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Making sense of complex policy worlds using interpretive methods

Title of the paper

Mental health policy for severe and complex needs: the utility of an interpretive approach in understanding program implementation.

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Abstract

In 2011 the Australian Federal government announced a new mode of mental health support for people with severe and complex mental ill-health: Partners in Recovery. This program aimed to address a mental health and social support system which was fragmented and overly complex.

Our study evaluated PIR in two regions in Western Sydney with high rates of mental ill-health and social disadvantage. Using interpretive methods we conducted 101 interviews at three time-points over three years in order to understand the implementation of the program within this complex setting. Our analysis showed that Support Facilitators developed their role around processes of connection and communication that made sense in their own local contexts.

Keywords:

Interpretive analysis, policy, mental health, Australia

Introduction:

This paper focuses on the implementation of an Australian national mental health program for people with severe and complex mental ill-health called Partners in Recovery (PIR). The AU$549.8 million PIR program was announced in 2012, to be implemented Australia-wide by local consortia of government and non-government organisations within 61 Medicare Locals, which were the meso-structure established in the Federal Labor government's attempt to build greater integration across Australia's fragmented system of primary care. The government stated that the aim of the program was to address a mental health and social support system where "severe and persistent mental illness is not adequately integrated or

coordinated, and people with complex needs often fall through the resulting gaps". The government aimed for PIR to:

> "…support people with severe and persistent mental illness with complex needs and their carers and families, by getting multiple sectors, services and supports they may come into contact with (and could benefit from) to work in a more collaborative, coordinated and integrated way." - (DoH, 2014a)

These quotations are presented with little variation in multiple PIR guidance and information documents (e.g. DoHA, 2012a; DoHA, 2012b; DoHA, 2013) and encapsulate both the policy problem and its proposed solution.

The policy problem

The primary policy problem stems from the complexity and fragmentation of mental health services, which leads to people falling through gaps or unable to navigate the labyrinth of funding models and service providers. Government announcements launching or promoting PIR positioned the health and social support system for mental ill-health as one riddled by "holes", "gaps", "cracks", wrong turns and disconnection through which individuals must battle (Butler, 2012). The Labor Health Minister of the time, Mark Butler, who stated that "The last thing people with severe mental illness, their families and carers need is to battle with multiple service systems." He blames this on a "lack of coordination" which led to people "falling through the cracks" (Butler, 2012; Butler, 2013). Multiple PIR policy and implementation documents also emphasise these problems:

> "One of the most consistent themes fed back to the Australian Government is that care for the most vulnerable people with severe and persistent mental illness is not

adequately integrated or coordinated, and people with complex needs often fall through the resulting gaps." - (DoHA, 2012b, p.10; DoHA, 2013, p.9).

In contrast PIR was to provide "Coordinated Support and Flexible Funding for People with Severe and Persistent Mental Illness with Complex Needs" (DoHA, 2012, p.4) to address systematic *in*coordination, *in*flexibility and complexity. The policy problem is therefore a problem with two parts. One is the mental health system ("multiple sectors, services and supports") (DoH 2014a). The other is those with "severe and persistent mental illness". While the government do not direct blame in the documents for system complexity, Australian community based mental health care is made significantly complex by receiving funding from both federal and state levels of government and the provision of services by government and non-government actors working across health and social care:

> "Addressing severe and persistent mental illness requires a complex system of treatment, care and support, requiring the engagement of multiple areas of government, including health, housing, income support, disability, education and employment. The Australian and state/territory governments as well as the nongovernment sector, all deliver programs for people with mental illness and their carers. Building a coherent system of care is a challenging task."
>
> - (DOHA, 2012b, p.10)

The PIR client is also seen as the source of the problem with their "complex needs", their propensity to "fall through the gaps", and their "disconnection" (DOHA 2012; PIR 2013). They are also seen as prone to "extensive reliance" on multiple services (DoH 2014b).

The policy solution

The policy solution to these problems was to derive a system based on coordination and collaborative working implemented in local regions and based in consortia of government and non-government actors already working in the sector. The *Funding Guidelines* for PIR describe the PIR approach as having four elements, as described here:

> "The ultimate objective of the initiative is to improve the system response to, and outcomes for, people with severe and persistent mental illness who have complex needs by:
>
> - *facilitating better coordination* of clinical and other supports and services to deliver 'wrap around' care individually tailored to the person's needs;
> - *strengthening partnerships and building better links* between various clinical and community support organisations responsible for delivering services to the PIR target group;
> - *improving referral pathways that facilitate access* to the range of services and supports needed by the PIR target group; and
> - promoting a community based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental illness with complex needs."
>
> - (DOHA, 2012b, p.4, emphasis added)

The first three elements of the solution relate to coordination, partnerships, pathways and access. The solution is framed in the language of systems, but in implementation documents

these systems are anthropomorphised and actions given to key new roles with the fix only possible if those in these roles take action and embody the change that needs to take place.

