USING COLLABORATIONS AS A CAPACITY BUILDING TOOL

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FOREWORD

The Victorian Alcohol and Other Drug (AOD) sector has undergone a period of almost constant change, and this appears set to continue. Managing change can be challenging, and during these times it's easy to forget the value and power of relationships in an environment where agencies are asked to compete with each other for funds, services and even clients. In response, the Victorian Alcohol and Drug Association (VAADA) produced the 'Capacity Building and Change Management – A guide for community services' in early 2016 which was designed to offer services an overview of how they might go about best implementing some of these changes. It noted, but did not fully explore however, the power and value of collaborative networks and relationships.

As we grow and develop, we need to think more creatively about how we can better utilise our limited resources to continue to address the complex needs of our client populations. Experience from other jurisdictions tells us that developing systems to encourage sectors and agencies to work with one-another more collaboratively has benefits to clients in relation to improving shared care treatment pathways, as well as for cost-effectiveness to services. Systems which encourage inter-sectorial collaboration also promote the pooling of knowledge, and workforce development opportunities for clinicians.

In this new manual VAADA presents a step-by-step guide to enhancing collaboration through the development of relationships and partnerships between service providers, through the use of systems such as alliances and networks. The manual incorporates knowledge obtained from available literature, together with drawing upon the experiential learnings of a successful alliance in the Eastern Metropolitan Region of Melbourne.

VAADA would like to thank and acknowledge the Australian Government Department of Health and Bronwyn Williams, Eastern Health and Cathy Keenan, Department of Health and Human Services for their time and expertise in assisting VAADA to produce this latest resource.

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CONTENTS

1. PURPOSE

This manual aims to provide AOD services and staff and other cross-sectoral agencies with a resource to assist in the establishment of alliances and partnerships in your local areas. Alliances can be developed with a range of purposes in mind, but this resource focuses on capacity building. Most not-for-profit agencies receive funding which is only to be utilised for direct service provision, yet effective and higher quality service provision is unlikely to occur without capacity building activities such as resource and workforce development.

2. INTRODUCTION

We live in a world of limited funds and resources, yet the need for additional supports in communities is increasing. Not-for-profit organisations are constantly being asked to achieve more with less. They must prioritise the development of more efficient, effective and sustainable ways of working and delivering services. Governments are continually looking for cost-effective propositions.

In recent years there has been increasing recognition that client-centred approaches reflect best-practice, and that they promote better outcomes for clients. Contemporary health and community services are seeing more people presenting with multiple and complex issues such as AOD, mental health (MH), family violence (FV), forensic issues, and homelessness to name only a few. As well as being specialists in their own fields, workers must develop a broad range of skills so they can meet the various needs of their clients and consumers.

The development of a more client-centred approach means that organisations must learn to work with each other in a more integrated way. This means developing working relationships with agencies and organisations outside their own sectors, whilst keeping the consumer as central, to tailor effective treatment pathways and responses to meet the needs of their client groups.

There are lots of ways that organisations can work well together, with building alliances and partnerships being cost-effective, sustainable and yielding numerous benefits. To achieve great outcomes via alliances and partnerships, organisations and funding bodies must be committed to developing a shared vision of what they want to achieve and be prepared to invest at some level in the longer-term.

> ***"For many nonprofits, building their own capacity is operationalised by leveraging relationships with other organisations in a network, which offers an antidote to the challenges of limited funding by providing access to vital resources, expertise, and peer support."*** (National Council of Nonprofits, 2015 pp 3)

Alliances are created for a range of reasons, depending on needs, but to be successful their purpose should be clear from the outset. Depending upon their strategic standpoint, alliances can operate to present a united position to agitate for change even at the political level, or they can simply concentrate on improving client services. Implicit in the creation of alliances and networks is the notion that their reach goes beyond that which can be achieved by individual agencies.

Given the current importance of not-for-profit agencies being able to find innovative ways to cost-effectively increase capacity, the focus of this handbook is about establishing collaborative relationships to undertake capacity building activities.

We define capacity building as being **"an improvement in the ability of public sector organisations, either singly or in cooperation with other organisations, to perform appropriate tasks".** (Leeder S. 2000 in Determine Consortium, 2009 pp 3)

In addition, like any new initiative, creating and building a capacity building alliance or partnership means implementing change at some level. This means that those involved need a working knowledge of change management. This should include an understanding of how to identify and overcome any potential barriers that could occur during the process, as well as any positive benefits to be built upon.

This resource provides you with a step-by-step guide to setting up your own local capacity building alliances, based on what we already know works to illustrate how it can be done.

If you feel that you need to revise your knowledge of capacity building and change management and how it might relate to building an alliance, you are strongly encouraged to read ***Capacity Building & Change Management: A guide for community services*** published by the Victorian Alcohol and Drug Association in 2016. (click here to access)

3. ABOUT ALLIANCES

3.1 What are they?

'Alliance' is a term which is used interchangeably with other terms throughout the not-for-profit, community sector. They are also known and referred to as networks, collaborations, communities of practice, groups, councils, and associations. All these words are synonyms, however in some instances there are some subtle differences between them.

Their size, type, role and the tasks they undertake will vary depending on variables such as the number of organisations involved and the scope, but they are almost always established to encourage the achievement of the common and shared goals of their members. Establishing a clear shared agenda is critical to an establishing an effective alliance.

Alliances can exist both within the different programs of larger organisations, between organisations in one sector, or across numerous sectors.

An alliance/network can be broadly defined as:

> ***"A group of people or autonomous organisations which choose to work together collectively to achieve not only their own goals, but the collective goals of the network as a whole."*** (Mollenhauer, Johnston and Gates, 2011 pp 2)

Alliances can involve staff participation from all levels of management and clinical settings, in addition to consumer representatives. We will cover this later, in particular how to involve and support consumers throughout the process of both establishing and maintaining your alliance.

There are slight differences in language and naming, but for the purposes of this manual we will use the words 'alliance' or 'network'.

Other terms include:

- Alliance vs Coalition - Alliance is more about mutual interests or benefit, while coalition is more about doing some action (Lave & Wenger 1991)
- Council: a body of persons specially designated or selected to act in an advisory, administrative, or legislative capacity
- Collaboration: Cooperative arrangement in which two or more parties (which may or may not have any previous relationship) work jointly towards a common goal
- Association: a group of people organized for a joint purpose.

