From Vision to Action?
An Analysis of the Implementation of *A Vision for Change*
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1. Introduction

A policy which is embraced by a Minister, approved by Cabinet, announced publicly, but inadequately delivered is worse than no policy at all...¹

Ireland’s national mental health policy A Vision for Change² was adopted by government at the end of 2005 and formally launched in January 2006. The policy describes a comprehensive framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness³.

A Vision for Change was widely welcomed and was embraced by all parties as the framework for developing services for people with mental health problems⁴. The policy was one of the first in Ireland to seek to include the views of service users and carers comprehensively. A service user and a carer representative were members of the Expert Group and extensive consultation to inform the policy was conducted⁵. There was much optimism regarding the potential to bring about profound change in the nature of mental health service delivery and improve outcomes for service users, particularly as substantial funding was also provided for the first two years following the launch of the policy. However, this optimism has been replaced by disappointment with the lack of progress in implementing the policy and the lack of any significant change in the mental health services received by most service users⁶. This disappointment is reflected in the many concerns voiced by different groups regarding the implementation of A Vision for Change.

It is acknowledged that the implementation of a complex policy, with many recommendations, in a system that is already undergoing significant change is a chal-
lenging process. It is also acknowledged that some progress has been made by the Health Service Executive (HSE) in specific areas. The statutory mandate of the Mental Health Commission is to promote high standards in the delivery of mental health services. In pursuance of this mandate, the Commission published *The Quality Framework for Mental Health Services in Ireland*. This framework comprises eight themes and associated standards which define a quality mental health service. These themes were derived directly from stakeholders, including service users and carers. The *Quality Framework* complements very well the key recommendations of *A Vision for Change*. The slow pace of implementation of *A Vision for Change* impacts directly on the quality of mental health services available to service users, and this is of concern to the Mental Health Commission. The Commission has prepared this paper to draw together the central issues outlined in several publications, present the evidence base around effective implementation and highlight possible ways forward and specific priorities for the HSE to consider.
2. Concerns about implementation

The Expert Group on Mental Health Policy recognised that a failure to implement the policy would have serious consequences for service users and that piecemeal implementation would be undesirable given the interdependencies that underpin the key recommendations of the policy. The Expert Group was also mindful of the challenges to implementation faced by the previous mental health policy, *Planning for the Future*. For these reasons a recommendation was made that an Independent Monitoring Group be established to oversee and report on implementation. This group was established in March 2006 and has produced three *Annual Reports* on the implementation of *A Vision for Change*. Each of these reports has expressed serious concerns on the slow pace of implementation and the lack of attention to specific key actions by the HSE. The First Report of the Monitoring Group *found issues for concern, principally the lack of a systematic approach to implementation of the Report [A Vision for Change] and the lack of clarity in responsibility for implementation in the Health Service Executive*. The Monitoring Group put forward recommendations as to how the challenge of implementation might be addressed by the HSE and other responsible bodies.

In its second report the Independent Monitoring Group found that *by and large the recommendations in its first report were not addressed in 2007*, and the Group continued to be concerned *about the absence of a clear, identifiable leadership within the HSE to implement A Vision for Change*, and that the recommendations of *A Vision for Change* were not being addressed as a comprehensive package. There were also concerns about how allocated funds had been used. In the most recent third report the Monitoring Group found that *many of the recommendations made in its first two reports have still not been addressed*. Three years into implementation *a comprehensive implementation plan is still not in place and the Group is very disappointed with the slow rate of progress*.

A report from the Centre for Cross Border Studies analyses the policy implementation process in Northern Ireland and the Republic of Ireland. Both jurisdictions embarked on the process of developing new mental health policies at a similar time.
From Vision to Action? An Analysis of the Implementation of A Vision for Change

(the Bamford Review in the North and the Expert Group on Mental Health Policy in the South). Both jurisdictions also established groups to monitor progress in the implementation of these policies (the Board for Mental Health and Learning Disability Northern Ireland and the Independent Monitoring Group of A Vision for Change). In commenting on the HSE Implementation Plan for 2009-2013, the report notes that;

*The key deliverables are couched in the language of uncertainty, using phrases such as ‘expect to’ and ‘hope to’ and ‘to progress’. ...Given the slow rate of policy implementation to date coupled with the dwindling public finances, the public sector recruitment freeze and the fact that four months of 2009 have already passed by publication date even the initial goals could appear optimistic. (p.15).*

Discussions with both monitoring groups highlighted key lessons/challenges concerning leadership and funding which affect implementation. These insights are considered in more detail in the relevant sections below.

A recent report from Indecon Consultants\(^1\) noted that *at the current rates of progress, it could take up to 10 years before full achievement of the staffing targets implicit in A Vision for Change*. The conclusions from this report also indicate that the model of service delivery has still not substantially changed, with *an over-reliance on traditional acute and long-stay inpatient beds compared with the policy outlined in A Vision for Change*.

The Inspector of Mental Health Services has also voiced concerns about the slow pace of progress towards the provision of a *quality national mental health service*, and in the 2007 report\(^2\) noted that the change required to achieve this goal *remained piecemeal and disappointingly slow;*

*The wait continues for adequately staffed adult, and child and adolescent community teams, the closure of unsuitable large psychiatric hospitals, the arrival of a comprehensive national forensic service and the development of even a minimal service for people with intellectual disability and mental health problems. (p. 85)*\(^2\)
The Inspector of Mental Health Services in the 2008 report noted that *From the broader perspective of the quality of care and treatment, little has changed, despite the introduction of A Vision for Change* ... *people with serious mental illnesses requiring hospitalisation are in many cases still accommodated in 19th century buildings unfit for purpose*. Other system-wide changes had not been put in place; *Despite centralisation, there has been no real progress in equalising resources, financial or staffing, across regions. Comprehensive community-based services are still lacking in most parts of the country*. 

