Understanding Service Development in Statutory Mental Health Organisations in Aotearoa New Zealand: An Organisational Case Study

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Abstract

This research aimed to understand service development in statutory mental health organisations in Aotearoa New Zealand. Of major focus was the analysis of the elements that influenced service development as well as developing an understanding of decision-making in the service development process. The study involved an organisational case study of one statutory mental health provider, Living Well and included the collection and analysis of both primary and secondary data. The primary data included qualitative interviews, document analysis and the observation of meetings. Secondary data included literature, research, policy and external reviews of the organisation.

Archetype theory provided the theoretical framework for analysing the processes of service development within Living Well. This enabled a holistic assessment of service development as it related to the structures and systems of the organisation alongside its central purpose (raison d'être) and the values, beliefs and ideologies that comprised its interpretive scheme.

The use of an organisational case study contributed to the body of knowledge and theory building on service development and archetype transformation within statutory mental health providers in Aotearoa/New Zealand. The findings of this research supported the development of an approach for understanding service development within statutory mental health organisations and a guide for service development. The approach emphasises that Living Well's interpretive scheme was central to the service development process and was in an ongoing state of flux as the organisation attempted to balance conflicting priorities and demands with the delivery of responsive mental health services (the organisation's raison d'être). The complexity of the service development process within Living Well was exemplified in ongoing tension between clinical values and management priorities. The research findings reveal that service development within statutory mental health organisations like Living Well, requires alignment between the different factors that influence the service development process. Further, the likelihood of successful implementation is dependent on the priority

allocated to service development related to its necessity; the organisation's current operational and clinical demands; as well as the relationships and roles of those involved in the service development process. The guide for service development provides recognition of these core features of Living Well's interpretive scheme, utilising informal processes to engender support, to minimise opposition and to ensure client care is the primary focus.

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Chapter One: Introduction

It is unclear whether statutory mental health services in Aotearoa New Zealand are designed to meet the needs of their clients, are simply doing the best they can with what they know or if the legislative demands shape them into something entirely different. This research aimed to understand service development in statutory mental health organisations in Aotearoa New Zealand. This thesis explores the service development processes at one statutory mental health service, Living Well, in order to analyse the processes that inform service development within this environment.

Mental illness affects many people in Aotearoa New Zealand either directly or through having a family member or friend with a mental illness. A survey of the prevalence of mental illness in New Zealand found that 46.6% of New Zealanders will have a mental illness at some point in their lives, with a greater prevalence amongst people who are considered socially disadvantaged (Oakley Browne, Wells, & Scott, 2006). The experience of having a mental illness is often very distressing and associated with high levels of stigmatisation from society. Those people who access mental health services are frequently marginalised and the proportion of people who remain untreated is high (Oakley Browne, Wells, & Scott, 2006). The ability of statutory mental health services to develop and provide responsive and effective care and treatment for clients with a mental illness is a key concern of this research.

The purpose of this chapter is to introduce the research, to elaborate on key themes and to present the justification for the research. The chapter begins by introducing the aim of the research and the questions that have shaped data collection and analysis. An overview of the social policy context in Aotearoa New Zealand, the extent of mental illness and the nature of service delivery follows. Key terms are then defined and the chapter concludes with an outline of the thesis structure.

The Research

Understanding how service development occurs within statutory mental health organisations is the central focus of this thesis. In Aotearoa New Zealand, District Health Boards deliver the majority of mental health services to people with severe mental illness in partnership with Non-Government Organisations (NGOs). District Health Boards are a form of local government that receive their funding from central government. These organisations form the context for service delivery and determine the nature and scope of the services provided. This research involved an organisational case study of one adult[1] Mental Health Service provided within the context of a publicly funded District Health Board in Aotearoa New Zealand. This approach enabled a detailed focus on service development within this setting and contributed to knowledge and theory building around service development and archetype transformation within statutory mental health providers in Aotearoa New Zealand. The fieldwork involved a three-tiered approach to data collection: the analysis of documents sourced directly from the organisation, observation of strategic and operational meetings as well as qualitative interviews with key informants.[2] To maintain confidentiality the mental health service was given the pseudonym Living Well, and all identifiable information has been removed.

The questions developed to underpin this study aimed to understand the processes that informed service development within Living Well. The research was particularly interested in analysing the elements that influenced service development as well as gaining an understanding of decision-making related to the service development process.

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[1] Adult refers to people between the ages of 18 and 65.
[2] The methodology is explained in detail in Chapter Three.

The questions that formed the basis of this investigation are:

1. How are decisions relating to service development made?
2. What are the processes that inform service development?
3. What are the barriers and facilitators of effective service development?
4. What role do formal planning mechanisms including strategy, policy, reviews and projects play in service development?

I was interested in this research topic because of my professional background. The ability of clients to access mental health services that effectively meet their needs is a key goal of social work activity. As a social worker, my professional knowledge and frameworks shape my understanding of social service organisations. Throughout my social work career I have worked in a number of large statutory organisations. My experience working within these environments led me to be curious about whether there was a clearly defined, systematic approach to service development and if informed consideration was given to whether services were actually meeting the needs of the clients they were designed to serve. The desire to understand if statutory mental health organisations made service development decisions in ways that facilitated positive outcomes and experiences for clients, placing the best interests of clients at the forefront of decision-making triggered my interest in conducting this research. The research consequently explored the factors that promoted and galvanised positive experiences of service development as well as the barriers to effective service development within this setting.

The Social Policy Context

The broader social policy context in Aotearoa New Zealand has shaped the direction of statutory mental health services. Since the 1980s there has been a shift in emphasis from clinically driven service development to a more managerial approach to mental health

service delivery comprising elements of neo-liberalism[3] and new public management[4]. The development of mental health services in Aotearoa New Zealand is explored in detail in Chapter Four. This section serves to illuminate the broader social policy context that influences the nature and focus of social service delivery including that provided by statutory mental health services.

During the late 1980s and early 1990s, the state sector in Aotearoa New Zealand was retrenched. Philosophies of neo-liberalism and new public management pervaded the policy-making agenda and the focus was on market driven ideals of efficiency, competition, minimal state intervention and maximum individual freedom (Boston; Martin; Pallot, & Walsh, 1996; Cheyne, O'Brien, & Belgrave, 2008; Kelsey, 1997; Miller, 2006). In terms of social policy the costs of maintaining the Keynesian welfare state, which had been in existence since the 1930s, had become unsustainable due to an international economic recession and a growing number of people within Aotearoa New Zealand accessing state funded assistance such as the unemployment benefit. Therefore, government activity was directed at dismantling a costly and seemingly inefficient welfare state (Cheyne, O'Brien, & Belgrave, 2008; Miller, 2006).

From the time the fourth Labour government was elected in 1984, the shape and context of social service delivery in Aotearoa New Zealand changed markedly. This government and the subsequent National government began a process of reducing the role of the state in the provision of welfare and adopted a model of corporatisation and privatisation in the form of new public management (Cheyne, O'Brien, & Belgrave, 2008; Kelsey, 1997). Following the perceived excesses of state spending during the 1970s, coupled with changes in the international economy, the welfare state, which underpinned social service delivery, was regarded as an unnecessary, cumbersome instrument that constrained individual freedom (Cheyne, O'Brien, & Belgrave, 2008). To address the

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[3] Neo-liberalism is a social and political theory that gives priority to individual freedom and regards an unencumbered market with minimal state intervention as key to social well-being (Cheyne, O'Brien, & Belgrave, 2008).
[4] New public management involves the implementation of private sector management techniques such as competition and deregulation within public sector organisations with the goal to improve their quality and efficiency (Hood, 2002).

inefficiencies of the public service a new model of delivery was introduced which saw the adoption of private sector philosophies including competition, efficiency and profit making within the state sector (Aldridge, 1996; Boston, Martin, Pallot, & Walsh, 1996; Cheyne, O'Brien, & Belgrave, 2008; Hughes & Smart, 2012). In order to achieve this, private sector managers were appointed to key roles within public sector organisations including health services (Aldridge, 1996; Boston, Martin, Pallot, & Walsh, 1996; Cheyne, O'Brien, & Belgrave, 2008; Kelsey, 1997). Public sector organisations were required to reinvent themselves in the guise of private sector organisations and as a result, managerialism[5] became the norm (Aldridge, 1996).

It is the reality for both statutory organisations and NGOs, including mental health providers, that government policy provides the context in which they work and often dictates the nature and/or scope of the services they deliver. The relationship between civil society and the state in Aotearoa New Zealand has been well documented (Ministry of Social Policy, 2001). Following the introduction of managerialism and other private sector business practices during the 1990s this relationship changed, with the state playing an increased role in determining the nature and scope of social service delivery by non-profit organisations, including statutory providers, through increasingly regulatory contracts (Cheyne, O'Brien, & Belgrave, 2008). The changes implemented during this period altered the way in which both statutory and non-statutory social services were provided. Funding contracts required value for money and evidence of cost effective service delivery. Essentially the policy and funding environment required those delivering social services to operate using a market model, which did not encourage cooperation or partnership, but rather emphasised competition between providers (Cheyne, O'Brien, & Belgrave, 2008).

Towards the end of the 1990s public sector organisations and many NGOs began to critique the changes implemented under the guise of new public management (Ministry of Social Policy, 2001). The strategies that had been implemented had damaged the

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[5] Managerialism is defined as being technocratic and consumerist, prioritising aspects of organisational performance and management control, including accountability, risk and efficiency mechanisms (O'Reilly & Reed, 2011).

relationship between the State and many NGOs, but also failed to deliver on many of the promises within statutory organisations (Ministry of Social Policy, 2001). In response to this and the growing dissatisfaction with neo-liberal ideologies, the fifth Labour government, in power between 1999 and 2008, adopted a 'Social Development' approach to social policy with close alignment to the 'Third Way' (Shaw & Eichbaum, 2011). This political strategy was an attempt to address the right wing concerns of neo-liberalism with some of the more moderate approaches from within Social Democracy (Fergusson, 2004). Social Development approaches and strategy formed an umbrella for policymaking in the early twenty-first century including the development and provision of statutory mental health services (Miller, 2006; Shaw & Eichbaum, 2011). In 2008, a National Party led government was elected,[6] while initially continuing with a focus premised on Social Development, they also began a process of disestablishing many public service positions in an attempt to reduce the costs and the 'burgeoning bureaucracy' of the state sector (Hughes & Smart, 2012).

The broader social policy context offers a foundation upon which to view the current development and delivery of statutory mental health services in Aotearoa New Zealand. It provides an insight into the wider elements that influence the direction of national mental health policy as well as the shape and scope of services delivered at a local level.[7]

The Provision of Mental Health Care and Treatment in Aotearoa New Zealand

Since its establishment in the mid-1880s the provision of statutory mental health services in Aotearoa New Zealand has faced a number of complex challenges, with numerous reviews and inquiries highlighting a failure of services to meet the needs of clients with mental illness (Barton & Barnett, 1981; Department of Internal Affairs,

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[6] The National led coalition government elected in 2008 was New Zealand's fifth National led government.
[7] These elements are explored further in Chapters Two and Four.