Liebler and Ferri (2004) note that despite these differences in naming, that there are some general characteristics of alliances. These include that they are created for a variety of purposes and embody a variety of structures, they have formal and informal associations, and that they are more than just a resource centre for their members.

3.2 Why do we need them?

Alliances are generally established across regions to achieve what cannot be done at the individual service level. Most not-for-profit organisations do not receive any specific funding for capacity building activities, yet there is a growing expectation that they will deliver services which are integrated, better co-ordinated and meet the complex and often diverse needs of clients/consumers.

Integration is in itself a complex concept, and one which appears to have different meanings in different settings, and whether it is internal, or external to an organisation. Generally speaking though, integration is designed to promote connectivity between and within sectors to enhance quality of care and quality of life. (Kodner and Spreeuwenberg, 2002)

ALLIANCES ARE NEEDED:

- To share information and resources
- To reduce costs and promote load sharing
- To promote collaboration between different organisations (both formally and informally)
- To encourage the development and maintenance of integrated referral and clinical pathways
- To promote service co-ordination
- To provide shared workforce development opportunities
- To enhance relationships between organisations and alliance members.
- To encourage increased visibility of issues and best practice
- To increase strength and address power imbalances

Remember, this list is not exhaustive! There are many other reasons why alliances are needed, and how they can be of benefit to you in your own region.

Michael Savic et al (2017) identified a series of strategies which could be used to improve an integrated care response for clients. These included:

Funding: system investment, inter-departmental partnerships within government and integrated working in service specifications.

Organisational: interagency relationships, co-location of services and common agency goals.

Service delivery: Staff training, information sharing, case-management, referral and professional networks.

Clinical: Screening, joint care planning and staff supervision.

Their research also indicated that implementation of these strategies was enabled by the cultivation of positive inter-agency relationships.

3.3 Types of alliances

Types of alliances vary depending upon the reason that they were set up, and their size. Alliances may be Formal or Informal.

Formal:

These alliances will often have been established with an overarching framework to provide leadership and promote sustainability in the longer term. The alliance will have structures such as clear Terms of Reference about its shared vision, as well as other factors such as rules of membership, meeting schedules and the roles and responsibilities of participants. Joining the alliance might require a formal expression of commitment including the signing of documents such as a Memorandum of Understanding (MOU) or partnership agreement. Some formal alliances also request financial contributions.

The level of organisation within a large formal alliance is not finite. Some formal alliances are so organised they even progress to adopting strategic plans, communications and activity plans, and methods for their own evaluation. The main difference however between a formal and informal alliance is that the decision-making responsibilities are more clearly delineated in formal alliances.

An example of a larger formal alliance is the Eastern Mental Health Service Co-ordination Alliance (EMHSCA). This partnership was established to improve collaborative care planning between clinical and community services in the Eastern Metropolitan Region of Melbourne and create pathways to care. Now with 25 partner organisations, EMHSCA has expanded over 10 years to include Aboriginal services, AOD, Family services, Homeless/Housing, Family Violence (FV), Community legal, Private sector Mental Health (MH) and Primary Health services amongst others. We will use this alliance (and how it was established) as the benchmark when we later describe how to establish your own.

Click here for EMHSCA

Another formal alliance in Victoria is the Change Agent Network (CAN). It was established in 2014 by the Department of Health and Human Services, in collaboration with a range of services including Turning Point and VAADA. It utilises a Community of Practice model to support the AOD workforce and promote sustainable evidence-based practices with measurable outcomes.

Click here for Turning Point

Click here for the Change Agent Network

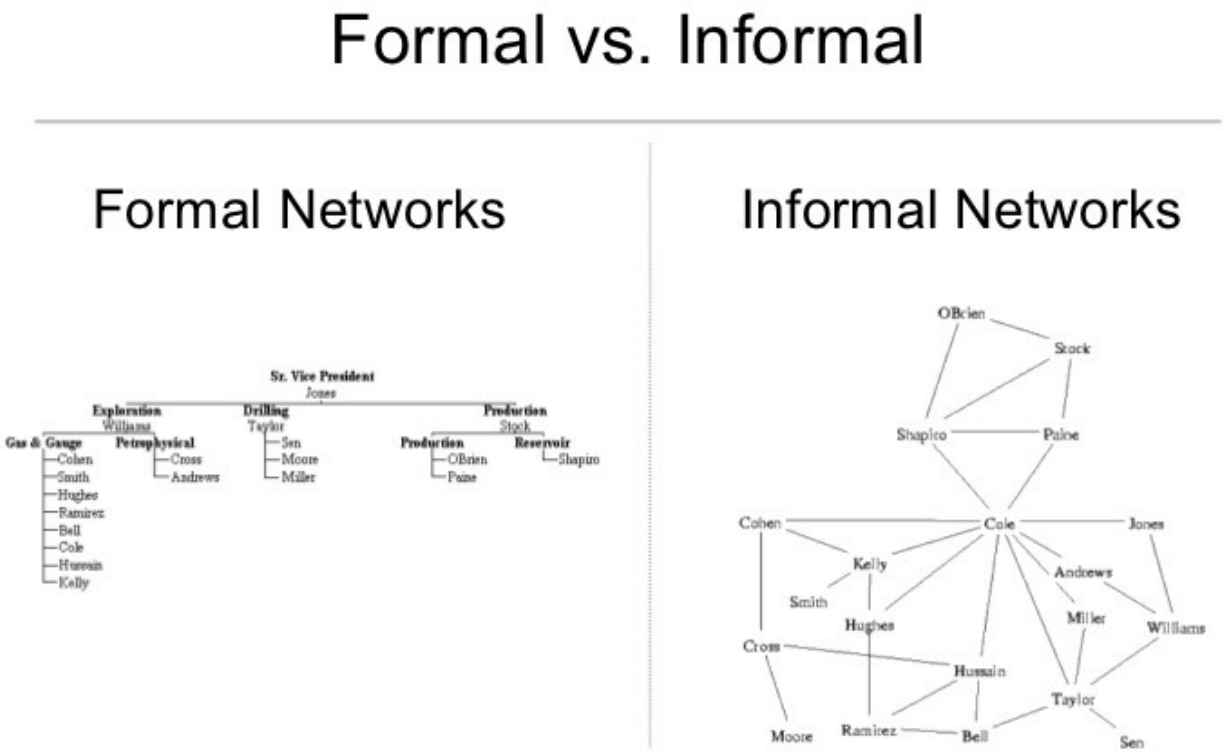
Informal:

Informal alliances and networks often arise in response to a local need, specific case or situation. Some might have developed their own Terms of References, however they do not require any formal agreement between participants.