The key roles of the new system are: 1. the partners working together in the local consortia; and 2. Support Facilitators (SFs) who are employed by the consortium to carry out the day-to-day work of PIR with clients (DoHA, 2012a; 2012b). The SF role, described further in the results below provides a brokerage model of case-management, identifying consumer needs and then identifying those publicly available services which would meet their needs, buying in services when needed through a pool of flexible funding. In doing so they were to provide "the benefits of system collaboration" (DoHA, 2012b, p.6) to clients and, to do this effectively, "support implementation of PIR within the region" (PIR, 2013, p.6).

Given the key positioning of SFs within the PIR implementation project an investigation of the SF role provides an interpretive lens through which to visualise the ground-level implementation of PIR. In this paper we demonstrate the use of an interpretive approach in our work by demonstrating the way that it allowed us to focus in on the SFs in order to understand policy implementation more broadly.

Interpretive policy analysis – why it was right for this project

Our research team was commissioned to evaluate PIR in two regions in Western Sydney by the local consortia operating in those regions. A national evaluation had already been commissioned which would evaluate the program as it was implemented across all regions, however our funders were interested in a more realist evaluation approach which took into consideration the context in which the policy was being implemented. An interpretive

approach to policy analysis appeared to offer us the tools to do this by considering the local complexities which might influence the program implementation.

Traditional models of policy making and analysis

Traditionally in Australia policy knowledge problems have been understood with reference to malfunctions apparent in the application of ordered, hierarchical policy, best represented by Bridgeman's adaptation of Laswell's 'policy cycle'. The policy cycle is the organizing concept in *The Australian Policy Handbook*, published since 1998 (most recently 2013), and widely used by Australian policy actors (Colebatch, 2005; Althaus, Bridgeman and Davis, 2013). This positivist view of policy making removes from view the messiness of the mixed motivations of individuals who must enact the policy in local settings. It can end up in a mechanistic schema that reduces policy change to the location (and pulling) of appropriate 'levers' (Grace, Meurk, Head, Hall, Carstensen et al, 2015). Colebatch (2005) critiques the 'policy cycle' thus:

> "The dominant paradigm presents government as a process of authoritative problem solving: there are actors called governments, they confront problems and make choices, which are then enforced with the coercive power of the state. This defines the 'normal expectation' of government, and in so doing, discloses 'problems'. Government is meant to be coherent, so if different public agencies have multiple and conflicting agendas, this is evidence of a 'problem' of 'fragmentation'. If the work of the bureaucracy cannot be presented as the execution of commands from superiors, this is a 'problem' of 'control'."

In other work Colebatch has argued that a reliance on the policy cycle sets up artificial accounts of policy making: "the model sets up a gap between the different sorts of

knowledge which officials hold, between 'sacred' accounts, which emphasise authority and purpose, and 'profane' accounts, which focus on conflict and its continuing management" (Colebatch, 2005, p.19; Colebatch & Degeling, 1986). Instead, it is argued, policy in practice cannot be fully comprehended without an understanding of day-to-day implementation (Colebatch, 2005) and the work of the individuals who are involved in that implementation – work that is "discursive, embodied, embedded, radically contingent [and] deeply interactional" (Gheradi, 2011: 58). Exploring policy at this micro level leads to an comprehension of how policy shapes local practice and the ways in which seemingly rational health policies become irrational through implementation.

