide them and to provide a wide range of services successfully. However, there are often turf issues and hierarchies, personal divisions and past resentments, and differing priorities and "languages" that need to be overcome to work respectfully together. Hiring practices and labor laws tend to be different for the "professionals" and "non-professionals" and "consumer staff" we want to integrate together. This requires a complex set of exempt and non-exempt, temporary and permanent staffing designations and timesheets. These "segregations" tend to degrade integration and morale by fueling the underlying issues.

4. Team structure. The more "specialists" are actually sited on a holistic team, supervised by the team leader, and regularly meeting together and problem solving with the team the more integration is likely to occur. Personal relationships grow between staff and with clients, goals and barriers are shared, mutual respect grows, and a shared culture and rituals develops. However, there are strong risks of "specialists" getting "sucked into" spending lots of time dealing with crisis, creating emotionally supportive and healing relationships with people, and helping out with the case management work of the team and neglecting their specialties. We don't want to create a the equivalent of a kids soccer team where everyone chases around the ball in a muddle, abandoning their positions on the field and their primary responsibilities. Also, there are benefits to specialist staff interacting regularly with other staff who share their specialty to learn from each other, support each other, and share resources. We've tended to create a complex design of holistic teams and specialty teams that overlap with "too many meetings" as our pendulum swings from holistic to specialized.

5. **Proactive, planful focus.** Most of the range of services people need to rebuild their lives are not crisis oriented, and yet accessible holistic teams tend to become crisis driven as staff react to people inundate them with pressing needs. Much specialist work - like medication management, job and housing development, and budgeting – tends to need to be proactive and planful. To the extent that specialists are drawn into the daily crisis our specialist work suffers. Team leaders must consistently be emphasizing long term goals and plans and pushing staff to avoid becoming overly reactive.

6. Management structure. Managing a diverse array of both generalist and specialist staff working in interlocking teams and supervision structures challenges our managers. Our organizational chart has become a crazy quilt and it has been difficult to maintain accountability for the drudgery tasks (like billing and charting) that no one wants to do. Balancing inclusion and transparency with efficiency and tightly bonded managers is an ongoing struggle. Should more or less people be included in management meetings? When is "protecting your staff" from destructive outside influences disempowering them?

7. Culture. It is crucial for staff to feel that their work has meaning and that being "productive" means more than creating billable service hours. We've tended to rely heavily on culture instead of policies

and procedures to promote both meaning and accountability. With a strong culture staff tends to respond to stimulus because of their alignment to organizational principles "the way things should be done" and managers value and reward staff based on shred meaning. Staff feels ownership of the agency and loyalty towards it. Conversely, in a weak culture where there is little alignment with organizational principles, control must be exercised through extensive procedures and bureaucracy creating an antagonism between staff and managers. Creating and maintaining a strong culture requires our managers, and others, to be strong, principle based leaders.

8. Services driven by people's goals. If an agency is really going to have people's goals drive their services, instead of people having to chose from the services that are provided, it has to be a flexible integrated services agency. Conversely, one of the best ways of integrating services is to have the services flow out of people's goals. If several staff are all providing services, for example, medications, substance abuse support, employment, housing and financial planning, that are in service of one goal of a member "to be able to get and maintain an apartment of my own and be a good neighbor" their services are more likely to be integrated than if they are all working on separate treatment plans and goals. Each staff's importance in a given situation is dependent not on their degree or position, but by how much they can contribute to helping the person achieve their present goal. As goals change, importance changes. Also, staff will often find themselves exploring new things and creating new services on the fly as they work with someone to pursue their goals.

Two closing thoughts:

Once an agency becomes principle driven, it must pay the price of never feeling like they've totally completed the job or are fully competent. Unlike an agency driven to provide a certain amount of housing or employment or serve a certain number of people – targets that can be achieved – principles can never be totally achieved. This inevitable falling short can be either demoralizing or drive them to keep learning and doing things better.

In order to have a sustainable organization, a good "business model" should focus on the intersection of three factors: 1) What are you passionate about? 2) What are you good at? And 3) What can you get paid for? These questions are much easier to answer when a program is focused than for an Integrated Services Agency. This discussion has, in retrospect, tried to answer these questions for our integrated services. MHA-LA exemplifies how, with ongoing struggle, integrated services can thrive and be sustained.