They are less structured and rigid than formal ones, with a focus on the sharing of information and knowledge, promoting reciprocity between their members and collective intelligence. Their effectiveness varies however depending upon their level of cohesion, and the achievement of goals can be dependent upon the relationship between its members making them harder to manage and their success less reliable.

Whether or not you wish to set up a formal or informal alliance will depend upon what you want to achieve, how many resources you have and how many organisations and people are involved.

Funding is always an obstacle to setting up formal



alliances, although this issue can be mitigated if all organisations involved agree to contribute funds. In addition, **"every formal network also has an informal network, but not every informal network includes a formal network."** (Van Kempen, 2015)

3.4 How are alliances formed?

Alliances can be formed in a range of ways, with the two most common being 'top-down' or 'bottom-up'. This depends upon whether the idea is generated at the 'big-picture' sector or area-wide level, or whether it is a concept developed at practice level and built upon from there.

Top-down:

The process of establishing alliances in response to "top-down" initiatives is usually driven by a policy direction from government, or by senior managers from within one or more organisations. In relation to the latter, direction to establish the alliance might either be reflected in a Partnership Agreement at the senior level between the organisations, or within the Strategic and Program Plans of the agencies involved.

EMHSCA , CAN and the family violence related Risk Assessment Management Panels (RAMPS) are all examples of top-down alliances. In each instance the Victorian State Government made funding available for their development, but there would be the usual guidelines and rules around expenditure and reporting against project deliverables and outcomes.

Bottom up:

These are the most common type of alliances, and often result from relationships forged by clinical/front-line staff seeking information around best-practice techniques for their clients, to establish better referral pathways, and to address power imbalances.

Through the process of staff and clinical supervision their supervisors can be lobbied to approach middle/senior managers to meet with the managers from related organisations and then commit the agreements and resources required.

VAADA facilitates several alliance meetings with key cohorts within the AOD sector across a range of specialist areas. The TORs of the alliances vary, however most have been established to bring together representatives from each cohort to share information, resources, support and ideas, and hear about each other's practice. These alliances include intake providers, non-residential withdrawal nurses, specialist pharmacotherapy and a registered training providers group.

4. GETTING STARTED WITH YOUR OWN ALLIANCE

4.1 Establish the need

You will require resources to set up and maintain your alliance, and to successfully obtain these you will have to demonstrate that there is an unmet need within your region through a scoping or baseline audit exercise. Some of the basic questions that you need to answer include:

- Why do we need to establish an alliance?
- What is the problem we are trying to solve?
- What is the purpose, the goals and actions required?
- What data/information do we need?
- How do we collect this?
- What will be the cost?
- Importantly, you should also ask, is an alliance the best means of solving this problem or unmet need?

Map what is currently available in the region to identify what services there are already in the area and ensure that you are not doubling-up or working at cross-purposes with existing alliances and groups.

The Queensland Council of Social Services (QCOSS) has developed some resources which are available from their website to assist you in this process:

Click here for QCOSS

Click here for Assessment Tool for Collaboration

Once you have completed your scoping exercise/audit compile and analyse your data, draw your conclusions and make your recommendations about how to address the gaps and problems you have identified. (Capacity Building and Change Management, 2016)

A scoping exercise will be necessary if you are:

a) Responding to a small tender/grant application. In this instance you will be answering some specific questions about already stated needs and goals, and how you would meet them, or

b) Surveying potential stakeholders to obtain the evidence to support the views/theory that you have formulated based on your experience and knowledge.

Once you have clarified and confirmed your ideas about unmet need you will be able to determine what type of alliance you wish to set up. For example, whether the alliance is state-wide or within your organisation's Local Government Area (LGA), whether your alliance is going to involve organisations from your own sector alone, or whether it could be cross-sectoral (with representatives from AOD, MH, FV etc.) The potential size and role of the alliance will also be dependent on what resources that you have access to.

Prior to undertaking any work on a new venture or project it is important to gain endorsement from your own agency. If the senior managers/CEO of your agency are unaware or do not fully support what you are trying to do, it is unlikely to succeed.

The most successful projects happen when there is investment from both the top down and bottom up of an organisation.

4.2 What resources do you need?

To set up your alliance you need to ensure that you have the resources to work towards meeting your goals. In your proposal you will need to identify what resources you need (e.g. people, time and infrastructure such as use of meeting rooms and computers etc.), and the list of resources should also include estimated costs for each item. Through the process of identifying the costs involved you will be able to determine whether your own organisation can meet the costs, whether all the involved organisations will need to 'chip in', or whether you will need to seek assistance from an external funding body.

The best way to represent these costs is by putting together a proposed budget which clearly outlines each task/item together with an estimated cost in the required time-frame. This will give your managers or an external funding body a clear indication of the financial level of commitment they need to make.

Share your resources wherever possible. The funding you seek will need to be enough to support a worker. For example, AOD Catchment Planners are not currently funded for full-time positions. Several agencies have entered into partnerships across catchment regions to allow for the employment of full-time workers who can work across several regions. This arrangement has a range of benefits for both agencies, and ultimately the provision of services to clients.

4.3 Approaching funding bodies

Funding bodies will only consider your request if

they can see that your proposal will directly result in improved practices, which in turn will promote better outcomes for clients.

Frame your proposal so that it relates to issues that are current and topical, and considers the systems that need to be put in place to achieve your goals. Look at existing structures and roles undertaken by agencies and workers, and also explain how your proposal can assist these functions, wider systems and clients. You should also identify any processes already in place from which you can leverage some cost free benefits.

Develop your own checklist of step-by-step questions to be answered:

- Does your proposal clearly outline how you intend to translate your ideas into practice? What are all of the steps involved to make this happen and how will you implement them?
- How will your proposal result in improved outcomes for clients, and what will these outcomes be?
- How does your proposal meet overarching funding body policies and objectives? For example, will your proposal result in better service co-ordination practices within your region? If so, list the potential outcomes of these.
- Is your proposal a priority in the current climate of service provision? For example, the funding body might be developing a response to an issue such as family violence. Is your proposal going to add value to this?
- Provide your own definition of capacity building. How will your initiative support the development of local systems?