2007; Joseph, Kearns, & Moon, 2009; Joseph & Kearns, 1996; Kavanagh, 1996; Moon, Joseph & Kearns, 2005).[8] The delivery of statutory mental health services in Aotearoa New Zealand has mirrored the provision of services in other Western democracies and will be discussed in greater depth in Chapter Four. The purpose of this section is to provide a broad overview of the nature of statutory mental health service delivery in Aotearoa New Zealand to provide justification for the need to explore service development within this setting.

Until the mid-1960s, mental health care in Aotearoa New Zealand occurred within psychiatric institutions with the predominant model of mental health treatment premised on the medical treatment of illness. People were admitted to psychiatric hospitals for extended periods of time, given medication, with little hope of improvement in their condition and even less of being reintegrated back into the community (Barton & Barnett, 1981; Brooker, 2001; Kavanagh, 1996). It was not until the late 1960s that Aotearoa New Zealand began to adopt a policy of community care and deinstitutionalisation as those administering mental health services began to look at alternatives to long-term psychiatric care (Barton & Barnett, 1981; Brooker, 2001; Kavanagh, 1996).

The process of deinstitutionalisation in Aotearoa New Zealand was initially very slow and then accelerated during the 1980s alongside changes to the welfare state (Joseph & Kearns, 1996; Joseph, Kearns, & Moon, 2009).[9] The process of deinstitutionalisation was influenced by a complex array of motivating factors including the development of new generation anti-psychotic medications which offered improved outcomes for people with mental illness, the development of the consumer/client movement with a focus on less restrictive care, as well as the need to reduce the costs of providing hospital based mental health services (Barton & Barnett, 1981; Brooker, 2001; Kavanagh, 1996). Unlike other Western countries such as the United Kingdom, the government in Aotearoa New Zealand did not legislate to ensure that the costs and resources from

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[8] See Brunton (2005) for a review of the role of inquiries into mental health care between 1858 and 1996.
[9] The process of deinstitutionalisation in Aotearoa New Zealand is discussed in greater depth in Chapter Four.

closing the old psychiatric hospitals shifted to the provision of resources in the community. Hospitals closed slowly and clients were shifted to care in the community without the explicit consideration by funders about the services that should be in place to support them (Joseph & Kearns, 1996; Joseph, Kearn, & Moon, 2009; Kavanagh, 1996).

During the 1990s, a number of tragic events occurred including the murder of Tony Ellis by his son Paul, which identified gaps in the extent and nature of statutory mental health services and the inability to respond and treat clients with mental illness. Consequently, a number of high profile national inquiries[10] were undertaken resulting in the development of new funding and policy strategies including the development of the *Mental Health Blueprint for Funding Services*, the introduction of the first national mental health plan entitled *Moving Forward* (1997) and the establishment of the Mental Health Commission.

The Ministry of Health is the statutory body which provides guidance and advice to the government on health delivery and health related matters. It provides strategic direction and oversight to District Health Boards, as well as overseeing the implementation of health related legislation such as the Mental Health Compulsory Assessment and Treatment Act 1993 and the allocation of statutory resources for the delivery of health related services (Ministry of Health, n.d.). Working alongside the Ministry of Health is the Mental Health Commission, an independent body which was set up to be a 'watchdog' for clients of mental health services and to provide advice to the government on the extent to which mental health services were meeting the needs of those experiencing mental illness (www.mhc.govt.nz).[11]

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[10] Reviews and inquiries since 1994 include: Mason 1994 (*Matthew Francis Inquiry*); Mason 1996 (*The Mason Inquiry*); Cull 1997 (*Jacko Paki Inquiry*); Mental Health Commission 2002 (*Auckland Services Inquiry);* Cull and Robinson 2003 (*Paul Ellis Inquiry*); Health and Disability Commissioner 2002 (*Southland DHB, Burton Inquiry*); Department of Internal Affairs 2007 (*Confidential Forum for former inpatients – response to Lake Alice Court case*).
[11] The Mental Health Commission is to be disestablished in 2015 (Mental Health Commission Amendment Act, 2007).

Currently, the provision of statutory mental health services in Aotearoa New Zealand occurs under the umbrella of District Health Boards (New Zealand Public Health and Disability Act, 2000). [12] Each District Health Board is comprised of two parts a provider of services, and a planning and funding arm (Ministry of Health, n.d.). Each District Health Board is expected to contract for (Funding arm) and deliver (Provider arm) mental health services to meet the needs of their catchment's population (Ministry of Health, n.d.). Funding is allocated on a population-based formula and it is the expectation of the government that quality mental health services will be provided (Brunton, 2011). While individual District Health Boards decide on the priorities for their own region, the key philosophies and targets provided by the Ministry of Health through framework and policy documents are designed to shape the service delivery environment (Brunton, 2011). In Aotearoa New Zealand, each District Health Board determines how contracted services are to be delivered and the service configuration[13] in which this occurs (Ministry of Health, n.d.).

The provider arm of each District Health Board, alongside other community providers, delivers the required health services, including specialist mental health. These services typically include acute inpatient services, community mental health services, and rehabilitation services provided to all ages and population groupings. The nature and extent of services provided depends on the District Health Board's area and the historical presence of old psychiatric institutions (Joseph & Kearns, 1996; Joseph, Kearns, & Moon, 2009).[14] Larger District Health Boards tend to provide a greater range of services and are also often the site of regional specialty services such as forensic services or inpatient child and youth services. Service configurations for specialist mental health services differ between District Health Boards. What may be provided in one area may not be provided in another. While the planning and funding arm of the District Health Board contracts for the services it is up to the individual provider,

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[12] There are currently 20 District Health Boards across Aotearoa New Zealand.

[13] Service configuration refers to the mix of statutory and non-statutory providers funded to provide mental health services for the region, including the location and groupings of services such as inpatient and community services.

[14] The location of historical psychiatric institutions typically means the modern day mental health service has a larger inpatient capacity and offers a broader array of services, due to the development and investment in mental health services that has occurred over time.

whether this is statutory mental health services or NGOs, to determine how these services will be delivered (Ministry of Health, n.d.).

As already noted, mental health services in Aotearoa New Zealand have historically faced a number of complex challenges related to the development and delivery of care and treatment. They have been frequently criticised for their inability to meet the needs of clients sometimes resulting in tragic outcomes. The Ministry of Health has the role of providing national oversight for strategic direction and policy advice to central government with the priorities for funding and service development identified by District Health Boards occurring at a local level. This has resulted in different priorities and configurations of mental health services across the country. This study will contribute to a greater understanding of the different elements that influence localised service development within statutory mental health services.

Living Well

This research was undertaken at Living Well, a large regional provider of mental health services located at the site of one of the large psychiatric institutions that dominated mental health care during the 20th Century. Its services mirror the scope of other large mental health services although the names and nature of clinical service delivery differ.

Established in the late 19th Century, the number of people admitted as inpatients to Living Well peaked in the 1970s at well over one thousand clients. Living Well embraced deinstitutionalisation in the late 1980s in a similar vein to other large institutions around the country, with long-term, inpatient bed numbers being reduced dramatically in the twenty years that followed driven by the combined imperatives of the need to reduce costs, to address public demand for increased accountability across mental health services and to respond to client requests for less restrictive care (Joseph & Kearns, 1996; Joseph, Kearns, & Moon, 2009). However, the old psychiatric institution that had been located at the site only finally closed its doors to clients at the

turn of the 21st Century when a new acute inpatient service was opened with a greatly reduced number of beds.

At the time of this investigation, Living Well delivered statutory mental health services and also had its own business unit for administrative, human resource and other business functions including training, research and clinical support. It provided the full spectrum of general mental health services including: Adult General Community, Adult General Inpatient Services, Maori Health, Forensic Services, Intellectually Disabled Persons Health, Specialty and Addiction Services, Rehabilitation Services, Child Adolescent and Family Services. Each service contained numerous smaller units organised in groups based on a number of different elements including: geography in the case of Adult General Community Mental Health Services; service focus such as inpatient and outpatient; or length of treatment including short and long-term rehabilitation services. This study focused on service development across the Adult General Community, Adult General Inpatient and Rehabilitation Services of Living Well and where relevant it also considered elements of the wider management structure.

Definition of Key Terms:

The following terms have been defined in order to ensure consistency in understanding throughout the thesis:

Archetype change/transformation[15]
Archetype theory identifies two forms of change across professional organisations namely convergent and radical change.

> ➢ **Convergent archetype change** refers to service development that occurs within the boundaries of an organisation such as changes to programme delivery or service configurations (Greenwood & Hinings, 1996).

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[15] Archetype change and transformation are discussed in greater detail in Chapter Two.

> **Radical archetype change** occurs when an organisation moves from one archetype to another in accordance with other organisations of a similar type within that field (Greenwood & Hinings, 1996). An example of radical archetype change is the transformation of accounting firms which in response to environmental pressures moved from small partnership organisations to larger corporations with external shareholders (Greenwood & Hinings, 1996).

This thesis is primarily concerned with understanding service development as convergent archetype change within Living Well. The terms archetype change and archetype transformation are used throughout this thesis to refer to the process of convergent archetype change unless stated otherwise.

Change

Change is used throughout this thesis to describe a process of consistent agitation where service development is started, but not necessarily ever completed.

Clients

There are many terms used to refer to people who access mental health services including: consumer; client; patient; and tangata whaiora.[16] I have chosen to use clients as a generic term to refer to people who access statutory mental health services.

Clinical Demand

Clinical demand refers to the acuity or level of 'unwellness' of clients and the clinical responses required to meet the needs of these people whether this is an assessment of mental state and suicidality; medical intervention such as the administration of pills or electroconvulsive therapy; a therapeutic intervention such as cognitive behaviour therapy; or undertaking other measures to ensure the safety and well-being of clients in the immediate to long-term such as restraint, respite, inpatient admission and sectioning under the Compulsory Assessment and Treatment Act.

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[16] Tangata whaiora is a Maori term that translates to people seeking wellness.

Clinician

Clinician is used to indicate all staff working at Living Well who work directly with clients including psychiatrists; registrars; nurses; social workers; psychologists; medical officers of health; Maori mental health workers; occupational therapists; physiotherapists; dieticians; community support workers; recreation officers; and pharmacists.[17]

Formal structures and systems

An organisation's formal structure and systems give it purpose and function (Brock, Powell, & Hinings, 2007; Olsen, 2008). The formal structure refers to the authority pathways mapped out in the organisational chart including service hierarchy and groupings. The structure is then translated into action by formal systems that exist as written rules and regulations including policies and service frameworks. These formal systems provide detail about the nature and scope of organisational activity and are the functional aspects of the business structure[18] (Blau & Meyer, 1971; Jaques, 1976; Casey, 2004; Kallinikos, 2004; Mouzelis, 1967).