In the 2008 report, a strong concern of the Inspector was the lack of a separate Mental Health Services Directorate and that this presented *a serious drawback to the implementation of what is Government policy and to the achievement of high quality standards*. The lack of progress overall is *damaging to the dignity* of those with mental illness.

An analysis of the reports of the Independent Monitoring Group, the Inspector of Mental Health Services and other documents has revealed four major themes of concern; the need for a clear, detailed implementation plan; the need for accountable, effective leadership; the provision and use of resources; and the closure of hospitals. The HSE Implementation Plan for *A Vision for Change* will be analysed using the evidence base for effective implementation. In light of this analysis, the major themes will be considered.
3. What works in implementation?

The ‘implementation gap’ has been of concern to many Western governments in the latter part of the 20th century. This gap between the policy intentions of policy-makers and policy as delivered in services for citizens, has led some governments in attempts to “reinvent government” (in the US in the 1990s) and in “modernisation” programmes (UK in the 1990s).

A possible contributing factor to the implementation gap is the failure to grasp the complexity of the implementation process. Effort tends to focus on the formulation of policies or programmes to bring about change, with little attention to the implementation of these policies and programmes, as if their implementation should be self-evident from their content. The need for specific skills and competencies in implementation is also not often recognised. In commenting on the progress in Ireland in modernising public services, the OECD noted that significant capacity building in terms of deepening project management and implementation skills is still required. There is broad agreement that implementation is highly complex, and that every aspect is fraught with difficulty, from system transformation to changing service provider behaviour and restructuring organisational contexts.

It is also well documented that while there is considerable knowledge of effective interventions at the individual level, these interventions are not consistently used to the benefit of service users.

3.1 Policy implementation

Much of the earlier literature on policy implementation focused on theoretical arguments over whether ‘top-down’ (public agencies and public servants putting government in place) or ‘bottom-up’ (public servants interpreting policy and implementing according to their interpretation) approaches to implementation are more successful. However, these arguments do not accurately reflect the practical reality of policy formulation and implementation currently. Experts and citizens (direct users of public services) are generally more closely involved in the process of policy formulation and to some extent, implementation. Pilot
projects, review groups and public consultation are now increasingly used in policy making. The increased prominence and use of evidence in formulating and implementing policy has also changed the nature of the argument (the “What matters is what works” the philosophy of the Labour government elected in 1997 in the UK). Evidence-based policy is now a commonly-used phrase, although the nature of the relationship between evidence and public policy varies greatly with the policy area\(^2^0\). Policy makers are becoming more aware of the importance of implementation. In the UK, and Australia, for example, there is evidence of a more self-critical examination of policies. Implementation Checklists and guidelines have been introduced to the policy formation part of the policy process\(^2^1\). These guidelines force the policy makers to give explicit attention to the implementation aspects of a proposal before the final political decision-making at government level takes place.

### 3.2 Wider implementation literature

A systematic review of the wider implementation literature has indicated that effective implementation is synonymous with coordinated change at system, organisation programme and practice levels\(^1^7\). Peck and 6 contend that policy implementation requires a much richer understanding of organisational processes than has hitherto been employed\(^1^5\). They use organisational theory to describe how implementation can be realised through achieving settlements between rival ways of organising and through interventions in ‘sense-making’ (i.e. the way in which stakeholders interpret and perceive both the past and the future). The successful closure of Victorian psychiatric hospitals and the move to a new model of mental health service in England in cited as an example of this more complex conceptualisation of policy implementation. New organisational ‘settlements’ were developed, based on a broad coalition of service users, carers and mental health professionals working in teams. This was very different to the way of organising a service delivered in a traditional hospital. It was also found that the most powerful tool for creating confidence in the subsequent implementation timetable [for hospital closure] was the costed project plan... such project plans typically covered a
five year period, and contained detailed projections of the revenue release from ward closures and reinvested, capital secured from land sales and reinvested, bridging finance, capital from the NHS and new sources of funding\textsuperscript{15}. An important by-product of the project plans was that it could be demonstrated that the resources freed by hospital closure were staying in the mental health service.

A review of the commonalities among successfully implemented practices and programmes has identified core components for successful implementation at this level. These components focus on the level of the individual practitioner and on environmental factors which support successful implementation, and include\textsuperscript{17};

- the careful selection of practitioners to receive coordinated training, coaching and frequent performance assessments;

- providing organisations with the infrastructure for timely training, skilful supervision and coaching and regular monitoring and evaluation;

- the involvement of communities and consumers in the selection and evaluation of programmes;

- funding policies that create a hospitable environment for implementation.

These core components have a relevance to implementation at the policy level but are perhaps most useful in describing actions and outcomes to be included in implementation plans (e.g. the way in which training is conducted for example) and for describing organisational activities which need to take place to support implementation (e.g. training infrastructure and involvement of stakeholders).

The area of business has also focused on implementation, particularly from the point of view of businesses putting into effect strategic decisions. Work in this area tends to be very process focused with an emphasis on making a business work in a commercial environment. Characteristics of effective implementation plans, and activities that are key to effective implementation, are identified based on what has worked in commercial environments\textsuperscript{22}.
3.3 Practical guidance for implementation

In spite of the wide literature on the theory and practice of implementation, there is relatively little practical guidance on what approaches lead to effective implementation. This lack of evidence-based guidance is happening at a time when politicians and policy-makers are more focused than ever upon the challenges of implementation (p.12). However, organisations and governments have prepared practical guidance on policy implementation based on their own knowledge and experience and drawing on the experience of others. A World Health Organisation publication provides practical guidance on how to prepare mental health policies, plans and programmes and the steps involved in implementation. The Government of Australia has had a concerted focus on implementation for some years. The Cabinet Implementation Unit, which is part of the Department of the Prime Minister and Cabinet, has produced a useful Guide to Preparing Implementation Plans. In addition the Australian Government has prepared a Better Practice Guide on the Implementation of Programme and Policy Interventions. This joint publication of the Auditor General and the Department of the Prime Minister and Cabinet has drawn together experience on how to implement government programmes effectively to address joint concerns:

Too often the challenges involved in turning a policy idea into effective outcomes, and the skills and effort required to do so, are not fully appreciated. Too often the results fall short of expectations. Yet we know that defects in implementation rob the community of the full benefits of a new policy and waste community resources. (p.i)
3.4 **Necessary factors for successful implementation**

From the evidence outlined above, several factors that have characterised successful implementation in other jurisdictions have been identified. It is acknowledged that the reality of implementation is considerably more than the rational order proposed by these factors. However, there are essential tasks and activities that need to take place in a certain order to increase the chances of effective implementation of a policy. These tasks and activities occur in three broad stages, the policy formulation process, implementation and monitoring. Figure 1 presents a diagrammatic representation of the steps which are outlined in a little more detail below.

*Figure 1: Evidence-based factors supporting successful implementation*
Pre-implementation: Policy formulation process

1. **Make implementation an important consideration during policy design** – this includes identifying different means of achieving policy objectives and identifying barriers to implementation. The inclusion of experienced implementers at the policy formulation stage can be important in assessing the feasibility of proposals. A consideration of risks, challenges and specific aspects of the policy that may impact on implementation should also be considered at this stage\(^\text{22,24}\).

2. **Involve as many stakeholders as possible in policy formulation process** – including and consulting with stakeholders serves to inform the policy and also the implementation of the policy. It also facilitates other tasks such as the dissemination of the policy and the generation of support\(^\text{23,24}\).

3. **Disseminate the policy** – all stakeholders need to know about the new policy. A rolling programme of communication, using different media and engaging with different stakeholders creates awareness and understanding of proposed changes and also helps to generate support\(^\text{22,23}\).

4. **Generate political support and funding** – active stakeholder participation and communication activities are important in achieving this. Political leadership and support can be crucial in ensuring implementation\(^\text{22,23,24}\).

Implementation

5. **Appoint a leader and an implementation team** – the WHO reports that a multi-disciplinary team to implement policy has proved successful in several countries. The leader and team members should be individuals with the appropriate skills, time and decision-making responsibility to ensure effectiveness\(^\text{24}\).

6. **Establish an implementation structure** – This national team should be echoed regionally and locally with, at a minimum, a regional leader and local leaders of the process. These local leaders and teams should be individuals with the appropriate skills, time and decision-making authority to ensure effectiveness\(^\text{23,24}\).
7. **Provide the necessary resources** – sufficient skilled attention to identifying the appropriate funding for implementation is identified as a key success factor\textsuperscript{23,24}. This includes an appropriately crafted budget, including managing contingency funding and financial risk. It is also strongly recommended that appropriately skilled and experienced financial management personnel should be part of the implementation team\textsuperscript{24}. The type of long-term strategic budgetary frameworks suggested by the OECD\textsuperscript{16} would provide a mechanism to allocate and manage the resources required to implement A Vision for Change.

8. **Prepare a plan** – Systematic and structured implementation planning is essential. A level of management experience and skills commensurate with the sensitivity, significance and impact of initiatives should be applied to the development of implementation planning. It is important to avoid the assumption that this is a low level technical task\textsuperscript{22,24}. An implementation plan should provide a map of how the policy will be implemented and should deal in sufficient detail with:

   a) Timeframes, including the different phases for implementation

   b) Roles and responsibilities of those involved in implementation

   c) Resources, including funding and human resources

   d) Risk management, including how any potential barriers to implementation will be addressed

   e) Monitoring and reporting requirements.

In implementing a complex, multi-layered policy, it may be necessary to have an overall plan for the complete policy and sub-plans or strategies which deal with specific complex tasks within the plan. These strategies should have the same format, with sufficient detail on timeframes, roles and responsibilities, resources, risk management and monitoring. The importance of implementation planning is recognised by the Task Force Report on the Public Service\textsuperscript{25}, which contains an implementation strategy, with identified
From Vision to Action? An Analysis of the Implementation of A Vision for Change

leadership and a leadership team (a proposed Programme Office), defined accountability, and dedicated resources to achieve the implementation.

9. **Communicate** – the need to *communicate relentlessly*²² throughout any change process has been highlighted. Policy implementation represents an extensive and complex change process, underlining the importance of communication. Communication is critically important to implementation because it is *an effective tool for motivating employees, for overcoming resistance to an initiative, for preparing employees for the pluses and minuses of change and for giving employees a personal stake in the process (p. 60)*²². For communication to be effective, especially during a change or implementation process, it must be ongoing; a single ‘big bang’ announcement will not produce significant benefits. This is even more important when other changes are also taking place in the organisation, and when there are other adverse events that need to be managed, such as financial cuts. Effective, ongoing communication is also essential for building and maintaining trust among staff. One business leader who turned around a failing company changed the communication policy, from “don’t tell anybody anything unless absolutely required” to “tell everybody everything”. He realised that *cultivating honesty, trust, dignity and respect becomes the job of the leaders. It may even be their most important job*²⁶.

10. **Include stakeholders and promote stakeholder interaction** – Stakeholder management is a key aspect of implementation²³,²⁴. The purpose of stakeholder inclusion in the implementation process must be clear so that the right stakeholders can be identified. For example, is their inclusion to obtain support, to provide a communication channel or to test the design or roll-out? Multiple interactions between different stakeholders need to take place at different levels. For example, between the Department of Health and Children and the HSE; between management and mental health professionals within the HSE; between service users and the HSE.

11. **Support interdepartmental coordination** – several departments outside health provide services that affect people’s mental health. An overall coordinating
role is essential to ensure all relevant departments are implementing actions within their remit of responsibility\textsuperscript{23}. Where cross-agency implementation is necessary, the likelihood of effective implementation is greater where there is a high-level implementation plan involving the relevant agencies\textsuperscript{24}. The need to think about the Public Service as an integrated “system” has also been emphasised by the OECD\textsuperscript{16}, and is an underpinning principle of the Report of the Task Force on the Public Service\textsuperscript{25}.