Identify the shared agenda items of the partnership that may attract funding in the current political climate and tender for resources as they become available.

Alternatively, you can develop a proposal to be submitted to a funding body at any time.

4.4 Who do you involve?

Identify your partners and stakeholders. These will be the people who will be doing the work, and who will have an interest in the potential outcomes of the alliance.

In relation to agency staff, involving as many stakeholders as possible lends legitimacy and commitment to the process. Stakeholders can inform planning, and you can delegate tasks to them. They provide valuable input, and if you involve different 'layers' of management and clinical staff, you can obtain a good perspective of the potential impact of your project objectives from all areas. Stakeholders can also help identify risks and assist in reducing any potential risks involved with the project.

Through involving and listening to your stakeholders you will get their 'buy-in', which will help to promote the success of the alliance in the longer-term. Your stakeholders should have reviewed the draft deliverables as you progress, therefore their final endorsement should be a formality in the end.

Stakeholders will generally include:

- Clinical and frontline staff
- Project Managers
- Senior managers
- Clinical managers
- External specialists
- Other organisations

(Capacity Building & Change Management, VAADA 2016)

4.5 Consumers and Co-design

The importance of involving consumers in an activity such as this cannot be understated. Consumers' ideas and views are based on a lived experience of the system, often giving them a unique insight into some of the issues faced by individuals when they present at service-delivery organisations.

There are various levels of consumer participation ranging from little, through to consumers having full control over their decision-making (Arnstein, 1969). The reality is that one size does not fit all, and that the level of consumer participation will depend on the task to be completed. Regardless of the level of participation however, it should be a meaningful process for all involved and there should be capacity within the alliance to accommodate consumers' feedback and expectations.

More recently "co-design" has been adopted by governments and the not-for-profit sector as being

the gold standard for participation by all stakeholders, including consumers.

> ***"The community services sector has adapted co-design to combine lived experience and professional expertise to identify and create an outcome or product. It builds on engagement processes such as social democracy and community development where all critical stakeholders, from experts to end users, are encouraged to participate and are respected as equal partners sharing expertise in the design of services and products."*** (NCOSS, 2017 pp 1)

Put simply, co-design means joint decision-making, not just token consultation with consumers.

The difficulty faced by many organisations though is how to engage and support consumers.

There are also a number of practical issues which should be considered such as their role, how they will be oriented to the work and how they will be remunerated.

Depending upon which sector you are operating in, there are organised consumer groups which can provide you with some guidance on these questions:

The Association of Participating Service Users (APSU), a program of The Self-Help Addiction Resource Centre (SHARC): Click here

Victorian Mental Illness Awareness Council Inc.: Click here

Tandem Inc.: Click here

Council for Homeless Persons: Click here

Thorne Harbour Health: Click here

Co-design Case Study

The Eastern Dual Diagnosis Service (EDDS) has been active in developing and promoting service provision for clients presenting to both AOD and MH agencies with dual-diagnosis problems for over 15 years. Its work has included partnership building, resource development and education and training across the region in addition to providing primary, secondary and tertiary consultation to local agencies.

An active cross-sectoral component of the EDDS is the Dual Diagnosis Working Group (DDWG), which is a cross-sectoral sub-committee in the Eastern Metropolitan Region (EMR) of Melbourne, with membership that initially included local AOD and MH agencies, APSU and Victoria Police. This committee commenced in 2010 with the objective of developing a consumer committee, which was later to become the Dual Diagnosis Consumer and Carer Advisory Council (DDCCAC).

The DDCCAC was then established to work directly in tandem with the DDWG to provide a consumer and carer driven action plan, supported by a committed group of mental health and AOD leaders.

The establishment of DDCCAC involved:

- The development of "job descriptions" for council members.
- The development of guidelines as to how carers and consumers would be supported in the role (e.g. if they became unwell).
- Orientation and induction procedures (e.g. Service systems across the eastern metropolitan region, chairing meetings, taking minutes etc.).
- Advertising for consumer and carers across organisations.
- Job interviews conducted by members of the DDWG.
- Establishing the amount and method of remuneration for attendance.
- The development of Terms of Reference (TOR). From 2014, both the DDWG and DDCCAC adopted a joint TOR. Click here

The committees now meet on the same day, with back-to-back meetings. This allows representatives from DDWG to sit in the DDCCAC meetings and vice versa, ensuring a joint approach to decision-making whilst maintaining space for each committee to discuss separate perspectives.

From 2018 representatives of the Victorian Dual Diagnosis Leadership Group (VDDILG) will attend the DDCCAC meetings to encourage greater consumer and carer participation at the state wide level. The VDDILG consists of CEOs and managers from each dual diagnosis service in Victoria and a VAADA representative.

4.6 Develop a Leadership Group/ Reference/Advisory Group

Convening a leadership/reference/advisory group is not a necessary stage of developing a small alliance, however in a larger group it will bring you additional skills and knowledge, and assistance with sharing the workload. This will become particularly relevant if you wish to establish a larger, cross-sectoral alliance.

You can invite representatives from agencies within your sector and/or cross-sectoral agencies depending upon your ideas for the purpose of the alliance, and its size. Representatives can also include experts from other regions or even academics who have experience in translating research into practice.

Your advisory group will be instrumental in assisting you with the following:

- Drafting Terms of Reference (TORs) for the advisory group and your proposed alliance.
- Facilitating relationships and partnerships with other agencies.
- Developing all other supporting documentation such as Memorandum of Understandings, Strategic Plans, Communication Plans, guidelines and procedures, and audit templates etc.

4.7 Developing your TORs

For a small alliance without a reference group you will need to do this on your own, however a reference group will provide you with a collective 'brains trust', which will make obtaining agreement from your stakeholders easier.

So what do you put in TORs?

Generally, TORs define the background, purpose and scope of the project, with a statement about the shared goal and the work to be done. They guide the workings and responsibilities of the reference/working group, in addition to the expected outcomes of the project.

The following example of the Table of Contents is by no means an exhaustive list of what can or should be included, depending upon what is needed for your project.

An example of a TOR can be found: here

TOR example Table of Contents:

1 Background
2 Objective
3 Scope
4 Membership/Stakeholders
5 Time schedule for the project
6 Meeting schedules

5. BUILDING YOUR ALLIANCE

5.1 Create your vision

Exactly what do you want to achieve by creating an alliance? What do you see as being the potential outcome of the process?