Interpretive Scheme

An organisation's interpretive scheme comprises the values, beliefs and ideologies of all members of an organisation, which then forms the framework for its internal politics, culture and ways of operating (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Kirkpatrick & Ackroyd, 2003; Powell, Brock, & Hinings, 1999). This thesis is concerned with how the interaction between clinicians and managers contributes to the interpretive scheme of the organisation and the process of service development.

Management

Throughout this thesis, management is used as a generic term to encompass the roles of General Manager, Operations Manager, Service Managers, Unit Managers and Clinical

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[17] This list of occupational groups is not exhaustive.
[18] The nature of Living Well's business structure is discussed in Chapter Five.

Managers. Senior management is used to refer to the upper tiers of Living Well's management structure including the General Manager, Operations Manager and Service Managers.

Operational

The term operational is used to refer to the management and administrative responses required to deliver mental health services on a daily basis including staff cover and rosters; bed availability; maintenance requirements; risk minimisation and audit; information technology; human resource concerns; and budgetary requirements.

Raison d'être

An organisation's raison d'être is central to defining its archetype. Hinings and Greenwood (1989) define an organisation's raison d'être as its main purpose, reason or justification for its existence. At Living Well the raison d'être was defined as delivering responsive mental health services.[19]

Recovery

Recovery is used in a specialised or technical sense throughout this thesis. It refers to a philosophical approach aimed at improving the involvement of mental health clients in their care as well as increasing their life satisfaction (Reed, 2006).

Service development

Service development in the context of this study refers to a process of changing the configuration of services and/or the scope and nature of clinical tasks undertaken within a work area.

This investigation identified two potential pathways for service development:

➢ **Formal service development pathways** that are pre-planned service development activities that occur because of: government and local policy; strategic frameworks; projects; reviews; and evaluations.

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[19] For more detail about Living Well's raison d'être see Chapter Four.

➢ **Informal service development pathways** that involve unplanned responses to: day-to-day operational concerns; immediate requests for services; responding to clinical demand or clinical reflection.

Structure of the Thesis

The thesis is structured in the following way:

Chapter One provides an introduction to the research. It outlines the research questions and provides a brief overview of the nature of mental health service delivery within statutory organisations in Aotearoa New Zealand.

Chapter Two introduces archetype theory as a conceptual framework for understanding service development in professional service organisations. It outlines the origins of the theory, and the value of understanding organisations as whole systems involving structural as well as value systems. Chapter Two also reviews the contribution archetype theory has made to the study of statutory professional service organisations and considers the tensions involved in implementing service development within organisations of this type.

Chapter Three presents the research methodology and methods used to undertake the study. It provides a justification for the choice of method, and outlines the processes for gaining access to Living Well as well as data collection and analysis procedures. The chapter also details the ethical considerations involved in the research.

Chapter Four provides an historical overview of the development of mental health organisations both internationally and in Aotearoa New Zealand. It captures the trends in service development in the area of statutory mental health service provision and the lack of reliable evidence upon which to premise service development. The chapter notes the fragmented and sometimes contradictory processes of service development that

underpin today's mental health services. This chapter concludes by introducing the archetype of Living Well.

The discussion chapters, Chapters Five to Nine, explore and analyse the processes of service development at Living Well. Chapter Five discusses the complex nature of service delivery at Living Well, the challenges presented by balancing the operational requirements of the organisation with clinical demand and the subsequent consequences for service development. Chapters Six and Seven focus on the priority given to formal change pathways at Living Well through the establishment of multiple service development processes. They also address the disconnection between planned service development, policy and strategy with the reality of service delivery. Chapter Eight extends the discussion of service development pathways by focusing on the role of clinicians in the service development process including the difficulties of engaging clinicians in formal service development, the role of clinical reflection and resistance, as well as the importance of leadership. The final chapter in the discussion, Chapter Nine, explores an attempt at archetype transformation that occurred during the research time frame. This attempted transformation encompassed multiple convergent service development changes. While the archetype was not adopted, the findings of this chapter support the emergence of an approach for understanding service development within statutory mental health services, where priority is given to the daily demands of delivering mental health services through a process embedded with tensions between the different value systems of clinicians and managers.

Chapter Ten concludes the thesis by presenting the key findings from the research and the implications of these findings for the on-going development of statutory mental health services.

Conclusion

The purpose of this chapter has been to introduce the research topic and provide justification for its choice. This included a brief overview of the social policy and historical service delivery context. The chapter also defined key terms and concluded with presenting the overall thesis structure.

The following chapter explores archetype theory's contribution to analysing service development in professional service organisations including statutory mental health services.

Chapter Two: Archetype Theory

Introduction

The central concern of this research is to develop an understanding of how service development occurs within statutory mental health organisations through an analysis of the processes that inform service development at Living Well, a statutory mental health provider. Archetype theory provides a useful perspective to inform the analysis of the processes of service development within this setting. The purpose of this chapter is to provide an overview of archetype theory in order to identify the theoretical framework for the thesis.

Archetype theory is concerned with the relationship between the formal structures and systems of an organisation and the values, beliefs and ideologies that represent the organisation's value system known as its interpretive scheme (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999).[20] Archetype theory views the interpretive scheme as being critical to achieving organisational change and posits that for successful change there needs to be alignment between an organisation's interpretive scheme and any proposed service development or new archetype (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999).

The chapter begins by locating archetype theory within the broader body of organisational theory with its origins more specifically in discussions of the typology of organisations, neo-institutionalism and contingency theory. A general overview of the theory follows as well as an analysis of the role of an organisation's structure, systems, values, beliefs and ideologies in organisational change. The process of classifying

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[20] The interpretive scheme is embedded in the structure and systems of an organisation and includes the organisation's values, beliefs and ideologies (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Kirkpatrick & Ackroyd, 2003; Powell, Brock, & Hinings, 1999).

archetypes and an analysis of factors influencing both radical and convergent change is presented.

Archetype theory has mainly focused on explaining the nature of professional organisations and the processes that support and impede organisational change within these environments (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999). Statutory mental health service providers are classified as professional organisations, but the nature of their archetype encompasses characteristics from the original bureaucratic archetype[21] as well as the professional bureaucracy[22]. Archetype theorists assert that society's dissatisfaction with the nature of bureaucratic organisations and the proliferation of new public management and neo-liberal ideas across the public sector have created the potential to dramatically alter the nature of the professional organisation towards a more corporate or quasi-bureaucracy (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999). This chapter uses archetype theory to explain developments in the professional organisation, addressing the characteristics of the original bureaucracy, the professional bureaucracy as well as the nature of the interpretive schemes that are peculiar to these organisational archetypes. In addition, the conditions that have altered the nature of the delivery environment in which statutory professional services[23] operate are discussed. The chapter also highlights the critique of archetype theory, which suggests that the drive to achieve consistency and coherence within an organisation's archetype fails to acknowledge the inherent instability and lack of coherence in organisational design often apparent within statutory professional organisations.

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[21] The original bureaucratic archetype refers to Weber's (1948) typology of an organisation characterised by high degrees of specialisation, clear lines of authority, a hierarchical structure and the use of written rules and regulations.

[22] Mintzberg first identified the professional bureaucracy in 1979; it is an organisation with similar structure and systems to Weber's bureaucracy, yet with a different power and authority structure premised on the expertise of staff delivering services.

[23] Within the context of this thesis professional services are defined as tasks delivered by a registered health professional that requires a tertiary qualification to practice.

Locating Archetype Theory

Archetype theory is part of the discipline of organisational theory having roots strongly embedded in neo-institutionalism and contingency theory (Brock, Powell, & Hinings, 2007). It locates organisations within organisational fields and examines the role of the environment in shaping organisations. The primary aim in archetype theory is to understand the nature of organisations through an analysis of the relationship between an organisation's informal value system or interpretive scheme, and its more formal structure and systems. It attempts to balance organisational theory's preoccupation with management with a more considered analysis of how the informal elements of an organisation can influence change. This section provides a brief overview of the general tenets of organisational theory in order to create a foundation upon which to view the discussion of archetype theory in relation to professional organisations such as statutory mental health organisations.

Organisational theory as a discipline has existed since prior to the industrial revolution, but has grown with the increasing prevalence and dominance of organisations in society. There is now a substantial body of knowledge concerned with the study of organisations strongly influenced by different theoretical perspectives or schools of thought (Williamson, 1990). While the perspectives underpinning organisational theory differ, there are some global properties that all organisations have in common (Hall, 2002). These properties include an organisation's size, location, age, function, profitability and assets (Elridge & Cromie, 1974). The structure of organisations can also be determined by other characteristics including the complexity of the organisation; the levels of rules and controls that exist as formalisation within the organisation; the degree to which these rules and controls are formalised; levels of hierarchy; and the organisation's relationship with its external environment (Hall, 2002). The different theories then explain how these properties are constructed, the functions they perform, their relationship with the environment and the reasons for these characteristics (Gergen, 2003; Kieser, 1994; Perrow, 2000).

The role of management within organisations has dominated organisation theory since the 1950s. However, even earlier than this, in the 1930s Henri Fayol directed his attention to the functions of management and the implications of management for the organisation. The shift towards a more managerial function within organisational theory was reflected in an increased focus on developing the professional career of managers through the provision of management and business education (Gergen, 2003; Starbuck, 2003). Unfortunately, the dominance of management as a key construct of organisation theory led to fragmentation between the direction of management and sociology with regard to understanding power and efficiencies within organisations (Gabriel, 2001; Gergen, 2003; Hinings & Greenwood, 2003; Perrow, 2000; Starbuck, 2003).[24] Management theories focused on improving the efficiency and effectiveness of organisations and left discussions relating to power within organisations to sociologists to explore (Hinings & Greenwood, 2003). Consequently, strategy, strategic choice and organisational effectiveness are widely written about in management textbooks with considerable space devoted to the strategic planning process and to providing business leaders with advice regarding increasing the efficiency of their organisations. Whereas, organisation theorists with their roots in sociology focus primarily on analysing the process and context of decision-making within organisations and view strategic choices as being made on the basis of bounded rationality[25] (Hall, 2002).

As already noted, archetype theory has its roots in neo-institutionalism and contingency theory. A fundamental premise of this group of theories is that organisations have deeply embedded cultural norms and values that ultimately shape their functioning (Brock, Powell, & Hinings, 2007). Neo-institutionalism classifies organisations into groups based on shared characteristics that define an organisational field. It focuses on an organisation's ability to respond and adapt to demands from the external environment alongside pressures to change from other organisations within its field as well as the internal culture of the organisation (Greenwood & Hinings, 1996; Kirkpatrick &

[24] Starbuck describes this as a time when organisation theory became "self absorbed and irrelevant" (Starbuck, 2003).
[25] Bounded rationality refers to individuals not having enough time, information, and cognitive capacity to make fully informed decisions.