**Monitoring**

12. *Put in place a governance structure*\textsuperscript{27} – governance arrangements are required to ensure adequate reporting and review mechanisms. Monitoring is essential to determine if the desired outcomes are being achieved and also to identify risks to implementation so that corrective action can be taken. *Monitoring and review is more effective when it is performed by personnel with skills and knowledge specific to the implementation being undertaken*\textsuperscript{24}. Timely and relevant information also needs to be readily available.
4. Analysis

The evidence identifies specific tasks and activities that are associated with effective implementation. These include; attention to implementation in the policy formulation process, skilled leadership in the implementation process, appropriate support and governance arrangements, adequate resources, a detailed plan and continuous communication. This evidence-based framework is used to analyse A Vision for Change and the HSE Implementation Plan with a view to identifying areas which could be addressed and therefore increase the likelihood of effective implementation. It should be noted that this analysis concentrates on the provision of specialist, secondary level mental health services.

4.1 Pre-implementation

The process of formulating A Vision for Change paid particular attention to several factors which impact on implementation. Significant efforts were made to both include and consult with stakeholders in a meaningful way. Service users, carer representatives, mental health professionals and others were members of the Expert Group on Mental Health Policy and were also members of the several sub-groups formed to cover specific areas. In addition, a three-phase consultation process was conducted to ensure service users in particular, had as much opportunity as possible to contribute their views. The consultation process included a call for written submissions, two facilitated workshop style meetings and an in-depth survey of 100 long-term service users. This engagement facilitated the dissemination of the policy when it was completed and particularly helped in generating support for A Vision for Change. This was evident in the broad welcome from all major stakeholder groups for the new policy in 2006.

However, it is possible to identify three factors which may have had a negative influence with regard to implementation. Firstly, while an attempt was made to include all stakeholders in the Expert Group, high-level HSE management was represented by only one member of the Expert Group (who moved to a new area of responsibility before the Group completed its work and was not replaced) and
HSE management was not represented on many sub-groups. This lack of representation was compounded by the second factor; the major transformation which the HSE was undertaking while *A Vision for Change* was being formulated and for some time after its publication. This transformation programme commanded the time and attention of senior HSE management at a critical time for the new policy. In addition, the uncertainty over what structures were to be proposed meant that the proposal for new management structures in the policy, which would be key to implementation, were necessarily vague in some areas. Finally, detailed attention to implementation was not part of the policy formulation process. The final chapter of the policy recognised the overall challenge involved and recommended the appointment of an Independent Monitoring Group to oversee the implementation. However, a detailed consideration of the challenges, risks to implementation and specific aspects of the policy that could impact on implementation was not evident in the final document. This ‘building-in’ of implementation to a policy has been identified as the key factor for successful implementation (better practice guide).

4.2 **Implementation**

Evidence-based factors that enable successful implementation will be considered in detail here; leadership, implementation structure, resources, implementation planning, communication, stakeholder involvement and interdepartmental collaboration.

4.2.1 **Leadership**

The strongest and most consistent point to emerge from the implementation literature and guidance documents is the importance of leadership to successful implementation\(^{22,23,24}\). The key requirement is identified as a senior officer who is accountable for the delivery of the policy and has the appropriate authority, skills and resources to do so. In terms of the specific skills required of the person leading implementation, it is noted that *this is not a matter to be left to chance, or to learning on the job – include the use of a mentor or specialist expertise (p. 13)*\(^{24}\).
However, a single leader alone is not sufficient to ensure effective implementation. The leadership model described by the evidence is one that includes a skilled leader, supported by a team with the necessary skills, knowledge and experience, and including someone with financial expertise. This group must have the authority to make decisions, and the resources to implement those decisions. Given that stakeholder involvement and consultation has also been identified as a success factor stakeholder membership of an implementation group may be an effective way of ensuring this happens, and that service user concerns are kept to the fore.

Implementing any policy, especially one which requires substantial change both in systems and work practices, is challenging and the full support of the organisation is essential; *The implementation of policy is more likely to succeed if there is strong executive-level support for the delivery processes for the policy. ...A critical prerequisite for successful implementation ...is an executive that is committed to, supports and models best practice. Without strong and visible top-down support, any underlying changes will be ineffective.* (p. 11)

The model of leadership recommended in *A Vision for Change*; a National Mental Health Service Directorate, had both strengths and weaknesses. The recommended Directorate was multidisciplinary consisting of senior professional managers and senior clinicians and was inclusive of wider stakeholders with a service user member. However, the Directorate was described as advisory in function and the links with the HSE structures were unclear as these were in transition at the time *A Vision for Change* was drafted. The evidence base points to the need for an accountable leader with supporting team, and the necessary resources and authority to ensure implementation. The HSE has appointed an Assistant National Director for Mental Health Services and this is welcome. However, this individual will have many responsibilities, including the implementation of *A Vision for Change*. There is no mention of a National Directorate as recommended in *A Vision for Change* to provide the supporting structure indicated by the evidence in successful implementation; a supporting team with the necessary skills, service user membership, appropriate resources and decision making authority. It also seems the new Assistant National Director for Mental Health Services will not have
direct access to resources as the job description for this post notes that he/she will advise ...on resource allocation. A small group has been identified as a national steering group. There was no service user or multidisciplinary involvement in this group and all members were continuing with their other responsibilities.

The absence of dedicated leadership for the implementation process has been a central concern of many;

...the Independent Monitoring Group considers that the recommendations of A Vision for Change cannot be implemented effectively without a National Mental Health Service Directorate. The absence of a dedicated leader at senior, national level has impeded progress in the implementation of A Vision for Change and may be contributing to continuing poor facilities and standards of care in some areas and an inconsistent approach to embedding the recovery ethos in services. The Group recommends that the HSE should immediately appoint a leader of a National Mental Health Service Directorate to drive the implementation of A Vision for Change. (p. 2).