You can develop your vision statement with the assistance of your reference group, but be mindful that it must resonate with all of your stakeholders so involve them to give ideas and provide feedback where possible.

Your vision will give the process of establishing an alliance direction, and will help to ensure that the project stays on track.

5.2 Identify and target your alliance partners and participants

Who will you involve in the alliance?

Having undergone the process of scoping, establishing the need and defining your vision will have given you strong ideas as to who the alliance should include. At least some of your reference group members are likely to be from those agencies, and this will also make it easier for their senior managers to be approached for agreement when you are ready to sign your Memorandum of Understandings (see 5.3, MOUs)

Be clear about what level of participants you want to attend. In a larger alliance having all layers of managers and clinical staff promotes a sense of inclusion and the flow of information. As we mentioned previously having a range of managers, clinical staff and consumers ensures that everyone has a voice, and that a wider range of ideas and potential issues are discussed and managed.

Invite your participants, meet with them and provide as much background as you can about the project to encourage them to participate.

5.3 Memorandum of Understandings (MOUs)

MOUs are a great way to involve your stakeholders, and get them to commit to investing the time, energy and resources to establish and maintain the alliance.

An MOU is a document that records the common intent of two or more parties where the parties do not wish to assume legally binding obligations. An MOU is usually less complex and less detailed than a contract, but provides a framework and set of principles to guide the parties in undertaking a project or working arrangement. (Victorian Government Solicitor's website, retrieved 11012018)

5.3.2 Functions of MOUs

MOUs can assist government departments and agencies clarify roles and responsibilities and manage expectations associated with projects and endeavours that are to be undertaken with other government parties or non-government parties. Non-binding MOUs may be terminated without legal consequence in some circumstances. This flexibility is considered to be a significant advantage for government.

(Victorian Government Solicitor's Office website, 31072018)

5.3.3 Why have an MOU?

There are lots of reasons to have MOUs:

- MOUs clarify roles and responsibilities, and boundaries. They set the basis of "who does what".
- They promote commitment, and accountability on the part of participants.
- They allow for partners to exit the partnership without any legal ramifications.
- The negotiation of an MOU does not necessarily require legal advice.
- MOUs can be as detailed or as general as you like, and they can be as formal or flexible as you want.
- MOUs can include agreement for financial contributions from each party to assist with establishing and maintaining the alliance.
- They do not need to be complex or long.

An example of an MOU can be found: here

The establishment of smaller, informal alliances might not require MOUs to be signed. In a larger alliance which has been established for a specific purpose over a longer period of time however, we would advise you to get your partners to commit to the relationship through signing an MOU. This will reduce the likelihood in the longer term that commitment will 'drop off' and/or that the organisation will continue to contribute at the level that they have agreed to. The specification of roles and responsibilities in MOUs also allows for clear

boundaries to be set and maintained as to who does what, and when.

5.4 Strategic Planning

Not all alliances and networks will require the type of detailed planning involved with strategic planning, however in a larger more formal group a Strategic Plan provides the overarching platform from which you can develop your other plans (Communications, Action, Training etc.), and identify the steps involved with their implementation.

The Alliance that we mentioned previously, EMHSCA operated for over six years prior to developing its own Strategic Plan, but we would recommend that undertaking this as part of your initial planning process would be more beneficial. A Strategic Plan can be developed by inviting all your alliance/alliance members to a facilitated/guided workshop and brain-storming the content. It is also best to involve staff from all levels of service provision including clinicians so that a range of perspectives can be considered and agreed upon.

A clearly articulated Strategic Plan will also allow you to identify what other resources, and structures you might need in place to support your alliance.

It will also act as a platform from which you can identify all the activities that you need to undertake, who will be responsible and what your time lines will be.

Store all your plans in a place where they can be accessed by the parties involved but be sure to have processes in place to manage version control. An online shared repository is a useful means of achieving this aim.

5.5 Evaluate

Evaluation should always be included in your initial plans, not just as an 'add-on' at the end. This allows for continuous checking as to whether the project is on track as you progress, and it will enable you to evaluate outcomes on an ongoing basis. Undertaking evaluation at specified points throughout the project will also provide you with additional benefits. These include providing an evidence basis for ongoing funding submissions and allowing you to review your strategic objectives where necessary.

There are numerous systemic methods of undertake evaluation, and within your own organisation you might already be using tools to measure your work as part of quality improvement and accreditation processes. If this is the case, plan how you could use your own organisational tools and systems to assist with evaluating the progress of the alliance. In doing this you can also incorporate some of the results from your alliance evaluations as evidence for your quality improvement and/or accreditation.

Don't forget to include data in your evaluation planning. What data will you need to collect to measure and demonstrate that your alliance is achieving its activities and goals?

Where, and from whom will you obtain the data? Who will collect it? Any agreements about data sharing will most likely need to be specified in your MOUs.

One tool that has been demonstrated to work well within organisations is Plan-Do-Study-Act (PDSA), also known as Plan-Do-Check-Act.

This is from the work of W. Edwards Deming, in Moen and Norman, 2010.

This tool outlines not only how you plan and implement your project but emphasises the importance of reviewing and reflecting what his happened, and how you integrate those learnings into adjusting your goal and changing direction into the future.