Ackroyd, 2003a). A key focus of neo-institutionalism is analysing organisational change over time, in particular focusing on the stability of organisational components in the face of these pressures (De La Luz Fernandez-Alles & Llamas-Sanche, 2008).

Contingency theory is concerned with understanding the different structures and decision-making systems of organisations (Kirkpatrick & Ackroyd, 2003a). It suggests that there is no 'one' right way to design an organisation and that organisational responses or adaptation will be dependent on the circumstances of the organisation and its responses to various situations (Cohen & Sims, 2007). Contingency theory views 'equifinality' or isomorphism as a key principle in organisational design explaining that organisations may end up very similar, but have taken very different paths to reach that point (Cohen & Sims, 2007).

Archetype theory draws on these elements of neo-institutionalism and contingency theory in an attempt to bridge the gap between management research and analysis and the sociological analysis of organisations by analysing the dynamics and location of power, the values, beliefs and ideologies embedded in the organisation as well as the structures and systems which inform the nature of the organisation's decision-making processes. Archetype theory argues that any analysis of organisational change needs to consider the role of both external environmental factors such as competition, political factors, changing markets, resource availability and client demand as well as the organisation's internal environment, in particular the role of the values, beliefs and ideologies representing the interpretive scheme within the organisation (Powell, Brock, & Hinings, 1999). It draws on neo-institutionalism and contingency theory's view of organisational culture and advances the concept of an organisational interpretive scheme as fundamental in all organisational change processes. Therefore, in order to achieve sustainable, effective change there needs to be close alignment between the dominant values, beliefs and ideologies of organisational members and the organisation's structure and system.

This thesis uses archetype theory as a heuristic device to analyse the structures, systems and values of Living Well, in order to understand the process of service development decision-making within this setting. An understanding of the interplay between structures, systems and interpretive scheme as discussed by archetype theorists provides insight into the processes informing service development within statutory mental health services as well as the factors that contribute to decision-making in this area.

An organisational archetype is defined as "*a configuration of structures and systems that are consistent with an underlying interpretive scheme*" (Brock, Powell, & Hinings, 2007, p.222). Archetype theory suggests that within any given organisational field there is one dominant archetype that dictates the nature of all organisations within that field (Brock, 2006; Greenwood & Hinings 1993). It also assumes that the classification of organisations is based on their distinct structures and the ways in which decisions are made (Kirkpatrick & Ackroyd, 2003a).

Archetype theory draws on typologies of organisations classifying them into different organisational fields. While the classification of organisations is not the focus of this thesis, a brief outline of the typology of organisations is included in order to locate Living Well as a type of professional organisation. Organisations with similar characteristics are seen to have similar functions and act in similar ways. Mintzberg, Parsons, Etzioni, Blau and Scott have all contributed to the early discussion of the typology of organisations. Mintzberg (1979) focused on structural characteristics of organisations, Parsons (1960) based his typology on the type of organisation, Etzioni (1964) emphasised issues of compliance and authority, and Blau and Scott (1962) considered the beneficiaries of the organisation. However, Hall (2002) notes that there is limited replication in studies of typology as it is difficult to determine if organisational differences at a micro level can have a large impact on organisational behaviour and actions. Within archetype theory there is not a finite list of archetypal forms, rather archetype theorists classify and name archetypes based on their distinct characteristics including their raison d'être, structures, systems, and interpretive scheme.

The Informal and Formal Structures and Systems of Organisations

Archetype theory is concerned with understanding the relationship between the formal structures and systems and informal interpretive scheme representing the values, beliefs and ideologies of the organisation and its members (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Kirkpatrick & Ackroyd, 2003a; Mueller, Harvey, & Howorth, 2003; Powell, Brock, & Hinings, 1999). The following section further explores the role of both the informal and formal structures and systems of an organisation. Having an understanding of an organisation's structure provides insight into both its formal and informal control mechanisms, important factors when trying to identify the decision-making patterns within it. This section also addresses the nature of an interpretive scheme and the role this plays in understanding service development and change within an organisation.

The interpretive scheme is the central feature of an organisational archetype, but in order to classify the organisational archetype within an organisational field the structure and systems of the organisation as well as its interpretive scheme need to be considered (Hinings & Greenwood, 1989). Structure refers to how the organisation is physically constructed, including whether it is vertically or horizontally organised; as well as the division of labour (Hinings & Greenwood, 1989). Systems of the organisation refer to the policies, plans and procedures the organisation uses to complete its tasks including the use of meetings and committees (Hinings & Greenwood, 1989).

An organisation's structural form provides a key focal point for assessing its overall effectiveness and its decision-making processes (Bhargava & Sinha, 2001; Robbins & Barnwell, 2002). According to archetype theory an organisation's formal structure and systems provide the mechanism from which all other organisational functions flow including the implementation of strategy, command and control functions, information and production flows as well as defining how the organisation responds to its environment (Bhargava & Sinha, 2001; Robbins & Barnwell, 2002). The formal

structure and systems of an organisation give it purpose and function, but they lack meaning without the consideration of the informal structures and normative values of the organisation which over time become entrenched in all aspects of its functioning (Brock, Powell, & Hinings, 2007; Olsen, 2008). The interpretive scheme includes the values, beliefs and ideologies of organisational members, it is embedded in the structure and systems of an organisation as part of its internal politics, culture and ways of operating (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Kirkpatrick & Ackroyd, 2003a; Powell, Brock, & Hinings, 1999).

The interpretive scheme is not formally prescribed, rather it emerges from the values, beliefs and ideologies of organisational members. These values, beliefs and ideologies exist as stories, patterns of behaviour, and expectations that over time become embedded in the organisation's memory and ways of functioning (Bennett, 1997; Hall, 2002; Hinings & Greenwood, 1989). The interpretive scheme is therefore a vital part of its functioning (Mueller, Harvey, & Howorth, 2003). It does not necessarily align with the official story, but rather captures the patterns of interaction across the organisation, the nature and location of power, as well as the ways in which day-to-day work is actually undertaken (Hinings & Greenwood, 1989). According to archetype theory, the interpretive scheme is consequently the most important determinant of change within an organisation as archetype transformation is determined by the alignment between the values, beliefs and ideologies of the organisation and the proposed change (Mueller, Harvey, & Howorth, 2003).

Archetype theorists believe that an holistic approach needs to be taken in order to understand an organisation, meaning that the interpretive scheme needs to be viewed alongside the physical structure and systems of that organisation (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). This process enables insight into the values, beliefs and ideologies embedded within these systems (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). The interpretive scheme thus becomes the mechanism to make sense of and "*activate*" the structures and systems

turning the formal structure and systems into meaningful mechanisms for undertaking the work of the organisation (Brock, Powell, & Hinings, 2007, p. 224). The interpretive scheme can therefore be isolated by identifying the patterns of values, beliefs, and ideologies across the organisation that become part of the accepted way of operating and are "*passively reflected in and reproduced by clusters of structures and systems*" (Hinings & Greenwood, 1989, p.18).

Despite the primacy given to the interpretive scheme in archetype theory, Brock (2006) describes the relationship between the structures and systems of the organisation and the organisation's interpretive scheme as being reflexive where neither has greater importance or significance than the other. An analysis of an organisation consequently needs to explore the relationship between the different structural and interpretive components including the physical structure; culture; power and politics entrenched in these systems (Brock, Powell, & Hinings, 2007). Often the values, beliefs and ideology are so deeply embedded and therefore impervious to organisational change, including implementing service development. Archetype change in such circumstances requires strong challenges to the dominant value systems to de-legitimate them thereby undermining the exiting archetype and creating opportunities for both convergent and radical archetype change (Brock, 2006; Brock, Powell, & Hinings, 2007).

This section has identified the role of interpretive schemes and their relationship with the formal systems and structures of an organisation as discussed in archetype theory. The organisation's structure and systems give it both purpose and function and are captured within its formal processes and policies; in contrast an organisation's interpretive scheme is the embodiment of values, beliefs and ideologies within the structure and systems of the organisation. According to archetype theory, for service development to be effective, the interpretive scheme must align or take account of the values of staff contributing to the interpretive scheme of the organisation, and analyse their interaction with the formal structures and systems. In order achieve (successful) change the interpretive scheme needs to align with, or at least take account of the

different value systems within the organisation and their relationship with the formal structures and systems.

Identifying Archetypes

In order to classify an organisational archetype assessment of an organisation's interpretive scheme occurs alongside its structure and systems. The identification of an organisation's archetype is a way in which theorists explain organisations from the outside. Typically, organisational members would be unaware of the different value systems within the organisation or the process of transition between archetypes. Archetype theory consequently offers a heuristic device to make sense of organisational change rather than providing a guide for organisational members to implement service development and change.

Greenwood and Hinings originally presented the criteria for assessing an organisation's interpretive scheme in 1989 as part of their seminal work on archetype theory. They suggested that in order to isolate the interpretive scheme of an organisation firstly the organisation's purpose known as the domain, or raison d'être, needed to be identified (Hinings & Greenwood, 1989). The second step involved classifying the principles that underpinned the development of the structure and systems of the organisation (Hinings & Greenwood, 1989). The third step required that the systems for evaluating performance be established (Hinings & Greenwood, 1989).

Following the identification of the different components of an organisation's archetype further analysis related to service development can occur. As part of this analysis, information is generated regarding how the different components relate to each other, the role of the interpretive scheme in this process and the main barriers to achieving transformation within the organisation. Through the process of identifying and analysing the characteristics of an organisation's archetype insight is provided into the nature of the organisation and the process of service development. While this study is not

concerned with classifying the archetype of statutory mental health organisations in Aotearoa New Zealand an analysis of the main features of an organisation's archetype offers insights into the process of service development as well as the different elements and value systems that affect this process.

There have been a number of studies using this classification method, one relevant to this research is a study by Kitchener (1999), who used the process of classifying archetypes to describe the interpretive scheme within the United Kingdom's Health system prior to the adoption of a what he termed a quasi-market hospital archetype. He described the raison d'être or domain of the health sector as the provision of medical treatment and care to people who need it, free of charge in an environment where providers work together to ensure positive outcomes.[26] The principles of organising were about separate administrative and medical structures where the administration did not intervene in medical matters and professional values, autonomy and self-discipline guided clinicians in their practice. The evaluation system was peer reviewed where other professionals were responsible for overseeing each other's work on a collegial basis rather than performance monitoring (Kitchener, 1999). Kitchener's study provides one example of the identification of an organisation's archetype within the health sector, highlighting the complexity of this environment and the different factors that shape organisations within this field including statutory mental health providers.