The report by the Centre for Cross-Border Studies concluded one of the biggest lessons for the Southern Monitoring Group was the need to identify one person who is solely responsible for leading the implementation process. There is a sense of frustration that no single person within the HSE is driving the implementation but instead a number of people who are trying to balance their part-time responsibility alongside a range of other responsibilities. (p.11).

The Inspector of Mental Health Services has also been critical of the unwillingness of the HSE to appoint a Mental Health Directorate, arguing that a well-run, accountable and partly autonomous division would be budget-beneficial and improve outcomes.

In the absence of a full time leader with skilled support team, concerns remain over the successful implementation of A Vision for Change.
4.2.2 Governance and management structures

Allied to a skilled and resourced leadership team, a clear management structure is required both for ongoing management of mental health services but also to ensure effective local implementation of any plan or policy\textsuperscript{24}. \textit{A Vision for Change} recommended a management structure of Mental Health Catchment Area Management Teams, managing the new enlarged catchment areas, and management structures for local community mental health teams (CMHTs). In order to support the governance and management structures outlined in \textit{A Vision for Change}, mental health catchment areas were to be redrawn to support larger populations with appropriate management teams. These new catchment areas have recently been finalised.

These necessary supporting structures and changes have been slow to appear. However, the appointment of executive clinical directors, with responsibility for the new ‘super’ catchment areas is a positive development. The next step requires the establishment of multidisciplinary management teams to work with the executive clinical directors. Although these teams are not yet in place they are to be charged with developing an appropriate, time specific, monitored Catchment Area Implementation Plan based on this plan (p. 85)\textsuperscript{14}. It is not clear from the HSE Plan if Catchment Area Management Teams are to be given the necessary resources and decision making authority to implement these local plans, or whether they will have the necessary skills and expertise to produce such plans. If this is not the case, the evidence suggests that this delegation of the task of implementation will not succeed.

In the absence of these teams, the current work of the implementation of \textit{A Vision for Change} is largely left to Local Health Managers, who have a very wide brief and who may not necessarily possess the necessary expertise or knowledge of the mental health system. The 2008 HSE Interim Implementation Plan\textsuperscript{28} had an appended section on governance, describing a structure with National and Area Steering Groups, and Local Implementation Groups. Although there was little detail on the composition of these groups, the national group was not multidisciplinary,
did not have a service user member and was not working full-time on implementation. Local multidisciplinary implementation groups were to be established but it is unclear if these are in place in all areas, what work they are undertaking or if they are actively meeting currently.

At the service user level, CMHTs are to be the means of service delivery. This basic unit of service delivery is still not widely in place. The Inspector of Mental Health Services has noted that the concept of a national network of comprehensive, community-based, multidisciplinary mental health teams is still far from realisation. Community teams often exist at the most basic level with insufficient approved posts. It was recommended in A Vision for Change that these teams have a three-part management structure of a clinical leader, a team coordinator and a practice manager. There is little evidence of this structure as fewer than ten team coordinators are in place throughout the country. This gap in the provision of fully staffed community teams creates a gap not just in service provision but in the governance and implementation structure, and has a direct and significant negative impact on the mental health services available to service users.

The appointment of Regional Directors of Operations and Assistant National Directors in the Care Groups signals a new management structure within the HSE. The two national service delivery ‘pillars’ are now to be integrated into a single Directorate for Integrated Services. Four regional operating units will be created to bring together the eight hospital networks and four Primary, Community and Continuing Care Areas. The new posts of Regional Directors of Operations will be responsible for all the health and social care services in each of the four regions. At the national level, Assistant National Director posts have been established for Children and Families, Disability, Mental Health and Older Persons Services. It is hoped that this new structure will facilitate the coordination and support required for the full implementation of A Vision for Change. There is a possibility that within the national care group structure a directorate for mental health may be created and this is to be welcomed.
4.2.3 Resources

Successful implementation of any policy requires the provision of adequate resources. In making recommendations on how the policy should be funded, A Vision for Change recognised several factors which characterise the funding of mental health services in Ireland, including the consistent relative underfunding of mental health services in the past number of years, the presence of substantial staff and land resources within some services, the inequitable distribution of current resources and the need for mental health service funding to be used to provide specialist mental health services, not to fund services which are the responsibility of other agencies (e.g. housing). The two methods of resourcing the changes recommended in A Vision for Change were firstly the reorganisation and reconfiguration of current service provision and associated resources, and secondly the provision of new funds. A non-capital investment of just under €22 million was recommended for each of the seven years of implementation (2006 to 2012). A capital requirement of close to €800 million to provide infrastructure was estimated, although it was argued that this figure could be substantially provided for through the closure of the old psychiatric hospitals and the re-use and sale of their associated buildings and land banks.

Close to full funding for A Vision for Change was provided in 2006 and 2007 (€26.2 million in 2006 and €25 million in 2007). In mid 2009, the HSE Implementation Plan reported that €19 million of the 2006 allocation had been used and that only €10.5 million of the 2007 funds had been committed by the end of 2007. The Plan predicts that 94% of this total resource of €51.2 million would be committed by the end of 2009, although there is no detail on how this will be achieved. On this basis it will have required four years (beginning 2006 to end 2009) to fully use the funds provided in 2006. Although over €30 million has now been spent, there is little evidence of significant improvements in the range or quality of mental health services available to service users. The additional funds do not seem to have brought about identifiable direct benefits for service users.
It was acknowledged by the HSE that funds allocated to mental health were used to cover gaps in other areas of the health service. This is one factor which led to the delay in using the mental health funds within mental health services. Other significant delaying factors include; the lack of a timely, detailed implementation plan and the lack of leadership to oversee implementation. The delay in using funds has had several negative consequences. Firstly and most importantly, it delays the delivery of benefits to service users, those for whom services are provided. Secondly, it has resulted in a lack of confidence on the part of Government that further funds for mental health will be appropriately used in a timely manner; 