Interpretive Policy Analysis (IPA) is an approach which seeks to understand how policy is interpreted and put to use in practice. IPA has developed as a challenge to the positivist accounts of policy making referred to above and had its naissance in the 1980s and 1990s through the work of theorists such as Torgerson (1985; 1986), Palumbo and Calista (1987; 1990) and Yanow (1990; 1993; 1997) whose focus was on the 'problem' of implementation. Yanow (1993) writes that policy implementation problems relate to difficulties of interpretation of policy meaning. This interpretation is integrally an embodied process where people draw on their existing knowledge and the contexts in which they work. It must therefore be understood through reflecting on the actions and understandings of those people implementing the policy. Yanow states (1993, p.41) that an interpretive approach "calls on us to ask: what does a policy mean; to whom…does it have meaning; and how do various interpretations of meaning affect policy implementation?" Her 1997 book *How does a policy mean?* encapsulates the IPA approach – the focus is not on 'what' but 'how'. In this paper we demonstrate the way that we have used IPA in a practice evaluation to understand

the practices of policy implementation from the perspective of those who were charged with its implementation

Our evaluation of PIR

Because our task was to provide a large-scale program evaluation over a three-year period we utilised a broad range of methodological approaches in data collection including interviews with providers, stakeholders and consumers, statistical data collection and a system mapping exercise. The research aimed to evaluate PIR via the following five research questions:

1. Who are the clients using PIR and what are their needs?
2. To what extent are those clients of the PIR program experiencing an improvement in their unmet needs and their overall recovery?
3. Is there any evidence that the mental health system and human services system more broadly in the two regions becoming more connected as a result of the implementation of the Partners in Recovery program?
4. What does the use of Flexible Funding data tell us about client needs and how these needs were met through the use of these funds?
5. What can we learn from PIR which will assist with the implementation of the National Disability Insurance Scheme[1] for the PIR population?

We used a variety of qualitative and quantitative tools to answer these research questions and our approach to data collection was flexible and adaptive in order to allow us to address new research questions as they became important over the course of the project. We

describe all of the data collection methods here to provide an understanding of where interpretive methods fit into the overall project design.

An IPA approach was most apparent within our methodology in our sampling choices and the questions we sought to answer through data collection. We were interested in on-the-ground experiences of PIR and how it was established in an existing sector. We therefore chose to speak to those doing the implementation and those stakeholders directly engaging with the project. Our interview questions were also focused on the practices of implementation and the motivations, knowledge and experiences of those involved in the implementation.

Quantitative de-identified data

The first and second, fourth and fifth the research questions were answered through gathering de-identified but individually coded data from validated measures of need (Camberwell Assessment of Need Short Scale – CANSAS), and personal recovery (Recovery Assessment Scale – Domains and Stages (RAS-DS). We also gathered matched demographic and other health-related data on those consumers using PIR. Case study data was collected for a cross section of WSPIR clients which included referral, demographic, outcome data and flexible funding expenditure data. Data on the use of Flexible Funding for the needs of individual clients were also downloaded. Referral data and other information on communications between the consortium members was used for a Social Network Analysis to answer question 3.

Qualitative Data - Interviews

The third, fourth and fifth research questions was answered through interviews with key actors in mental health within the Western Sydney region. Follow up interviews were conducted annually over a 3 year period (2014-2016) in order to gauge system changes. We interviewed 101 respondents as per the box below.

Initial interviews – 40 conducted. 52% were conducted with PIR staff (Support facilitators, team leaders and consortium members). The remaining 48% were conducted with PIR stakeholders.

Progress interviews – 41 conducted. 53% were conducted with PIR staff (Support facilitators, team leaders and consortium members). The remaining 47% were conducted with PIR stakeholders.

Final interviews – 20 conducted. 55% were conducted with WSPIR staff (Support facilitators, team leaders and consortium members). The remaining 45% were conducted with stakeholders and PIR flexible funding grant recipients.

Interview questions:

Interview questions were developed which sought to provide a map of the service field engaged with PIR, the knowledge that they draw on and produce in their work and the mechanisms for establishing collaborative relationships with PIR in this setting. The questions were adapted as the project progressed in order to address emerging issues and reflected the interests of the funders, our own research interests and developing contextual issues that had been observed as impacting on the progress of the sector. A full list of the interview questions at each stage of the research is provided in Appendix A.

Additional data collection methods:

These core parts of the project were supplemented as the project progressed by a consumer satisfaction survey and interviews with consumers who received the PIR program to understand what the concept of 'recovery' means to them in the context of PIR. We also worked on a mapping project which mapped the community services provided to people with severe and complex mental ill-health in Western Sydney. This was used in order to identify gaps in services, particularly in relation to the needs identified by people receiving PIR.

Interview analysis

All interviews and documents were thematically analysed according to research questions utilising the basic analysis approach outlined by Braun and Clark (2006). Results have been structured according to the research questions and quotations to illustrate the data have been provided with possible in order to more clearly translate the meaning of the data to the reader (Coffey, 2015; Gill & Colebatch, 2006).