Archetype Change

As already discussed, organisational change can be either convergent, which occurs within the boundaries of an existing archetype template, or radical which occurs when an organisation moves from one archetype to another (Greenwood & Hinings, 1996). This research is concerned with understanding service development as a form of convergent archetype change at Living Well. The purpose of this section is to discuss

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[26] Market philosophies acted to challenge this belief and alter the dominant values of this interpretive scheme hence the shift to the new archetype, which involved a composite of the old professional values with the new market values in a hybrid archetype (Kitchener, 1999).

the different forms of archetype transformation, the main factors that impact on this and the role of different levels of staff support known as commitment for organisational change.

As already outlined, archetype theorists believe that to achieve successful organisational change there needs to be alignment within the interpretive scheme of the organisation or with another system of values, beliefs and ideology that is gaining legitimacy at that point in time (Brock, 2006; Brock, Powell, & Hinings, 2007). While value systems can be deeply entrenched within organisations, they are at the same time dynamic incorporating new ideas over time that align with the core values of the interpretive scheme such as the inclusion of a new process or way of working that still achieves the same result (Brock, Powell, & Hinings, 2007). An example of this is the shift from institutional treatment to care within the community for clients with mental illness. Overtime staff saw the value in the new approach to delivering mental health care and it is now the dominant ideology across statutory mental health services.[27]

The process of incorporating new ideas alongside changing levels of support to the belief patterns within an organisation creates opportunities for both shifts within the existing archetype, convergent change, as well as radical change (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). Radical archetype change is very difficult to achieve as the dominant ideology of an organisation needs to become realigned with a new way of delivering services. Convergent change is much more frequent, involving adjustments within the current archetype and is the central concern of this thesis.

Convergent Archetype Change

Archetype theorists describe convergent change as a process by which the organisation maintains or achieves archetype coherence and stability (Hinings & Greenwood, 1989).

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[27] The shift from institutional treatment to community care across mental health services is discussed further in Chapter Four.

Convergent change occurs within the current organisational archetype and involves adjustments to the structure, systems, and interpretive scheme of the organisation in order to reorient rather than alter the way in which work is undertaken (Hinings & Greenwood, 1989). This type of change also known as intra-archetype change is the most common form of change within organisations (Hinings & Greenwood, 1989). An example of this may be the introduction of a new service or programme which complements the existing services rather that altering the direction or focus of the organisation.

Convergent archetype change requires support or at least indifference from the dominant value system within the organisation. The cumulative impact of on-going convergent archetype change over time may eventually result in radical archetype change occurring. As already outlined, understanding the process of convergent change resulting from service development at Living Well is a central concern of this thesis.

Radical Archetype Change

Radical archetype change occurs when an organisation shifts from one archetype to another. Moving to a new organisational archetype is a complex process and consequently radical change is not a frequent occurrence (Brock, 2006; Powell, Brock, & Hinings, 1999). Radical archetype change requires fundamental shifts in the perception of an organisation's members about how the system should be structured, what the best mechanisms are for delivering services, as well as the values, beliefs and ideologies ascribed to this (Powell, Brock, & Hinings, 1999). Consequently, the process of implementing radical archetype change involves challenging and questioning the deeply held beliefs of organisational members to create opportunities within the interpretive scheme of the existing archetype and encourage them to see the value of the new organisation form (Brock, Powell, & Hinings, 2007).

The Process of Archetype Change

Assessing an organisation's readiness to change is the first step in implementing any form of service development. This involves weighing the constraints of the external environment alongside the location and dominance of power within the organisation as well as the institution's capability to fully embrace and implement the result (Hinings & Greenwood, 1989).

Despite the often deeply entrenched nature of interpretive schemes, they are not static and are subject to challenge from both internal and external factors (Brock, Powell, & Hinings, 2007). The iterative nature of the interpretive scheme can cause stakeholders to question the legitimacy of aspects of the original archetype, as a result, creating opportunities to integrate new values into the existing scheme altering it or facilitating the process of archetype transformation (Brock, Powell, & Hinings, 2007). Within an organisation there are often different value systems, which can exist in conflict with each other, for example, organisational members may hold diverse views about whether to remain a locally based organisation or embrace a global market (Hinings & Greenwood, 1989). Hinings and Greenwood (1989) suggest that this acts to destabilise the structure and systems of the organisation and creates opportunities for new interpretive schemes to emerge as eventually the value systems merge into a new archetype through a process of reorientation.[28] [29] Consideration of the relationships between these aspects of the organisation will indicate whether there is the potential to introduce change within the organisation, as tensions within any aspects of these areas create opportunities to introduce and implement service development (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999).

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[28] Cooper, Hinings, Greenwood and Brown (1996) discuss the emergence of hybrid archetypes the Global Professional Network (GPN) and the Managed Professional Business (MPB) in response to value systems and interpretive schemes that were previously in conflict with each other.

[29] The level of stability prescribed by Greenwood and Hinings (1989) is a key critique of archetype theory and discussed later in this chapter.

Staff support for service development, evident within an organisation's interpretive scheme, is vital to successful implementation of any archetype change. According to the seminal contributors on archetype transformation, Greenwood and Hinings, there are four different levels of "*commitment*" from staff which influence an organisation's ability to implement archetype change through the transformation of the organisation's interpretive scheme (Greenwood & Hinings, 1996; Hinings & Greenwood 1989). The four levels of commitment are: status quo; indifference; competitive commitment; and reformative commitment (Greenwood & Hinings, 1996; Hinings & Greenwood 1989). These differing levels of commitment will either support a proposed change or undermine it resulting in different "*change tracks*" within the organisation (Greenwood & Hinings, 1996; Hinings & Greenwood 1989).

In the first level of commitment, staff seek to maintain the status quo, in this situation all or the majority of staff are in agreement with the current methods and scope of service delivery or shared values, beliefs and ideology so archetype change is very unlikely to occur (Greenwood & Hinings, 1996; Hinings & Greenwood 1989). In the second level of commitment staff do not express an opinion about either the current situation or the proposed change, they are indifferent to it. Greenwood and Hinings note that this situation may result in unwitting acquiescence to a change due to failure to participate in the process (Greenwood & Hinings, 1996; Hinings & Greenwood 1989). The third level, competitive commitment, is the most contentious in that some members of the organisation will be proponents of the change and others will be opposed to it. In this situation, a stalemate often occurs and the change does not proceed (Greenwood & Hinings, 1996; Hinings & Greenwood 1989). The final level involves all organisational members being against the proposed change and preferring instead an alternative solution known as reformative commitment, as a result an alternate change could potentially be implemented (Greenwood & Hinings, 1996; Hinings & Greenwood 1989). Powell, Brock and Hinings (1999) suggest there may even be a further level of commitment where the organisation becomes trapped between two archetypes the original and the proposed new scheme in a hybrid, schizoid or what Cooper et al.(1996) term a sedimented state. It should be noted that despite the differing levels of staff

commitment, described above, as part of the process of implementing any archetype change, there is likely to be a period of internal conflict or "*archetype incoherence*" as a transition takes place between old and new interpretive schemes (Brock, 2006, p.168). Interestingly, there is no level of staff commitment describing when archetype transformation occurs as a straightforward process without any staff resistance.

Hinings and Greenwood (1989, p.26) align the levels of staff commitment with "*change tracks*" which archetype theorists use to measure an organisation's movement within and between archetypes (Kitchener, 1999). The change tracks correspond with the different levels of commitment as well as the degree of satisfaction with the current interpretive scheme. Hinings and Greenwood (1989, p.26) describe the tracks as relating to the "*interpretive decoupling*" from the existing interpretive scheme and then "*recoupling*" to a new set of values, beliefs and ideologies. The tracks are identified by Hinings and Greenwood (1989) as:

- Track A: Organisational Inertia or retention of the current archetype;
- Track B: Aborted Excursion which is where new ideas are tested and then rejected and the organisation reverts back to its original ways of functioning;
- Track C: Reorientation where a new archetype design is successfully adopted;
- Track D: Unresolved excursion where the organisation becomes pulled into a hybrid or schizoid state torn between two archetypes.

Archetype theory asserts that organisational change whether radical or convergent is about achieving consistency and coherence within an archetype (Brock, 2006; Hinings & Greenwood, 1989). In situations where archetype transformation cannot be achieved archetype theory states that the organisation will revert to its original archetype or shift to an alternate archetype rather than remaining in a state of flux between two archetypal forms (Brock, 2006; Hinings & Greenwood, 1989). Kirkpatrick and Ackroyd (2003 a & b) critique this perspective stating that hybrid archetypes do exist, and conflict and flux are much more common within professional bureaucracies than is acknowledged within archetype theory.[30]

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[30] This is discussed in greater depth later in this chapter.

The purpose of this section has been to outline the process of archetype change. It has explored the different forms of archetype transformation, the relationship between staff support known as commitment to a proposed change and successful archetype transformation as well as the change tracks related to archetype change. These elements are the key factors that influence service development within organisations and offer an understanding of the relationship between the formal structure and systems of an organisation and its informal interpretive scheme.

The Archetype of the Professional Organisation

The majority of research undertaken using archetype theory has focused on the professional organisation. The professional organisation is an organisation mainly staffed by people with a professional qualification and can be found within either the private or public sector including organisations like accounting partnerships, law firms, medical practices, welfare providers and hospitals including Living Well, among others. While there is not a definitive list of organisational archetypes, researchers in the area of archetype theory have identified a number of different organisational types under the umbrella of the professional archetype. These include professional partnership organisations, the professional bureaucracy as well as new emerging archetypes such as the managed professional business, quasi-market bureaucracy, the managed professional bureaucracy and the corporate bureaucracy. Table 1, p. 35 provides a summary of the different variants of the professional organisation that have been identified by archetype theorists.

Table 1: Archetype Variants of the Professional Organisation

ARCHETYPE OF THE PROFESSIONAL ORGANISATION	NATURE OF THE ARCHETYPE
Professional Bureaucracy	Mintzberg (1979) • Power rests in professional autonomy and discretion • Lack of formalisation • Reliance on peer review
Professional Partnership Organisations (P²)	Greenwood, Hinings and Brown (1990) • Founded on professionalism and partnership • Work independently • Decisions made collegially
Managed professional business/ Managed Professional Bureaucracy	Cooper et al.(1996) • P² with a layer of managerialism and business values
Global Professional Network	Brock and Powell (2005) • Focus on managerialism • Global network focus • Corporate • Individualised reward systems
Star	Brock (2006) • Small to medium organisation • Peer controlled • Individuals expected to bring in clients • Professional specialities
Quasi Market Bureaucracy	(Kitchener, 1999) • Hybrid archetype in UK health system combining professional bureaucracy with new public management • Professional Manager role responsible for fund management and allocation

The ability to translate the research findings of archetype theory across professional archetypes has been questioned. However, Suddaby, Greenwood and Wilderom (2008) emphasise the shared concerns of professionals working across professional service organisations including both the public and private sector in their introduction to a special issue journal on professional service firms. They listed work/life balance, change management, recruitment and retention as some of the similarities across professional service organisations (Saddaby et al., 2008). These researchers (Saddaby et al., 2008) found that professional organisations were all reliant on expert knowledge and intellectual capital held by professionals to deliver unquantifiable services separating them from other traditional organisational forms such as factories and retailers. The similarities across professional organisations enable the findings of Greenwood and Hinings as well as other researchers studying archetype change to be translated across this organisational field.