*Before any additional funding is provided it is essential that the HSE are in a position to demonstrate that money allocated to mental health services is efficiently used and that the substantial changes in the organisation and delivery of mental health services envisaged in A Vision for Change are progressed.* (Minister for Health, January 2008)

Thirdly, continuous erosion of funding in services which already have a low funding base has a strong negative impact on staff morale. Staff in mental health services have brought about significant changes in service provision over the past two decades and support for further change can be negatively affected by a failure to reward good practice. Finally, a failure to use funds in a timely manner can erode the staffing base and therefore the long-term funding base of mental health services. Anecdotal reports have indicated that, in this climate of financial cuts and staff embargoes, the failure to fill posts can result in these posts being permanently ‘lost’ to a service. This results not just in the loss of another staff member, but the permanent loss of the funds associated with that post. There is also little evidence that the funds from newly vacant posts within the mental health services are being used for posts required under *A Vision for Change*. Instead it seems these funds are going towards achieving savings in budgets. This ‘perfect storm’ of delays in using funds, financial cutbacks and staff embargoes results in the erosion of the long-term funding base of mental health services. This impacts negatively on the quality of mental health services available to service users, and also results in a built-in resource deficit into the future.
There are no costs attached to any of the many actions listed in the HSE Implementation Plan, nor is there any clarity on how the actions will be funded. No distinction is made between resource neutral and more costly actions. There is also a lack of creativity in pursuing or prioritising alternative ways of providing services and supports that achieve the same outcomes but at lower cost. There are many examples of this from the literature; providing support to people with mental health difficulties to live independently in local authority housing is not only less costly than community residential accommodation, it has many other benefits for the person, such as living in non-segregated housing in the community, with many more opportunities to be integrated into the community instead of simply ‘located in’ the community. This is a concrete example of recovery-focused, cost-effective service provision that is lacking in the HSE Implementation Plan. Another example is supporting adolescents with mental health difficulties. The *jigsaw* model is mentioned as a community-based mental health promotion project which the HSE should “continue to support”. The potential of *jigsaw* as a new model of providing mental health supports for young adults is not recognised, and the integration it achieves between primary and secondary services and supports is also missed.

### 4.2.3a Closing hospitals

The second source of funds envisaged for the implementation of *A Vision for Change* was the resources to be released from the reorganisation and reconfiguration of current service provision. The recommended closure of the old psychiatric hospitals not only addressed human rights concerns, but would release both funds and staff to implement *A Vision for Change*. The staff for the new CMHTs were to be provided through redeploying staff from hospitals and through employing new staff, especially those with low numbers such as occupational therapists and clinical psychologists. It was not envisaged that more staff would be employed *without* redeploying staff throughout the mental health services, particularly from hospitals. It was also envisaged that the capital funds for implementing the policy would be obtained from the sale of lands attached to psy-
chiatric hospitals. However, detailed hospital closure plans are still not publicly available. The initial funds provided by Government, which could have been used to provide the bridging finance required while the closure was underway (to fund the ‘double provision’ of services for a period of time) has been largely expended on other actions. In addition, €40 million already obtained in land sales has not yet been returned from the Department of Finance to the HSE and the Department may take 15% of funds from land sales for the general exchequer\(^\text{32}\). This loss of time and financial resource represents a significant lost opportunity to make substantial progress in implementing *A Vision for Change*.

### 4.2.3b Using funding models to achieve real change at the service user level

The HSE Implementation Plan notes that a *resource allocation model...needs to be agreed* , but no detail is specified. In the current funding allocation model, there is no incentive to change to community-based, recovery oriented mental health services if psychiatric hospitals still receive the bulk of the funding allocated to a service. The Indecon report\(^{12}\) recommended that changes in resource allocation will be required to successfully support the required reconfiguration of existing resources in mental health services.

A new allocation model is needed to *shift funding in a logical and incremental manner from old ways of practice to new ways*\(^{33}\). This model should also ensure that a move to evidence-based practices is not accompanied by a permanent increase in funding. This has not been the practice in Irish mental health services. ‘New’ services have tended to be overlaid on older practices, resulting in double-funding in a way that is unsustainable. A resource allocation model which incentivises evidence-based practice will lead to measurable improvement in the quality of mental health services. Any resource allocation model needs to take account of the need to reconfigure human resources to *ensure that resources are allocated on an equitable and efficient basis, both in terms of the functional and geographical distribution of these resources*.\(^{12}\)
4.2.4 The need for a detailed Implementation Plan

The Australian *Guide to Preparing Implementation Plans* describes characteristics of successful implementation plans. Plans should be based on sound programme logic, presenting a clear pathway from the policy and government expectations, to the inputs required and how they will achieve these expectations. The outputs to be delivered should be described, along with how these outputs will deliver the desired outcomes. A strong emphasis on outcomes echoes the central goal of the *Transforming Public Services* report, which states that the purpose of the Public Service is to achieve valued outcomes for the citizen. The recommendations of the Task Force report include the linking of resource allocation to specific outcomes to be achieved, and performance reporting based on outputs and outcomes.

This ‘delivery chain’ of *policy-inputs-outputs-outcomes*, needs to be explicit, and the assumptions underlying it also need to be explicit. Essentially, three important questions an implementation plan should address are:

- What is this plan aiming to achieve?
- Why is it important to achieve it?
- How will we know if we have got there?

The HSE Implementation Plan provides no sense of the overall HSE vision for mental health services. The aim seems to be to implement on a piecemeal basis, the recommendations of *A Vision for Change* as if this is an end in itself. Essentially, the HSE has not made *A Vision for Change* ‘its own’ in the sense of how the policy can guide the HSE to provide the best possible mental health services for people in Ireland.