In this paper we focus on the data produced through the interviews as this was the aspect of the research for which an interpretive approach was most useful.

Results

These results focus in on the experiences of SFs in the implementation of PIR and the way in which they were portrayed by other stakeholders in the process. The results are structured around four key themes that emerged from the data – who the SFs were, the construction of the SF role, the tools and strategies used for implementing PIR and barriers to doing so.

<u>Who were the SFs?</u>

The personal qualities required of SFs are described in the PIR Guidelines produced by the Federal government, which state that "In undertaking their roles effectively, PIR organisations and their staff (including Support Facilitators) will need to…be confident… communicate… negotiate… analyse… share [and] engage" including "with people who have often been difficult to work with" (DoHA, 2012, p.7). They are told that in order to successfully implement PIR they must "possess personal qualities such as humane concern, empathy with both the client issues and service provider experience, imagination, hope and optimism." These individuals must first embody the qualities of PIR if they are to be able to model and transmit its goals to those inhabiting the fragmented, gap-ridden, complex mental health landscape.

The SF role was not associated with a particular degree or training background as it was designed to be a generic case-management role which did not have clinical responsibilities. SFs came from a variety of training, work and volunteering backgrounds including nursing, psychology, homelessness services, disability, psychology, policy, refugee advocacy and social work (13)[2]. These backgrounds gave them a broad range of skills that were "based on a position description" rather than qualifications [SF4]. When directly asked about what knowledge they drew on in their work most did not mention training but rather spoke about 'experience' or 'own knowledge' or mentioned previous work roles [SF2; SF8]. The diverse backgrounds were viewed as a valuable resource for SFs in allowing them to understand problems from different perspectives and to access contacts established in previous roles (11), as one SF commented:

> "I've worked for different programs and I've also known people from different programs, so it's good for me to say, hey, I'm so-and-so, can you help me with this client? They will help me if there is a spot." [SF7]

Several SFs stated that own personal experience was valuable for the role (5) including their own experience of mental ill-health and as carers for family members.

In contrast to the otherwise consistent SF view that their diversity of backgrounds was an asset, two respondents commented that a lack of clinical experience could also present a barrier to their acceptance in the field, especially from clinical mental health services, for example one person mentioned: "I've been asked my background and my qualifications. I feel like saying pole dancer." [SF5] and another: "…you go into a clinical team and say, I'm from Partners in Recovery and they go what are your qualifications? You say why is that relevant? I'm not diagnosing anybody. I'm not medicating anybody. I am supporting them." [TL1] This resistance to the new PIR workers entering a traditional clinical setting reflects the challenges that SFs encountered in negotiating a new space for themselves, and by connection PIR, within an already established system.

<u>How did SFs build the role?</u>

The SF role was a new role with only a limited template provided for how the role should function beyond the basic guidelines referred to earlier. It was a new role within the sector and the SFs therefore had to not only find out what the role should mean to them and how it should function, but to relay that role identity to the sector with which it was attempting to engage.

Six respondents emphasised the interconnected nature of SF work. SF2 spoke about the role of the SF being something that they "build" in the 'talk' and through the development of a collective SF team: "we talk about everything. We share…. It is developing that team…". While SFs held and used their individual knowledge which they drew on to make connections they also worked as a team with other SFs and TLS across the consortium and this greatly enhanced their practice through the sharing of experience and knowledge:

> "It's SF, team leader knowledge and networking and sharing information essentially. So we have a very large breadth of knowledge across the whole [team]…. So they all bring with them that knowledge… and you share that and so the kind of the depth of knowledge has just developed". [TL1]

> "…we work together as a team, so it's a combination of drawing on the collective experience of [our] colleagues…" [SF11]

> "the other knowledge that we do draw on is a reliance, I suppose, on everyone. Share their knowledge." [TL4]

This peer support between SFs who worked at "sharing and encouraging each other" [TL3] was viewed as key to the development of the role and its success in the field. Three respondents went so far as to speak about a shared identity between all SFs in their region. For example: "…all the SFs are there for the consumers and we're all there because we want the best outcomes for these people. So we're more than happy to share our knowledge and experience with each other." [SF6] This establishment of a common SF identity helped to strengthen the SFs when presenting themselves and the work of PIR to the field.