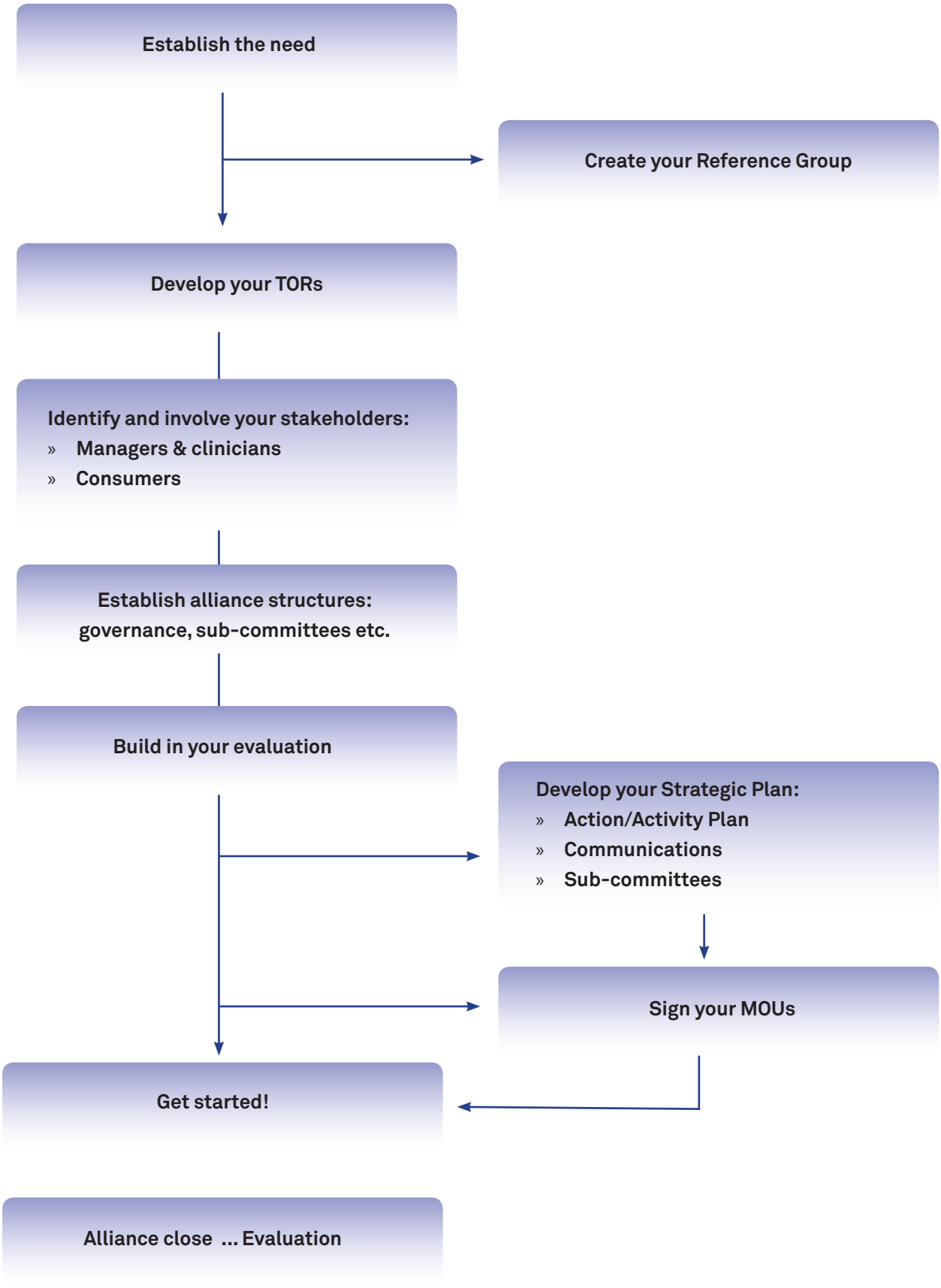
A more detailed description of these steps can be found in VAADA's Capacity Building and Change Management Manual, 2016 pp 34. (click here to access)

5.6 Timelines

Your evaluation should give you an indication about the progress that you have made in achieving the goals of the alliance. Depending upon the purpose for which they were established, some alliances will be ongoing, however others will have been implemented for a finite time period.

If the goals of your alliance have been achieved and the needs met, then consider whether your alliance needs to continue. The time and energy that is required to keep the alliance running might not be worth its continuance, or it might be that you elect to utilise the existing structure of the alliance to take on another project.

SETTING UP YOUR ALLIANCE FLOWCHART



5.7 Managing your alliance

Once your alliance is successfully up and running there are some other things that you will need to consider.

Who will assume responsibility for managing and 'driving' the alliance if you are unable to? If your alliance has a funded project officer then this will not be such an issue in the short-term, however if the funding is withdrawn after a period of time then what contingency plans might you need to make to ensure the alliance's longer term survival? Systems to replace members who leave should be built in to your plans. This can be included in your MOUs that the responsibility rests with each agency to replace their staff member.

How will new members be inducted? In a larger alliance it is advisable to develop an orientation package for the new member so they have a clear understanding of what the alliance is all about, what will be expected of them and who to contact to obtain further details. The package might include the TOR, a list of participating agencies and a calendar of the scheduled meetings for the year. A clear indication of suitable membership (e.g. for decision making, active participation etc...).

Collate all your information and resources into one, easy to access spot for both members of the alliance and the general public if applicable. If you do not have the funding to develop your own website (which most services do not) then obtain agreement from your lead organisation to include it as a page on their existing website. Share your resources as far and wide as you can across regions and with other groups.

Regularly communicate with your members and stakeholders to maintain interest. If you have the time and resources create a newsletter, or if not send out regular updates via email. Use aids that give you feedback about what is being viewed such as Mail chimp to monitor your progress. Offer video and web-conferencing if you are able to encourage attendance at meetings.

Over time you can start to think about what other functions the alliance/alliance might fulfil. For example, after a period of time EMHSCA identified some areas of priority for future development, so subcommittees who manage workforce development, collaborative pathways and strategic planning were then implemented.

APPENDIX
The EMHSCA experience

1.1 Background

In the eastern region the Dual Diagnosis Service commenced in 2002. In the first few years it became clear that in order to support people with mental health and substance use issues effectively, the service sectors needed to be aligned and better integrated. The Dual Diagnosis Linkages emerged out of this need in late 2007 and continue today with over 100 members from a wide range of health & community services across the region. This occurred around the same time that the Eastern Health Adult Mental Health Service (EHAMHS) and Psychiatric Disability Rehabilitation Support Services (PDRSS) formed the Eastern Mental Health Alliance which aimed to support the delivery of more accessible, appropriate and coordinated mental health services to improve the experiences of mental health consumers, carers and practitioners. In 2008 Mental Health alliances were funded across the state. They were variously supported by the regional Dual Diagnosis Services and initiatives. When MH Alliance funding ceased in 2010 so did many of these alliances. In the east we were fortunate to have departmental support to continue as a funded alliance and our focus broadened to include a wide range of health and social services.

Since 2010, the Eastern Mental Health Alliance has continued to expand to include a wide range of other regional partners to support a stronger focus on mental health service coordination across the service system. The range of sectors includes Alcohol & Other Drugs (AOD), Homelessness & housing, Family services, Family violence, Aboriginal services, Primary and Community health, Consumer advocacy and legal services and is supported by the Department of Health and Human Services (DHHS). This alliance serves all parts of the inner and outer east and is now well known across the Eastern Metropolitan Region as EMHSCA.