The Original Bureaucratic Archetype

The research, which is the focus of this thesis, is concerned with understanding the process of service development decision-making within statutory mental health organisations. Statutory mental health services including Living Well are professional organisations which comprise characteristics of the original bureaucratic archetype and the professional bureaucracy as well as combining elements of institutionalism and community care as features of their archetype. Chapter Four provides a full discussion of the development of mental health services. This section aims to explore elements of the original bureaucratic archetype followed by a discussion of the nature of the professional bureaucracy in order to expand upon the core attributes of these organisational archetypes. The following discussion provides an approach upon which to analyse service development at Living Well.

Bureaucracy is an organisational archetype, with clear structures and systems based on hierarchy and rational legal administration (Hinings & Greenwood, 1989). Each

bureaucracy's domain or raison d'être is defined by its purpose outlined in policy which is implemented by street level bureaucrats[31] who adjust this to encompass their normative and professional values.[32]

One of the earliest theorists working on a typology of organisations was Max Weber who was the seminal contributor in the area of bureaucracy. His focus was on describing an administrative ideal-type that reflected the most basic common features of rational/legal administration where organisations were governed through the adherence to legitimised rules and regulations (Beetham, 1987; Blau & Meyer, 1971; Blau & Scott, 1962; Mouzelis, 1967). Weber's theory was that this form of administration would contribute to the generation of the most efficient organisational type "*superior to any other form in precision, in stability, in the stringency of its discipline and in its reliability*" (Weber, 1947, p. 337). According to Weber, strict adherence to his definition of bureaucracy would result in organisations that were efficient machines with employees selected based on merit; clear lines of authority and control; job security; and standardisation in performance (Beetham, 1996; Gajiduschek, 2003; Healy, 1996; Robbins & Barnwell, 2002; Robbins et al., 2003). The ideal-type bureaucracy has a rational/legal authority base, it has a division and specialisation of labour; a hierarchical authority structure; use of written rules and regulations as well as clear separation between private and public domains (Weber, 1947; 1948). Organisational systems are followed by staff because they were legitimised by the authority of those appointed to positions of seniority (Olsen, 2005).

Bureaucratic organisations are governed by a body that formulates the original goals of the organisation and appoints its foundation members (Beetham, 1987; Jaques, 1976). The role of the bureaucracy, in its simplest form, is to coordinate, execute and translate policy into tasks undertaken by the staff of the organisation (Beetham, 1987). The members of the governing body are typically elected officials who provide broad direction to the bureaucracy, ensure the necessary financial resources and are

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[31] Street Level Bureaucrats are public servants involved in the delivery of statutory services.
[32] Normative and professional values include personal and professional ethics, defined through life experience and education.

responsible to forces external to the organisation (Beetham, 1987).[33] In contrast, the members/staff of the bureaucracy are always appointed and are responsible to positions located within the hierarchical authority structures of the organisation (Beetham, 1987; Weber, 1947).

The existence and adherence to the written rules and regulations of the organisation form one of the defining characteristics of a bureaucracy and provide the organisation with the rationality described by Weber (Blau & Meyer, 1971; Blau & Scott, 1962; Jaques, 1976; Kallinikos, 2004; Mouzelis, 1967; Olsen, 2005; Olsen, 2008). Rules and regulations are transformed into policies, which set the parameters for organisational behaviour and activity, and provide the basis for rational/legal authority (Blau & Meyer, 1971; Casey, 2004; Jaques, 1976; Kallinikos, 2004; Mouzelis, 1967). This may include the production of clinical guidelines, frameworks and policies that formalise routines ensuring consistency and precision through the removal of the personal aspects of the individual from the organisation (Beetham, 1987; Blau & Meyer, 1971; Blau & Scott, 1962; Casey, 2004; Kallinikos, 2004; Matheson, 2000; Mouzelis, 1967; Olsen, 2005; Olsen, 2008). The existence of rules and regulations provide accountability, protection and prevent the abuse of power within the organisation as well as defining the relationships between organisational members (Blau & Meyer, 1971; Pandy & Bretschneider, 1997; Weber, 1947). They clearly articulate the different roles and responsibilities of every member of the organisation and provide methods of accountability should errors occur.

The impersonality of bureaucracy is the feature that distinguishes it from other historical forms of organisation (Blau & Meyer, 1971; Blau & Scott, 1962; Olsen, 2005; Olsen, 2008; Pandy & Bretschneider, 1997). Impersonality is meant to ensure equality and uniformity in the appointment of staff and the administration of tasks and acts to free the organisation from "*the unpredictability of personal connection*" (Beetham, 1987, p.15). These characteristics appeal to policy makers in terms of the administration of welfare including mental health services as the public require the delivery of unbiased services

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[33] At Living Well this represents the members of the District Health Board.

to ensure that gaps in the system generated by human error are minimised (Olsen, 2005; Olsen, 2008).[34]

Weber's writings have been strongly debated, with organisational theorists accepting Weber's definition of what constitutes a bureaucracy, however many question the claim that bureaucracy produces the most efficient form of organisation (Beetham, 1987; Mouzelis, 1967). The bureaucratic archetype is often criticised for its apparent inefficiencies, inability to adapt to changing circumstances and lack of flexibility often brought about by strict adherence to the principles articulated by Weber (Balfour & Grubbs, 2000; Beetham, 1987; Gajiduschek, 2003; Healy, 1996; Kallinikos, 2004; Olsen, 2005; Olsen, 2008; Robbins & Barnwell, 2002).

Within a bureaucracy, the hierarchy is dependent on its staff, the bureaucrats, taking a subordinate position to their managers and following orders based on their belief in the authority vested in the manager (Jaques, 1976). Acceptance of appointment to the organisation is assumed to represent the staff member's allegiance to the organisation and its values (Beetham, 1987). Consequently, in adhering to the rules and regulations of the bureaucracy the organisation requires the bureaucrat to put aside any personal or conflicting views not specifically related to their duties within the organisation (Beetham, 1987; Brower & Abolafia, 1997; Kallinikos, 2004; Matheson, 2000; Mouzelis, 1967; Weber, 1947). As Weber detailed, the worker becomes dependent on their manager for task allocation and is guided by the policies of the organisation in terms of the nature and limits of the tasks to be undertaken (Weber, 1948). Weber stated that the bureaucrat becomes "*a single cog in an ever-moving mechanism which prescribes to him [sic] an essentially fixed route of march*" (Weber, 1948, p.228). This removal of self and the strict focus on the implementation of rules and regulations increases the rationality of the organisation, but has been criticised for depersonalising and limiting the opportunities for organisational members to demonstrate innovation and

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[34] The role of public scrutiny of the bureaucracy will be discussed in greater depth later in this chapter in the section entitled Creating the conditions for change.

creativity in their work (Beetham, 1987; Blau & Meyer, 1971; Blau & Scott, 1962; Jaques, 1976, Kallinikos, 2004; Kohn, 1971; Mouzelis, 1967).

Goal displacement can be a by-product of the power of bureaucracy. Goal displacement involves substituting the original goals of the organisation for other goals that do not reflect the purpose of the organisation (Etzioni, 1964). Goal displacement often occurs as organisations struggle for survival and respond immediately and often impulsively to risk and operational concerns. In bureaucracies, the adherence to the minutiae of rules and regulations and/or a fixation with internal problems often surpasses the original goals of the organisation, impeding effectiveness and resulting in bureaucratic pathology (Beetham, 1987; Blau & Meyer, 1971; Blau & Scott, 1962; Etzioni, 1964; Gajiduschek, 2003; Olsen, 2005; Olsen, 2008; Robbins & Barnwell, 2002).[35] In addition, bureaucracies can become fixated on maintaining stability within the parameters prescribed by their rules and regulations (Blau & Meyer, 1971; Brower & Abolafia, 1997; Matheson, 2000; Olsen, 2005; Olsen, 2008). They consequently become impervious and incapacitated by any changes that do not fall within the scope of these parameters restricting their ability to take risks and develop innovative services (Blau & Meyer, 1971; Brower & Abolafia, 1997; Matheson, 2000; Olsen, 2005; Olsen, 2008).

Weber's assertion that bureaucracies are the most efficient type of organisation is in part due to the separation of personal and business matters, however, it ignores the role of informal dynamics and personal external pressure that comes to bear on organisation members and ultimately influence the organisation's environment; a key concern of archetype theory (Blau & Scott, 1962). Etzioni argued that to truly understand the nature of power within a bureaucracy the role of both informal networks and hierarchical authority need to be considered (Etzioni, 1964). Archetype theory addresses this concern by regarding the interpretive scheme of the organisation alongside its structure and systems.

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[35] An example includes the excessive completion of forms related to resource usage for instance the use of company vehicles requiring staff to complete multiple forms such as mileage books, personal log book, booking sheets, petrol usage, out of area forms, overnight travel forms taking time away from actually delivering services directly to clients.

In Weber's ideal organisation hierarchical authority and specialist knowledge are present, however Weber did not elaborate on the inevitable conflict between the two (Beetham, 1987; Blau & Scott, 1962; Mouzelis, 1967). Conflict results from disparities and conflicting expectations evident in the organisational requirements imposed by managers with no specialist professional knowledge on those they supervise who hold strong professional allegiances (Beetham, 1987; Blau & Scott, 1962; Brower & Abolafia, 1997; Parsons, 1960). Bureaucrats are also able to exert power within the organisation through the informal structures and mechanisms of the interpretive scheme, something Weber did not contemplate (Matheson, 2000; Olsen, 2005; Olsen, 2008). They can delay task completion, selectively interpret results, withdraw their commitment and limit their behaviour in terms of strict rule following (Brower & Abolafia, 1997; Matheson, 2000). Additionally, informal methods of communication can be used to facilitate unsanctioned change within the organisation (Brower & Abolafia, 1997).