SFs also spoke about the difficulties associated with being in a role that was new to the system [SF3; SF5; SF8], for example:

> "I think one of the challenges could be that it's a very particular type of role that you do that hasn't – it's not something that you can kind of go, oh yeah we're a case manager, or oh yeah – it doesn't fit…" [SF3]

They expressed difficulty in getting those outside of PIR to understand this role and in differentiating it from existing roles in the system: "I think some of that's been based on role, a sense of we're doing the same thing, so what are you doing that we're not." [SF8] Getting their clients to understand the limits of this new role also meant that they sometimes went beyond its limits:

> "So then it's very easy to turn into a support worker. I try really hard not to, but sometimes you are like look someone is trying really hard to do something. I'm going to take them – for example to their appointment because it's raining and they're near…" [SF5]

The role of a support worker is about intervention by the worker and therefore has a different role to a support facilitator. This role establishment was, understandably, prominent in the early interviews but less significant in the latter interviews as PIR became more accepted as part of the mental health and social care landscape.

<u>The work of SFs: communicating, connecting, meeting</u>

The daily work of the SFs centred around meeting and connecting in order to establish themselves and PIR in the system. Most of their time was spent in establishing connections through individual meetings with clients and other practitioners, attending interagency

meetings and SF forums, site visits, connecting online and committee meetings. SFs met face to face with PIR clients in order to establish their needs and follow up on whether these were being met or had changed. They also met with fellow SFs and consortium members through intra-agency meetings and met with practitioners from other organisations in order to establish interagency connections. These connections were made with the aim of familiarising the sector with PIR, validate their place, to encourage referrals (of new clients) and to secure referrals (for current clients) to relevant services (which can be space limited). The process of making and concreting connections was thus the most pressing task that SFs dealt with in their jobs and was at the heart of their work.

Stakeholder accounts held personal connections as primary in system collaboration around the PIR intervention (Stakeholder 12, Stakeholder 9, Stakeholder 10; Stakeholder 16). Personal connections were seen to "strike up a relationship" that could then be drawn on further as needed (Stakeholder 9). This is also related in the following quotations:

> "I'd put money on the reason that Partners in Recovery in the [named region] get referrals is because they went out and they sourced referrals and they met with people and they discussed - like they came to us and really, really wanted to get involved and link. They come to one of our meetings every week… You've got a guy or someone from PIR ringing you, PIR ringing up saying 'hey, you know, my name - I'm from PIR, I'd like to come and meet with your team'." (Stakeholder 10)

> "it's always better, that face-to-face stuff, than just getting it in an email that you don't get time to read." (Stakeholder 1)

These personal connections were made in individual meetings and through collaborative working groups.

Interagency connections

The most frequently cited types of forum in which connections were made with external services were interagency meetings (12). Interagency meetings are commonly used in community health and social care to bring together various organisations working in a particular area, such as those dealing with homelessness and drugs and alcohol dependency, to share information about difficulties, successes, needs and so forth. For example, "we're talking to lots of different services … all these places that have the same thing happening, working with consumers that have issues with hoarding and squalor and about how they're supported." [SF3] Participants explained that some interagency meetings focus on a particular place or client group and all those services who deal with that group will attend, for example, "It's a combined inter-agency, so you've got age mental health, housing, pretty well everything" targeting a particular locale [SF2]. SFs reported using these interagency meetings to: get services to refer clients to PIR; make contacts which they could then use to find services for their clients; and to educate the sector about the role of SFs and PIR (12). The interagency meetings were therefore key to the functioning of PIR and core tools for developing broader understanding of the role of SFs. They operated as ways to channel into the consortium knowledge from the broader sector and consolidate knowledge being collected by SFs in their interactions with clients.

Intra-agency connections

Another commonly cited forum for sharing knowledge and structuring the PIR program as it progressed were groups involving all the SF and TLs in a PIR region (5). These forums were used by SFs to share knowledge about a particular topic, or to invite in a guest speaker to provide information about a topic relevant to the work of PIR:

> "…every month or so we've had each of the host agencies organising presenters from the different services that are out there to come in and speak with the wider team…. [or] a wider team meeting where all of the support facilitators and perhaps the team leaders as well can share some information or have discussion about what's going on and what are the areas of concern." [TL2]

> "Yeah it is very helpful because in that forum sometimes they invite services like Centrelink, could be Housing or…the psychological team to come and give us information about a specific topic." [SF1]

The SFs also presented client cases in the forums. They did this for two main reasons. First, to illustrate or exemplify the work that they were doing with a particular population (e.g. hoarders [SF3]), and second to draw on the knowledge of the assembled group in assisting their work with a particular client [SF7,SF10]:

> "…basically if someone's a bit stuck with someone they can just bring that client and everyone can contribute and see what we can come up with…. So this way if someone's really stuck on something they have somewhere to take it and they've got a room full of people who are passionate." [SF10]

> "…we do have support facilitators meeting every month and we share good stories and difficult… We can talk to people and see what type of client challenges they've got and what type of service challenges they've got. We could be learning thinking, oh we work in a different way, but this is all right too…. there was comparison and also there was learning there too." [SF7]

SFs and TLs use these meetings to assist each other to meet individual client needs, but also to learn and change practice based on the experiences of other SFs, building together shared effective practices for service delivery.