The focus of EMHSCA has been the implementation of improved systems and processes to support service coordination for the benefit of people with mental health and other co-occurring concerns. Alliance members have introduced these improvements to their organisations following a process of collaboration with EMHSCA sub committees.

1.2 Structure

The 25 EMHSCA partner organisations are signatories to the EMHSCA Memorandum of Understanding (MOU). This document has existed for 10 years and is reviewed every 3 years. The work of EMHSCA is guided by the EMHSCA Strategic Plan.

To support the achievement of the EMHSCA objectives as described in the Strategic Plan, three sub committees have been formed:

» Collaborative Pathways,

» Workforce Development,

» Strategic Planning.

These groups routinely report to the EMHSCA committee which consists of more than 40 leaders from EMHSCA member organisations who have a decision making capacity. The various work plans for the sub committees can be located on the EMHSCA Shared Repository: here

The EMR Dual Diagnosis Response has a reporting relationship with EMHSCA. This enables the work of the various Dual Diagnosis groups in this region to be disseminated via the EMHSCA member organisations.

These sub committees consist of members of the EMHSCA member organisations.

The EMR Dual Diagnosis response consists of:

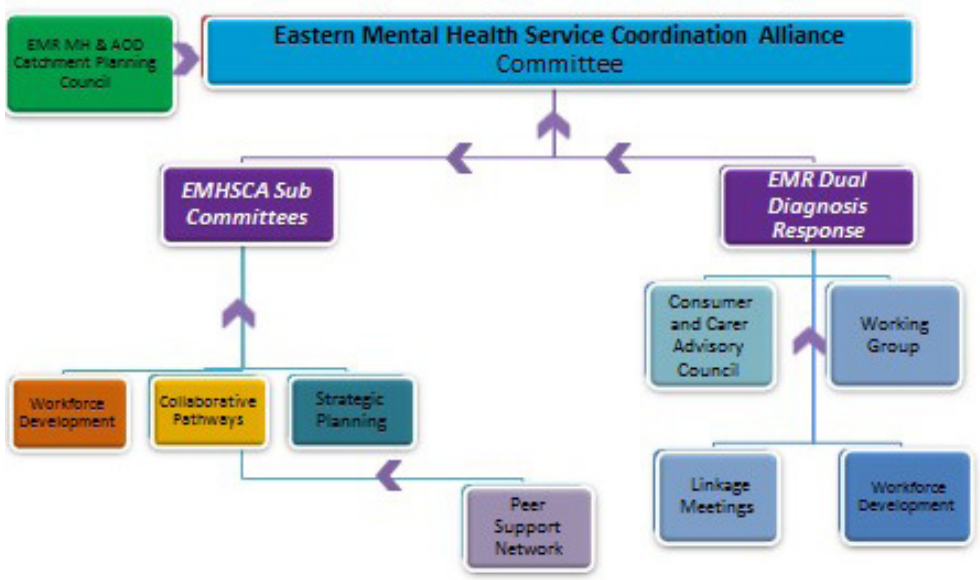
» Dual Diagnosis Working Group,

» Dual Diagnosis Consumer and Carer Advisory Council,

» Dual Diagnosis Linkage meetings,

» Dual Diagnosis Workforce Development.

The EMR MH & AOD Planning Council has a communication mechanism with EMHSCA via shared membership and standing agenda items allowing for routine reporting across projects. The aim is to align and complement rather than duplicate priorities. Similarly, the Eastern Peer Support Alliance, an EMHSCA initiative, reports to EMHSCA via membership on the EMHSCA committee and the standing agenda item. Interested groups who are seeking improved collaboration but not currently aligned with EMHSCA are invited by the project officer to present at EMHSCA meetings. A number of these engagements have led to EMHSCA



membership. The SPSC provides the mechanism to consider membership requests.

1.2.1 Consumer and Carer involvement

Partnership with the Dual Diagnosis Consumer and Carer Advisory Council (DDCCAC) provides a means by which EMHSCA can seek advice from Peer advisors with a lived experience of mental ill-health and substance use issues. A process has been developed to ensure coproduction and co-design of EMHSCA activities via the DDCCAC. The DDCCAC is represented at EMHSCA committee meetings (leadership group) and the DDCCAC and DDWG report routinely to EMHSCA.

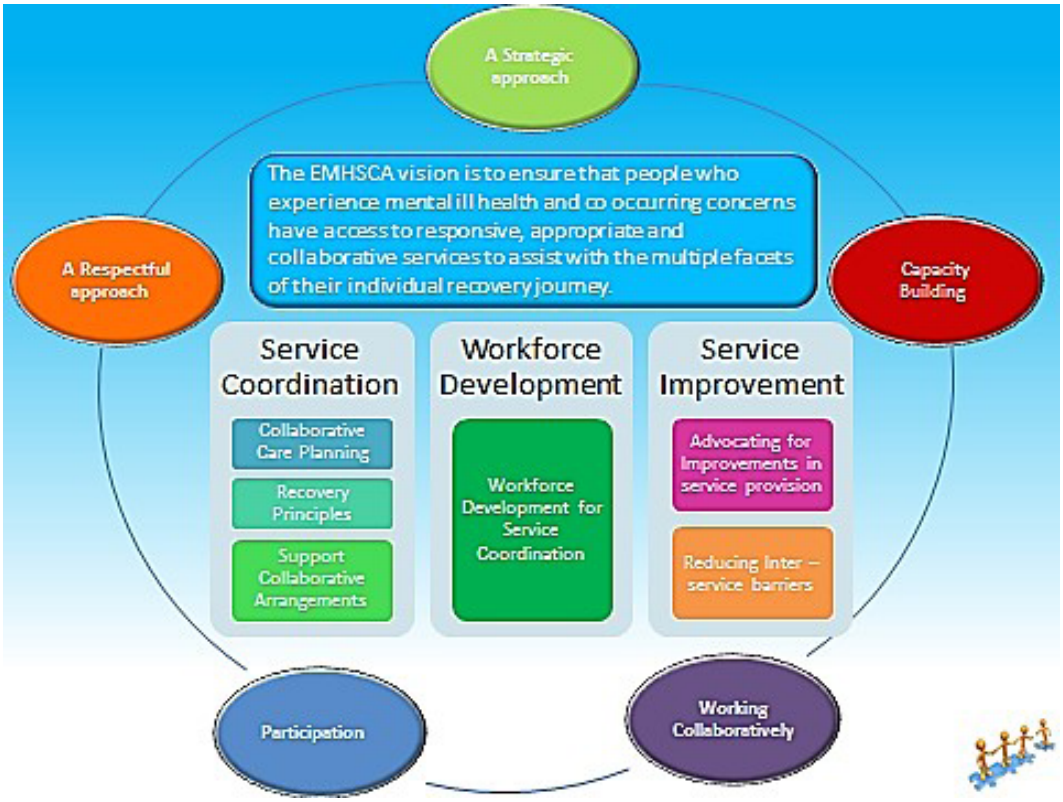
1.3 Strategic Planning

In 2013 EMHSCA looked at the idea of Collective Impact via a workshop facilitated by Dawn O'Neil. This lead to the development of the EMHSCA shared agenda. A Strategic Planning Subcommittee was formed with the intention of identifying regional priorities for Mental health service coordination across sectors and the vision was clarified.