If the desired overarching outcome is a recovery-based mental health service for all who need it, every action in the implementation plan should be checked against this to establish how it will contribute to achieving this central outcome. In the current Plan, the emphasis throughout is on the *process* with little evidence of focus on *outcome*. There are many possible outcomes along the way to achieving...
recovery-based mental health services. These need to be mapped out so that the outcome determines the process – not the other way around. Drawing from the literature, what would help in terms of an implementation plan from the HSE is:

1. An overall sense of the HSE vision for mental health services – what is the Implementation Plan aiming to achieve and why is this important;

2. A statement of specific outcomes;

3. A map of the steps needed to achieve these outcomes with relevant targets, timelines, resources and responsible agents all clearly described;

4. An outline of the measurable benefits arising from the implementation. This should enable the necessary monitoring to demonstrate that outcomes are being achieved and answer the question ‘how will we know if the policy objectives have been achieved?’

Currently, many of the proposed actions in the HSE Implementation Plan are simply re-statements of the recommendations of A Vision for Change, with little recognition that a policy document structured in terms of describing services does not contain the necessary links between related recommendations. In a sense, the recommendations are artificial lists of desired outcomes. The task of an implementation plan is to take these recommendations and fashion meaningful outcomes from them. Tackling implementation based on outcomes would help to create meaningful links between recommendations that are interdependent. It also creates a clear monitoring and review structure based on these defined outcomes. In the current HSE Implementation Plan, there is no detail on how the actions are to be achieved, no targets, milestones or outcomes to measure if they are being achieved, and no associated resources to enable them to be achieved. The timelines for many actions are non-specific (many beginning in the first quarter 2009 and finishing in the last quarter 2013). Designations of responsibility are equally non-specific (e.g. Estates or Health Promotion) or denote a position with full-time responsibility elsewhere (e.g. National Director of Integrated Care). Quality and training, and the need for standardised policies also need to be included so that
mental health services are of an equal standard across the country. An implementation plan with clear outcomes would facilitate the necessary linkage between training, quality and outcome.

4.2.5 Other factors affecting implementation

Communication: The HSE has been faced with a significant challenge in implementing A Vision for Change at a time when the organisation itself is undergoing substantial change and reorganisation. This means that communication is even more important to ensure the many staff in the mental health services are aware of the priority placed on the new policy and how changes are to be effected. An inference from the many concerns quoted above is that the HSE has not been effective in communicating its own vision for mental health services and how this will be implemented. There are also concerns that the important distinction between primary care and specialist mental health services is not fully understood. The Inspector of Mental Health Services noted that in such an all-encompassing directorate as Primary Community and Continuing Care, specialist mental health services did not have adequate focus and were regarded as secondary in importance, and that because of the absorption of mental health into the overall community service, confusion abounded as to the proper line of demarcation, if any, between primary and specialist services. Some HSE personnel had expressed to the Inspectorate that psychiatry or mental health services were purely of primary care concern. This lack of understanding of community-based mental health services has resulted in the assignment of staff from specialist mental health services into primary care services, beyond the needs for reasonable and effective liaison.

Including stakeholders and promoting stakeholder interaction: There is contradictory evidence of the desire to include stakeholders in the implementation process and to encourage different levels of interaction. There is a stated commitment in the HSE Implementation Plan to involving service users and carers in all aspects of service development. In addition, the HSE has provided considerable support to the establishment of a National Service Users Executive as recommended in A...
Vision for Change. This Executive represents an excellent forum for the formal and structured inclusion of service users at all levels and is a very welcome development. However, service users and other stakeholders have not been included in the implementation process or in the creation of an implementation plan to any significant degree. Instead of leading the way with an open and involving process to create an implementation plan, there is a sense that the plan has been created with little involvement of many stakeholders, from front-line staff to service users to external organisations and departments.

Supporting interdepartmental cooperation: A small proportion of the recommendations of A Vision for Change relate to action required by other government agencies and departments. Following an initial concern in the first report in 2007, the Independent Monitoring Group has been generally positive of the actions taken by these other agencies in fulfilling their responsibilities under A Vision for Change. The creation of the Office for Disability and Mental Health has been particularly welcomed as facilitating the joined-up-government that is required in these other action areas.

Monitoring: The mechanisms for monitoring and reporting on progress in implementation are not clear from the HSE Implementation Plan. The establishment of a governance structure as outlined in section 4.2.2 and the publication of a plan with sufficient detail on actions and outcomes (section 4.2.4) is also necessary before monitoring can be carried out. The lack of such structures means it will be difficult to measure the extent and quality of implementation.

Other concerns: There are many concerns regarding the provision of specific services such as child and adolescent mental health services, forensic mental health services and others. A detailed consideration of the expansion of these services is not included in this paper, largely because there is a sense that if the issues discussed above are not addressed, there will be neither the resources nor the governance system in place to ensure the optimum outcomes from this increase in services.
4.2.6 Conclusion

The reports commenting on the implementation process express disappointment and frustration that many of the requirements to begin the implementation of *A Vision for Change*, namely a leadership team, a detailed plan, changes to catchment areas and revised management structures could all have been put in place relatively quickly. These actions are largely resource neutral and were necessary first steps to proceed with further implementation. Three years on there is still no leadership team and an implementation plan has been published with no resources, clear targets or defined accountability.
5. A change in how mental health services are delivered

The central theme of *A Vision for Change* is the need for a new paradigm in the delivery of mental health services; *Service providers should work in partnership with service users and their families and facilitate recovery and reintegration through the provision of accessible, comprehensive and community-based mental health services* (p.10). The recovery ethos and associated principles, underpin the recommendations in *A Vision for Change*. The implementation process needs to bring about a profound change in how mental health services are delivered. Many of the actions in the HSE Implementation Plan will simply result in a replication, on a larger scale, of what is already in place. There is no sense in the Implementation Plan of the transformation that needs to take place in how mental health services are delivered. The report of the monitoring group captures this well; “This recovery ethos is not being pursued consistently across the HSE... The embedding of a recovery ethos in the provision of mental health services will not only benefit the service user, but also society and the economy as a whole” (p.19). The 2008 report of the Inspector of Mental Health Services observes that *A cultural change is needed towards a value-driven service where behaviours are aligned with professed values*.