The ability to draw on fellow SFs' background knowledge, connections and developing knowledge about the field was the key driver for the establishment of SF and TL forums for sharing knowledge. This was a further way of developing the role and ensuring that PIR was able to effectively understand and operate in the field.

Connecting for clients.

In finding services for clients SFs drew on multiple connections, for example those made through their previous work (8), the connections held by their organisation (3), their fellow SFs or current clients. Three respondents spoke about their interactions with current clients helping to extend the PIR network and develop links useful to other clients [SF9,SF4, SF8]. Focusing on the client was thus also a means of extending the PIR network: "…you have an individual and then because of that individual you might then talk to four or five different services. That I suppose opens up those conversations to further working." [TL1] All of the contacts were viewed as important because they extended the PIR network and may be useful for future clients or in getting new referrals to PIR. A good relationship with current clients could even lead to referrals through that client:

> "I had one consumer who I ended up getting through a consumer advocate who had worked with me with another consumer, and had kind of been talking about Partners In Recovery, and then had convinced another consumer who didn't really want support, that we were okay and we weren't so bad." [SF8]

Free communication is important

Free flowing communication via phone and email was viewed as particularly important to the effectiveness of the SF role (10). One SF spoke about the importance of "open communication and using all the communication tools. So…using the phone – sometimes just texting even – email – fax; whatever it takes to communicate with everyone." [SF3]. This was mainly used for working with existing networks, contacts or working groups in order to track down information to help clients:

> "We just ring each other if we're stuck for a service and we'll send out an email saying 'hey, I've got this, I'm looking for a great female GP in the [local] area, does anyone know of one?' ...people will look and see if they have a contact that they've already worked with" [SF6].

One TL stated that quick flow of communication was so important that they consciously chose to fit out their SFs with the best tools for communication available: "…we're equipping our support facilitators and our team with laptops and mobile phones and iPhones and that kind of stuff" [TL2].

<u>The challenges and barriers faced by Support Facilitators</u>

Respondents articulated a range of barriers to their work. The most consistently reported barriers related to communication difficulties and confusion or resistance in the service community about what PIR had to offer.

Communication difficulties

Poor communication was viewed as a significant barrier to SF work. This can be seen as natural given the great importance on communication for establishing connections to bring

in client referrals and find services to work with PIR clients. Areas of communication difficulties were identified between the central PIR consortium management [SF2; SF5; SF9; TL2] and SFs or between the stakeholder organisations and PIR [SF2, TL1, SF5, SF9]. One TL stated that they felt "frustrated" when they could not provide effective communication supports or knowledge flows for the SFs [TL2]. Communication was so integral to the SF role that their work in connecting could not be done without effective communication taking place.

Communication difficulties with stakeholders was also a barrier to the work of the SFs. The reasons were variously given as confusion or scepticism about PIR, a history of competition in the sector, stigma and process difficulties internal to the stakeholder organisation. Respondents pointed out poor channels for communication to stakeholder organisations (for example could not ever speak to the person they needed to) [SF9], or other operational issues effecting the organisation. One respondent recounted an interaction with a stakeholder which included non-response, wrong documentation, repeated requests for further information, lost referrals, silence and then a final interaction: "called them a month later and they said there's a six-month waiting list and that's because of PIR." [SF5]

PIR and credibility: Scepticism about PIR and what it had to offer

As a new program important into an existing sector PIR destabilised the existing relations in the sector and SFs found that they had to justify the program as part of their work of connecting. Confusion or "scepticism" [SF8] about PIR was mentioned by five respondents. SFs described feeling that PIR was viewed by others as lacking credibility because it was a new program in the sector [SF3]. The struggle for SFs then was in "having other people know what we do, and getting that credibility about how we do it and what we're doing and the

point of it. The job of SF is very different to other jobs." [SF3] One respondent stated that "trying to have those conversations and sort of gain an understanding of what PIR does has been really difficult in that area, in my opinion." [SF4] Part of the difficulty could be, as discussed earlier, the "attitude of an individual service" [TL1] and resistance to what was deemed as PIR's incursion into another organisation's territory:

> "We're trying new things, they hate us because we are like yeah we are going to do this and they are like no you are no, we've been working with this person for 10 years. So it's really convoluted and grey and very messy." [SF5]

For this reason, SFs described needing to be 'strategic' in their approaches to the field [SF9]. Confusion was also expressed about the distinctive contribution of PIR "There are a lot of services out there, so filtering – having PIR being filtered through the noise of those other services so that they are the ones that people think of [is] going to be a challenge" [SF11]. Constant outreach involving presentation of PIR methods and goals was seen to be the key to "break through that noise" [SF11].

Respondents reported that it was particularly difficult to make contact with certain types of service for example GP practices or clinical services [TL2, SF9, SF4]. This was either because they were isolated or resistant to PIR operating within a traditionally clinical setting: "Clinical services don't respect us [because] we're an NGO." [SF5] Conversely non-clinical services which SFs needed to make contact with to address a client's non-clinical needs could be resistant to working with PIR because of stigma towards working with people experiencing mental ill-health [SF5, SF6, SF9].

Historic competition in the sector around funding was another disabler to the connecting work of SFs. While one respondent commented that the collaboration through PIR and other

joint collaborative projects was breaking this down, it was still something that stopped effective communication and connections being made: "…historically a lot of these NGOs, a lot of these services [are] competing for tenders, competing for funding, it's intellectual property, we want to look after ourselves and make sure [we do] all the capacity building ourselves and that kind of stuff." [TL2] Another respondent emphasised these intellectual property concerns "…people can think that you're trying to see what they're doing in their work… that you're making a judgement." [SF3] These historical divisions which had separated the system were thus a significant barrier to SF attempts to join it up again.

Over-reliance on individual connections.

Personal connections made between individual SFs through meetings was seen as important by both SFs and stakeholders for establishing PIR in the sector. However these personal connections were seen as unreliable in some circumstances. One respondent spoke about the difficulties they encountered when they had to rely on an individual SF to "do their bit" with a client. They felt that sometimes official structures such as MOUs were needed so that organisations were accountable (Stakeholder 13). Reliance on personal connections was also seen as problematic in the context of high staff turnover. When staff left connections made needed to be built up again, sometimes from scratch. (Stakeholder 3; Consortium 4; Stakeholder 10; Stakeholder 1). "One on one" connections were good but needed to be sustained beyond the individual level (Stakeholder 9). Interagency forums were seen as an antidote to this, allowing knowledge to be translated in such a way that when an individual leaves the knowledge keeps going (Stakeholder 14).

Discussion and conclusion.

SFs were the key identity charged with establishing PIR in the system. Our discussion of their experiences provides an account of the establishment of a new role from within and their attempts to then embody the new PIR program through their interactions with the sector. They describe meeting and connecting through multi-disciplinary forums and through their interactions with clients and they describe the challenges to this establishment, which came in the form of poor communication and conflicts with established hierarchies.

PIR was a new program in an existing sector – one that by all accounts was fragmented, dis-coordinated and producing poor outcomes for clients. Within the discourses surrounding PIR service, fragmentation and the navigation difficulties faced by clients were constructed as an effect of poor communication across the system – often seen in vertical terms - resulting in contradictory and poorly articulated constructions of the problem (Gardner, Banfield, McRae, Gillespie, & Yen, 2014). Difficulties in formulating problems and translating potential answers from one setting to another – the 'wicked' question problem well understood by policy actors – had resulted in most jurisdictions being flooded by a 'torrent of top-down actions' through previous programs but with little effect on the problem (Hannigan & Coffey, 2011). PIR broke from this centralist model of knowledge transfer and offered a fix to coordination based on local interactions. It set out national program guidelines, but much of the content – and even decisions about information systems for client management – were left largely to the local consortia who were best able to make decisions about their implementation context. This meant that SFs responded to the interests and needs of their local consortia and those circumstances when they entered the field to implement the program.