In developing his typology of bureaucracy, Weber did not consider what it would mean to deliver services to clients with mental illness at the turn of the 21st Century. While Weber extolled the virtues of the bureaucratic organisation he was also acutely aware of the risks created by bureaucratic growth brought on by the efficiency of this type of organisation (Beetham, 1987). He asserted that bureaucracy would become a very powerful force in society brought about "*by its purely technical superiority over any other form of organisation*" (Weber, 1948, p. 213) and certainly the power and prevalence of bureaucracy is now well-documented (Beetham, 1987; Mouzelis, 1967; Olsen, 2005; Olsen, 2008; Weber, 1948). Aware of the limitations of the bureaucratic form, Weber was concerned that the increasing rationalisation of society and the expansion of bureaucracy would pose a serious threat to both personal freedom and democracy and see the introduction of totalitarianism (Beetham, 1987; Mouzelis, 1967; Weber, 1948). He believed that bureaucracy would grow and infiltrate every aspect of social life and in the process democracy would be undermined resulting in bureaucrats being confined to a dull, disenchanted existence devoid of creative expression (Weber,

1947; Weber, 1948). Weber predicted that the fate of bureaucratic institutions lay in the hands of those who controlled the organisations (Weber, 1948). Today the bureaucratic archetype is characterised by high levels of formalisation, clear authority structures and prescriptive rules and regulations that constrain creativity and innovation in service development (Beetham, 1996; Gajiduschek, 2003; Healy, 1996; Olsen, 2005; Olsen, 2008; Robbins & Barnwell, 2002; Robbins Bergman, Stagg & Coulter, 2003).

In summary, this section has outlined the primary characteristics of the bureaucratic organisation as well as the critiques of this organisational form. Premised on rational/legal authority, Weber's typology of the bureaucratic organisation outlined an organisational ideal with clear lines of responsibility and employees appointed based on merit, who would uphold the values of the organisation irrespective of personal views. Over time, the role of the bureaucratic organisation has grown to be a dominant organisational form in western society. Unfortunately, the very characteristics of rationality and impersonality that made the bureaucratic organisation appealing to policy makers and managers also embody the main criticisms of the organisational form as slow to adapt, uncaring and unresponsive to clients.

The Professional Bureaucracy

The bureaucratic organisation is the dominant archetype used to administer and implement government policy especially in the areas of health and welfare and is a subtype of the professional organisation. Over time the nature of state bureaucracies has changed from the ideal described by Weber to one where professional and managerial power can be in conflict when embarking on change. First identified by Mintzberg in 1979, the professional bureaucracy is a variant of Weber's original bureaucratic ideal-type. The professional bureaucracy encompasses most of the structural characteristics and systems of Weber's original organisational form yet it differs in terms of the distribution of power within it. Mental health providers like Living Well have characteristics of the professional bureaucracy due to the highly discretionary nature of the work undertaken by professionals within this setting. This section builds on the

preceding discussion about the original bureaucratic archetype to clarify what the core characteristics of a typical professional bureaucracy should look like.

The seminal contributor to the study of professional bureaucracy, Mintzberg (1979), explained that the structures and systems of these organisations had little relationship with the services delivered directly to clients and the location of power within the organisation. Rather, the skills and knowledge of professional staff determined the power dynamics within it. The central focus of the professional bureaucracy is upon the professional expertise of its staff in the delivery of services directly to clients (Brock, 2006; Powell, Brock, & Hinings, 1999). The power of the organisation is derived from the complex nature of the work undertaken by the professionals, which is highly discretionary, based on their knowledge and skill, and is in high demand from the community (Mintzberg, 1979). Unlike Weber's bureaucracy where power was concentrated in management, in the professional bureaucracy power is dispersed across professional groupings, for instance in mental health this would be across nursing, psychiatry and the allied health professions[36] (Mintzberg, 1979). These different groupings have different skills that they use to provide services for the organisation. The tasks of these professionals cannot be easily formalised, and this consequently affords them a lot of freedom to undertake their roles. Professional values dictate the nature and quality of their work rather than administrative and managerial controls as is the case in the original bureaucratic archetype (Powell, Brock, & Hinings, 1999; Mueller, Harvey, & Howorth, 2003; Olsen, 2008). As a result, the interpretive scheme of the professional bureaucracy emerges from the culture of the organisation premised on professional values of appropriateness, peer review and shared expectations (Mueller, Harvey, & Howorth, 2003; Olsen, 2008). These characteristics are deeply entrenched in all aspects of the organisation's functioning and define the nature of professional identity (Denis et al., 1999).

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[36] Allied health professionals include social workers, occupational therapists, psychologists, physiotherapists, speech language therapists, pharmacists and dieticians; typically, a registered health professional that requires a tertiary qualification to practice.

The professional bureaucracy is a composite organisation of management and professional value systems (De La Luz Fernandez-Alles & Llamas-Sanche, 2008; Olsen, 2008). These values are embedded in the organisation's structure, policies and procedures. The professional value system is governed by expertise, autonomy, and peer review[37]; whereas the value system of managers exists alongside the politics of the external environment driven by cost efficiency and risk minimisation (De La Luz Fernandez-Alles & Llamas-Sanche, 2008; Olsen, 2008). The organisation is generally highly decentralised with separate functional units delivering services to clients under the umbrella of one organisation, each with its own set of values and standards about how work should be undertaken (Powell, Brock, & Hinings, 1999).

Sometimes the dispersed nature of functional units leads to a professional bureaucracy having a number of different value systems, based around the dominant professional group in each of those units. Kirkpatrick and Ackroyd (2003a) stress that this type of structure often means that there is little communication and connection between the different components of the organisation as the different value systems across the organisation do not always agree with each other. This leads to a system with multiple and sometimes contradictory processes which attempt to balance professional expertise, autonomy and peer review with the means-end process of rational legal administration often relying upon policies and audit requirements to achieve a sense of context (Olsen, 2008; Powell, Brock, & Hinings, 1999). The contradictions embedded in such systems means there is often an inconsistent approach to service development that is "*myopic, meandering and inefficient*" (Olsen, 2008, p. 29).

The role of professional expertise, autonomy and peer review within the professional bureaucracy's interpretive scheme creates the expectation amongst the professionals that any service development initiative will involve engagement with staff and have mechanisms for meaningful input. Yet, the nature of delivering services within a professional bureaucracy often means that the strategic direction of the organisation is

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[37] The value systems of both clinicians and managers are explored in greater depth in Chapters Four and Five.

swamped by operational demands leaving little time to plan for long-term contingencies, service development initiatives or the implementation of audit and accreditation systems (Kirkpatrick & Ackroyd, 2003a; Powell, Brock, & Hinings, 1999). The lack of a strong administrative or managerial framework to allocate tasks within this type of organisation means that there is increased likelihood of strong personalities as well as professional groupings dominating the service development and strategic planning process (Denis et al., 1999; Hinings, Brown, & Greenwood, 1991). This is especially evident in situations where service development and strategic goals are only vaguely articulated and where there is no clear process for implementation. In this situation, views become important and strategies and approaches can then be adopted or dismissed based on preference (Hinings, Brown, & Greenwood, 1991).

The function of management in the professional bureaucracy has historically been to undertake the administrative tasks required to support the work of the professionals (Kitchener, 1999; Powell, Brock, & Hinings, 1999). The formal structures and systems of the professional bureaucracy provide the rational pathways for the organisation and give legitimacy to processes and hierarchy (Olsen, 2005). They further provide mechanisms for determining the distribution and allocation of resources, tasks undertaken by management (Olsen, 2005). Over time the concerns of management have changed with manager's roles now emphasising administrative and managerial controls concerned with efficiency, risk management and human resource matters among others (Powell, Brock, & Hinings, 1999; Olsen, 2008; Mueller, Harvey, & Howorth, 2003). This change in role has altered the nature of the professional bureaucracy requiring adjustments to the relationship between managers and professionals and highlighting tensions with regard to the location of power.[38] [39]

Staff view service development initiatives as being structural changes that actually do little to alter the nature of the interaction between the client and the professional or question the professional's autonomy to undertake their work (Hinings, Brown, &

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[38] The changing nature of the professional bureaucracy in Aotearoa is discussed later in this chapter.
[39] Tension between management and professionals was a key feature of service development at Living Well and is explored in greater depth in Chapter Five.

Greenwood, 1991). The professionals working within these organisations often regard the introduction of regulatory mechanisms by management as constraining their professional freedom (Olsen, 2008). They therefore only follow pathways and processes, and adapt to administrative or managerial demands when it is in their interest to do so and when they regard the regulation as being necessary, whereas any change that threatens to undermine professional autonomy is challenged and likely to fail (Denis et al., 1999; Hinings, Brown, & Greenwood, 1991; Olsen, 2008).

In summary, the idea of the professional bureaucracy builds on Weber's original bureaucratic organisation, but rather than locating power in the rational authority structures and formalised rules of the organisation, this is located in the discretionary nature of the work undertaken by professionals. Professional characteristics of expertise, autonomy, and peer review come to define the nature of work undertaken within the professional bureaucracy and are embedded within the organisation's interpretive scheme. Professionals view managerial attempts to change the organisational environment as attacks on their values and only implement change when they regard it as being beneficial to clients and it benefits their professional interests (Denis et al., 1999; Hinings, Brown, & Greenwood, 1991; Olsen, 2008).

Factors Influencing Archetype Change Within the Professional Bureaucracy

Within a professional bureaucracy the authority system is controlled by groupings of professionals who have a shared understanding of the raison d'être of the organisation established through their professional values and ethics as well as traditions of the organisation (Hinings, Brown, & Greenwood, 1991). These beliefs, values and ideologies come together to form the interpretive scheme, and are deeply interwoven within the functional systems and processes of the organisation (Powell, Brock, & Hinings, 1999). The interpretive scheme fulfils a very powerful role in the process of both radical and convergent change within a professional bureaucratic organisation. It

can either support a new service development initiative or undermine and resist it ultimately meaning that all sustainable service development involves adjustments to the organisation's interpretive scheme (Hinings, Brown, & Greenwood, 1991).

Power within the professional bureaucracy can be dispersed across a number of professional groups and this dispersal is a critical determinant in the process of implementing archetype change including service development initiatives (Hinings & Greenwood, 1989). The process of securing consistent support for an initiative and its implementation process is complicated because the lack of a centralised power structure means that ideas are filtered and reinterpreted many times over and in the process different professional groups are able to dominate the decision-making process (Hinings, Brown, & Greenwood, 1991).

Staff can choose to support and incorporate change into their work or they can reject the change based on differing levels of commitment. The key to successful implementation is the degree to which the change aligns with the dominant value systems in the organisation and with the new emerging interpretive scheme. Any change that threatens to undermine the autonomy of professionals is likely to fail as powerful groups maintain the status quo by resisting attempts to change (Denis et al., 1999; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). A high level of satisfaction with the current systems and structures inevitably results in services remaining the same (Hinings & Greenwood, 1989).