The EMHSCA committee has agreed on their shared agenda for 2017-2019 (pp.15-19). There are many potential areas of focus for this functioning Service Coordination Alliance. However, the success of EMHSCA may be attributed in part to its ability to identify and maintain its scope of activity. The Strategic Planning subcommittee has considered the top six priority areas nominated by EMHSCA committee members and aligned them to the existing EMHSCA structures.

Work plans have been developed to provide further consideration to these key areas and actively address them as part of the EMHSCA Mental Health Service Coordination framework (pp.26-41).

As EMHSCA organisations continue to traverse the changing landscape of multiple service reforms including the National Disability Support Scheme, the EMHSCA continues to create opportunities for members to work strategically with a broad range of services, consumers and carers across the EMR to improve outcomes for people with mental health and co-occurring concerns.



1.4 Key work

As well as providing a platform for various health and social initiatives and planning in the region, EMHSCA has initiated a range of activities to support improved service coordination.

A number of key pieces of work remain the foundation of this alliance. The regional Shared Care Protocol; The region wide Service Coordination focussed Workforce Development events; The Shared Care Audit; and the Eastern Peer Support Alliance.

1.4.1 Shared Care Protocol

The regional Shared Care Protocol was developed in 2008 between Clinical and Community Mental Health Services. This protocol was updated in 2010 to include Alcohol & Other Drug, Family and Homelessness services and revised in 2013 for the use of all services involved in shared care. The protocol describes expectations, requirements and processes for shared care by EMHSCA member agencies/programs, with the objective of improving outcomes for consumers, their carers, impacted families and children.

The protocol includes guidelines on the collaborative practices:

- For service providers when working together with shared consumers.
- For the development of Shared Care Plans.
- For appropriate and effective sharing of information between parties to the Shared Care Plan.

1.4.2 Workforce Development

The EMHSCA Workforce Development Committee develops, provides, and evaluates Mental Health Service Coordination capability training for all services involved with EMHSCA. All events include peer workforce participation as a priority. The focus of these events is Recovery oriented and person centered Service Coordination with reference to the EMHSCA shared care protocol and its key principles of collaboration.

Background

In 2008 the Eastern Health Mental Health Alliance Education & Training (EMHA E&T) Committee was convened as a sub-committee of the Eastern Mental Health Alliance Group in order to develop and provide training that would enhance the collaboration between Mental Health services in the Eastern Metropolitan Region (EMR) who were engaged in working with people recovering from severe and enduring mental health concerns.

Over the past 8 years the focus of the committee has been refined to provide workforce development to EMR services involved in service provision to people who experience mental ill-health and aims to enhance service coordination in the region.

Activities

In 2017 EMHSCA provided five events as follows:

1. Collaborative Care Planning Workshop – for up to 70 staff to explore the principles of collaborative care planning and familiarise themselves with the elements of the EMHSCA Shared Care Protocol. This solutions focused event involves presentations by a G.P, allied health, a consumer who workshops their recovery plan, peer workforce, and a carer.
2. A Region-wide orientation - for over 200 new and existing staff to learn about the various services provided referral pathways, intake processes and an opportunity to alliance.
3. The Dual Diagnosis Consumer & Carer Advisory Council and Working group in collaboration with the Eastern Peer Support Alliance provided the annual peer workforce forum to over 120 people.
4. NDIS, Mental Health and Partnerships – Making it work together in the east! forum – More than 250 people attended this new event as part of the EMHSCA strategy for supporting services through system change and preserving partnerships in a changing environment.
5. "Bridging the Divide" Mental Health & Co-occurring Issues Explored (MHACIE) Workshop – An opportunity for up to 70 participants to consider how to approach complexity in the system as they work with people with multiple concerns.

In previous years a Leaders' Collaborative Care Planning workshop has been provided to leaders in the region to support their understanding of the need for collaborative practices and discuss ways of supporting their staff to engage in them.

To fund these events a small contribution is made by each member agency and administrated via the project officer.

1.4.3 Shared Care Audit

It is well established that provision of integrated care to people with multiple and/or complex needs is ideal. It is important that we monitor our shared care practices in order to improve the quality of our service provision to people with multiple and/or complex needs. The aim is to collect local data in order to examine the current level of shared care practices in the Eastern Metropolitan Region. This audit aligns with the EMHSCA Shared Care Protocol and is the key outcome measurement tool.

This data assists with organisational management regarding planning and improvements to service provision. EMHSCA has been conducting the Shared Care Audit annually since 2014 involving over 6000 client files from 16 partner services. A Consumer Care Planning Survey now supports the file audit.

1.4.4 Peer Alliance

The Eastern Peer Support Alliance was formed in 2015 to bring together the regional peer workforce in a similar way to the EMR Dual Diagnosis Linkages for general staff. The aim is to support the unique role of peer workers and reduce isolation. This group is coordinated by a person with a lived experience of mental ill-health and substance use and it has a direct relationship with EMHSCA. The EPSN coordinator is a member of the EMHSCA committee (leadership group).

1.5 Project support

The success of EMHSCA relies heavily on the funded project officer role. The Department of Health and Human Services in the Eastern Metro Region has identified funds to support the project officer role and Eastern Health has auspiced the role. This role was initiated in 2007. The project officer coordinates all of the EMHSCA activities and facilitates the EMHSCA committee and sub committees. For more information about the EMHSCA please contact Bronwyn Williams who is the current EMHSCA project officer Bronwyn.williams@easternhealth.org.au.

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