In the regions in our study a focus on local actions has been successful in the translation of PIR to some parts of the community mental health sector. However there have also been difficulties arising from the centrality of individual SFs in implementation as system knowledge about PIR was inevitably lost when individuals moved from their roles. A broader, collective ownership was therefore needed. Collective ownership of PIR beyond contact with individual SFs was effected by communication at interagency meetings, however these were primarily based in traditional health and social care boundaries. This meant that actors outside of these boundaries (e.g. justice system, private healthcare, housing, employment) often missed or misheard the PIR message. The other, connected, problem was that the embodied knowledge of the Support Facilitators was not valued in those settings where other types of embodied knowledge was valued, as seen in the dismissal by some of SFs from a non-clinical background. Colebatch (2005, p.21) writes that:

> "To a large extent, policy work is concerned with constituting a regime of practice which is congruent with the activities of existing players (whose concerns are legitimated by their standing as 'stakeholders'). It is about negotiation as much as it is about selection."

The back and forth dialogue within interagency forums and other meetings is a form of negotiation where the stakeholders and SFs learn from each other in order to establish the new program in the system. While a certain alignment of ideas must exist for dialogue to take place, congruence comes from familiarity and shared working.

The utility of an IPA approach to this project.

An IPA approach was of significant benefit to our project in that it provided a critical understanding of policy implementation and focused on the localised practices of

implementation. This approach made a great deal of sense to our funders who could see that the implementation of seemingly sound policy was often stymied by local factors. As our project progressed we fed our interpretive findings back to the funders who then made changes to their implementation.

We also were able to translate our IPA research to a range of different academic audiences through conferences and peer reviewed journals, including practitioners and those with a more established understanding of critical approaches to knowledge.

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We thank Ivy Yen who conducted the interviews for the project.

[1] The National Disability Insurance Scheme (NDIS) creates a personal budget which people with a disability may buy in social care services which meet their needs.

[2] Respondents are identified through alpha-numerical identifier. Support Facilitator (SF) respondents are identified by SF1, SF2 etc. and Team Leaders (TL) by TL1, TL2 etc. PIR means Partners in Recovery. NDIS means National Disability Insurance Scheme. Number in brackets e.g. (13) refer to the number of respondents who mentioned the particular theme.

* Please note: As this paper focuses on research which has been completed parts of this paper have been previously published in reports to the project funders and within two peer reviewed journal papers:

Smith-Merry, J., Gillespie, J. (2016). Embodying policy making in mental health: the implementation of Partners in Recovery. *Health Sociology Review*, 25(2), 187-201

Smith-Merry, J., Gillespie, J., Hancock, N., Yen, I. (2015). Doing mental health care integration: A qualitative study of a new work role. *International Journal of Mental Health Systems*, 9(1), 1-14.

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Appendix A. Interview questions at each time point:

<u>Interview questions – baseline interviews</u>

- What work does your organisation do?
- What is your role in your organisation?

- Which services or government bodies do you currently work with to carry out your operations in the Western Sydney Medicare Local region?
- What forums do you use to make contact with these organisations?
- What knowledge does your organisation draw on when carrying out its work? (e.g. policies)
- What knowledge do you draw on when you carry out your work (e.g. training, policies, advice from other colleagues, your own experience)?
- What measures do you currently use to track the performance of your organisation?
- Are any of these mandated from external services or government bodies?
- In what ways are indicators helpful/unhelpful?
- Do you share indicators of your organisation's performance with other organisations?
- What forms of collaboration with other agencies/services are useful in responding to mental health issues?
- What are the main enablers to collaborative working?
- What are the main disablers to collaborative working?
- What are the main challenges which will face the implementation of PIR?

<u>Interview questions – follow up interviews</u>

- Which organisations do you currently work with to carry out your operations in the Western Sydney medicare local region?
- What forums do you use to make contact with these organisations?
- What knowledge do your organization draw on when carrying out its work?

- What measures does you currently use to track the performance of your organization?
- Are any of these mandated from external organisations?
- In what ways are they helpful/unhelpful?
- Do you share indicators of your organisation's performance with other organisations?
- What are the main enablers to collaborative working?
- What are the main disablers to collaborative working?
- What are the main challenges which have faced the implementation of PIR?

Interview questions – final interviews

- Does your organisation have specific processes or guidelines regarding risk management?
- Have PIR staff been placed in risky situations?
- Have PIR clients been put at risk due to PIR processes?
- How do risk management policies and procedures work in with recovery orientated practices and person centred care?
- What has been the key opportunities and challenges working in a consortium?
- Has the PIR relationships had an impact on the way you partner?
- Do you think PIR has made changes to the 'connectedness' of the MH system and other services that work with people with mental health issues?
- Do you think PIR has had an impact on developing the capacity of the service system?
- Do you think the connectedness will remain after PIR?