While the HSE Implementation Plan states it has *remained faithful to the principles, values, service ethos and recovery approach promoted in A Vision for Change, which places service users at the centre of decision making, seeking to involve them and their families and carers at all levels of service provision* (p.3), this sentiment is not reflected in the detail of the Plan. Some examples are; the initial exclusion of service users from the National Steering Group to implement *A Vision for Change* (a service user and carer have only recently been appointed to the National Steering Group). The plans for hospital closure described in Section III of the Implementation Plan make no mention of asking service users what they want or developing discharge plans with service user and carer involvement. The focus on simply moving people to other institutions is a denial of the recovery approach.
Strong leadership is required to bring about such a profound change in the delivery of mental health services. Commitment from staff is also essential and support for staff can help bring about such change. One such support is training current and future staff in recovery competences. Such training has been successfully undertaken in other jurisdictions\textsuperscript{34, 35}. This is a long-term commitment that will need to be resourced and supported throughout the implementation process. It is also a comparatively low cost process that can profoundly change the nature of mental health services for those who use them.

6. Conclusion

The success of the HSE in implementing some of the recommendations of \textit{A Vision for Change} is acknowledged, notably the establishment of the NSUE and the progress in developing mental health services for children and adolescents. In addition, the finalising of the mental health catchment areas, the appointment of executive clinical directors, the appointment of an Assistant National Director for Mental Health and the establishment of National Care Groups and Regional Directors are all positive developments which go some way to creating the infrastructure necessary for implementation. It should also be acknowledged that the transformation programme undertaken by the HSE in the last number of years presented a serious challenge to the implementation of \textit{A Vision for Change}. A more detailed consideration of implementation at the policy formation stage, may also have assisted in the overall implementation process.

The aim of this paper is to highlight the evidence on successful implementation to facilitate the speedy implementation of \textit{A Vision for Change} so that service users can experience direct changes to the mental health services they receive. Some progress has been made in the area of leadership and management structures. However, the evidence clearly indicates the need for a skilled leader and team to drive and direct the implementation process, and the need for governance and management structures to drive the operational processes. Leadership with an
emphasis on transparency and communication is also required to build the trust and morale that is needed for such a significant challenge.

The 2009 HSE Implementation Plan provides some but by no means all the detail required for effective implementation. The preparation and communication of a sufficiently well worked plan, with clear actions, outcomes, costs, timelines and assigned responsibility, is crucial to the successful implementation of A Vision for Change. The Commission calls for the publication of such a plan without delay. As recommended by the evidence, stakeholders should be fully involved in the preparation of this detailed plan.

Resources will now be harder to secure for the required changes and developments. The publication of detailed hospital closure plans is essential as this process will provide some of the monetary and human resources required to implement A Vision for Change. However, a critical focus on how resources are allocated is also required. A multi-dimensional resource allocation model is required to ensure the transparent and equitable allocation of resources. This model should be sophisticated enough to encompass structural changes (e.g. from institutions to the community), environmental context (e.g. greater levels of socio-economic deprivation in some areas) and incentivising quality (e.g. supporting evidence-based clinical practice). In addition, creative thinking around how all resources are used is required. There is a need to start using existing, mainstream community resources in a more proactive way, to move away from the costly and unsustainable model of mental health services providing ‘everything’. It would also be useful to highlight the ways in which cost-neutral changes can happen now, so that service users can begin to experience recovery-based mental health services and supports in the near future.

In summary, most of the evidence-based requirements for successful implementation are largely missing. There can be little progress in the provision of high quality recovery focused mental health services without the following:
From Vision to Action? An Analysis of the Implementation of A Vision for Change

1. A leader with sole responsibility for implementation
   The assistant National Director for Mental health services will have many other responsibilities

2. A full-time implementation team with necessary skills and expertise
   Not in place

3. An implementation structure
   Not clearly defined

4. Necessary resources
   Not identified

5. Plans for reallocation of financial and human resources within the system
   Not included in the Implementation Plan

6. An outcomes-focused implementation plan with clear links between outcome-timeframe-resources-responsible officer-monitoring
   Not evident in current Implementation Plan

7. Effective communication policy
   Little evidence

8. Inclusion of stakeholders in the implementation process
   Recently in place

9. Interdepartmental coordination
   Mechanism for this in place

10. Monitoring system to track achievement in reaching outcomes
    Not identified in Implementation Plan

The evidence can point to specific actions that have been shown to facilitate successful implementation. Fundamentally however, a change is required in how mental health services are delivered and in how we think about mental health itself. The recovery approach provides a framework to do this and the HSE could use this framework to create its own vision of how the mental health of the population should be supported. Service users have made it clear that they want mental health services that focus on the possibility of recovery, rather than long-term dependency; services that focus on them as ordinary citizens using ordinary, integrated, community-based services where possible, not separate, isolated, special services; services that treat every individual with respect. Plans and leadership are needed, but a true commitment to better services for those who use them is also required.
Footnotes:


14 Health Services Executive (2009) A Vision for Change Implementation Plan. HSE.


25 Task Force Report


27 Governance is defined here as the set of responsibilities and practices, policies and procedures, exercised by an agency’s executive, to provide strategic direction, ensure objectives are achieved, manage risks and use resources responsibly and with accountability. Australian Better Practice Guide, p. 13.


31 Keyring [www.keyring.org/site/keyring_links.php](http://www.keyring.org/site/keyring_links.php)


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From Vision to Action?
An Analysis of the Implementation of A Vision for Change