While all of the professional groups have power in terms of their ability to influence and shape the nature of service delivery and the scope of service provision, they vary in the extent to which they can influence this process (Denis et al., 1999; Greenwood & Hinings, 1996; Hinings & Greenwood 1989). Each professional group has its own interests whether this is in terms of resourcing, professional identity or processes which they seek to protect often at the expense of other groupings and some have greater capacity to influence the organisation than others (Hinings & Greenwood, 1989). Dominant groups are able to protect their beliefs through a type of custodial

management, which involves giving priority to their beliefs and values above others, discrediting and undermining proposed changes that do not fit with their priorities (Denis et al., 1999; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989). Professional groups can therefore drive change from within the organisation as they struggle for power and dominance (Powell, Brock, & Hinings, 1999). Additionally, representatives of constituent groups may act to undermine the existing interpretive scheme by highlighting gaps and deficiencies with this approach and presenting alternative ways of working (Powell, Brock, & Hinings, 1999).

The different occupational groups within a professional bureaucracy have many of the characteristics of organisational clans (Ouchi, 1980). Hanlon (2004) writes that clan strategies mean that organisations attract and recruit staff members who share the same values. Certainly, at Living Well, the mental health organisation where this study took place, staff with similar values remained within the organisation and overtime moved into leadership positions. Ouchi's (1980) argues that members of an organisation come to share a commonality of purpose that creates a shared ideology or goal congruence which archetype theorists view as the organisation's interpretive scheme. The interpretive scheme embodies a sense of belonging as workers share the organisation's values and incorporate these into each individual's sense of self (Dukerich, Golden, & Shortell, 2002). The shared ideology also means that the ratification of decisions can occur with little evidence because those participating in the decision-making process all agree with the solution to the problem based on their shared values. The presence of shared values within the interpretive scheme also means that staff see little need for evaluation of existing services as there is already agreement about what the problem is as well as what needs to be done to resolve it.

Professionals cannot afford for the presence of a divergent view as this will upset the dominant value system and create confusion around the delivery of services. This situation creates a tendency to resist change that they do not initiate creating dependency or solidarity between the professional groups around maintaining the status quo (Greenwood & Hinings, 1996; Ouchi, 1980). Changes will therefore only be

implemented when they either support or are supported by the dominant group; or in the situation where organisational members are indifferent to the proposed change and consequently do not participate in the change process (Greenwood & Hinings, 1996). When professionals understand the reasons for change and see value in its implementation, that is, it aligns with their value system, then, the change will proceed to implementation (Denis et al., 1999).

Prasad and Prasad (1994) in their discussion of implementing a new information system in a professional health environment detail that professional groupings were more likely to accept change that reinforced their professional identities. Further, the perceived impact of the proposed change on their professional identity including professional esteem from other groups both internal and external to the organisation as well as their authority and autonomy determined the extent to which professional groupings accepted change (Prasad & Prasad, 1994).

Research has found that across professional bureaucracies including social service providers the priority or raison d'être for professionals in terms of service delivery is typically the universal delivery of services to clients free of charge (Kirkpatrick & Ackroyd, 2003a; Kitchener, 1999). Any change that threatens to undermine this raison d'être such as the rationalisation of resources or the targeting of specific population groups, is greeted with suspicion and discounted as a priority in terms of service development (Kirkpatrick & Ackroyd, 2003a; Kitchener, 1999).

Different professional value systems inform each professional grouping. Typically though in mental health organisations professionals come together in multidisciplinary teams to deliver clinical services. Within mental health organisations, a multidisciplinary dialogue defines clients' requirements and determines the best method to respond to these needs. Shared understandings of the best treatment approach to adopt when working with clients is generated through clinical discussion in formal settings such as multidisciplinary team meetings involving input from psychiatrists, nurses and

allied health professionals as well as informal discussion across professional groups within the team setting.

Within any organisation including the professional bureaucracy, staff are dependent on each other to perpetuate the environment in which they deliver services; change is heavily dependent on the commitment and involvement of organisational members (Jaskyte & Dressler, 2005; Powell, Brock, & Hinings, 1999). Democratic and collegial processes dominate change processes involving a commitment to consultation and input from across the organisation (Powell, Brock, & Hinings, 1999). Any change implemented within an organisation is likely to have consequences for staff and clients. Changes in service structure and processes while not necessarily changing the nature of services delivered directly to clients influence the underlying interpretive scheme of the organisation (Denis et al., 1999; Hinings, Brown, & Greenwood, 1991). Within the professional bureaucracy, the key concerns of staff with regard to proposed changes in service structure and processes include the effect this may have on the purpose of the organisation, the beliefs of staff members and the degree to which it may affect the autonomy of professionals (Denis et al., 1999; Hinings, Brown, & Greenwood, 1991).

Tradition and organisational memory also play key roles in the service development process within professional bureaucracies as historical patterns are pulled together to form an implicit theory about how the organisation should work (Ouchi, 1980). Meyer and Rowan (1977) refer to this process as organisational myth-making. They state that staff adopt historical patterns, policies and programmes ceremonially as fact (Meyer & Rowan, 1977). Rather than empirical evidence to support change processes preferential credibility is given to these traditions that support the adoption and subsequent implementation of a change, but only when this change reinforces the already held views or value system of organisational members.

The credibility of the person proposing a change is very important (Hinings, Brown, & Greenwood, 1991). Credible change agents are people who are in a position to engender support from staff. They do not need to be managers and may be others in positions of

authority including professional leadership positions such as a Director of Nursing or Chief of Psychiatry. The ability of this person to engender support from affected staff as well as their alignment with the interpretive scheme influences the likelihood of successful change (Hinings, Brown, & Greenwood, 1991). If this person is viewed by staff as having a set of values that do not align with the exiting dominant value system then the change will most likely fail (Hinings, Brown, & Greenwood, 1991). The role of the credible change agent is therefore to promote the proposed change, highlighting the justifications for this and aligning it with the interpretive scheme of the organisation (Hinings, Brown, & Greenwood, 1991). When a proposed change is not popular or undermines the ideas, beliefs and ideologies of professionals, management then have to spend large amounts of time engaging with staff, discussing their concerns and helping them to reinterpret the change in a positive light (Hinings, Brown, & Greenwood, 1991).

Project complexity is another factor influencing successful implementation of service development within the professional bureaucracy. The complexity of a project may not be realised until the implementation of the initiative. In this situation, there may be ambiguity about what the implementation process will involve and while a goal for the change may have been identified, how to implement the change has not been articulated. Hinings, Brown and Greenwood describe this process as the "*operational gap between the concept and the actuality*" and that the absence of a clear implementation process enables general support for the project at the start (Hinings, Brown, & Greenwood, 1991, p. 387). Once the project is commenced and the complexity of the tasks involved comes under scrutiny it becomes apparent that the proposed new structure or initiative actually contradicts or undermines some of the organisation's fundamental beliefs or raison d'être thereby dissipating support for the project (Hinings, Brown, & Greenwood, 1991).

As noted earlier, changes that are imposed on staff in a professional bureaucracy are very difficult to sustain in the long-term, especially where there have been varying levels of commitment throughout the implementation process (Hinings, Brown, & Greenwood, 1991; Hinings & Greenwood, 1989). Managerial control and attempts to

impose change are diluted by the views of dominant professional group resulting in the status quo in terms of service delivery (Denis et al., 1999). While staff may not overtly resist the implementation of a new change, their lack of commitment means that overtime systems and actions to support the new ways of working will not be adopted (Dent et al., 2004; Denis et al., 1999; Hinings, Brown, & Greenwood, 1991; Hinings & Greenwood, 1989; Kirkpatrick & Ackroyd, 2003a). The organisation will eventually revert to its original ways of operating or change into a hybrid structure more consistent with the organisation's interpretive scheme (Dent et al., 2004; Denis et al., 1999; Hinings, Brown, & Greenwood, 1991; Hinings & Greenwood, 1989; Kirkpatrick & Ackroyd, 2003a). In such situations, the interpretive scheme of the organisation remains unchanged despite the implementation of new systems and structures (Kirkpatrick & Ackroyd, 2003a). For successful implementation of directed change, the old interpretive scheme has to be eroded and value placed in the new way of working. Without securing sufficient commitment to the new scheme there is little likelihood of the change being sustained in the long-term (Denis et al., 1999; Hinings and Greenwood, 1989).

In summary, the professional bureaucracy is a complex organisation with multiple competing voices jostling for dominance at any one time. While in principle staff are committed to delivering quality services to those who need them, the wider political environment and the differing priorities of management and professional groups complicates the actual process, structures and systems for delivering care. The chaotic and sometimes contradictory change processes that emerge from within this environment reflect the dispersal of power within the organisation. Alignment of the interpretive scheme within a professional bureaucracy with a proposed change is consequently a critical component that either supports or undermines implementation of either radical or convergent archetype change within this organisational type. The purpose of this section has been to explain the utility of archetype theory in helping to understand the nature of power within professional bureaucracies to provide a foundation upon which to understand the complex nature of service development within a statutory mental health organisation like Living Well.

External Political Determinants for Change Within the State Sector

The purpose of this section is to address how the changing nature of the external environment has influenced the development and delivery of services within statutory professional organisations including the professional bureaucracy. This is undertaken through a discussion of government and civil society's dissatisfaction with the efficiency and effectiveness of statutory bureaucracies over the latter part of the twentieth century and the priority given to implementing new public management from a neo-liberal agenda within these organisations. These environmental conditions have undermined the dominance of the professional value system within this type of organisation further contributing to on-going conflict between regulatory managerial value systems and long-standing professional values of professional expertise, autonomy and peer review. This research is concerned with service development decision-making in statutory mental health providers. An understanding of the broader context that has shaped the development of statutory organisations provides a historical context for the analysis of current service development processes.

The last two decades of the 20th Century and early part of the 21st Century saw a growth in research and literature related to the organisation's relationship with its environment (Scott, 1995). Organisations have two environments: the internal environment namely its interpretive scheme; and the external environment defined as the forces and institutions outside the organisation that affect its ability to carry out its tasks (Brock, Powell, & Hinings, 2007; De La Luz Fernandez-Alles & Llamas-Sanche, 2008; Powell, Brock, & Hinings, 1999; Robbins et al., 2003). External conditions can place pressures on all organisations resulting in changes in the delivery of services.

Brock (2006) described the statutory professional bureaucratic archetype as a heteronomous organisation. Despite the discretionary power of the professional within the organisation ultimately the "*professionals are subject to bureaucratic control*" from the state (Brock, 2006, p.163). This type of organisation has to balance public and

political demands alongside the needs of clients and professional expertise in terms of delivering services. Accountability requirements mean that statutory organisations deliver services such as mental health care, welfare, and probation services that balance the conflicting demands placed upon them (De La Luz Fernandez-Alles & Llamas-Sanche, 2008). The nature of open government within modern liberal democracies including Aotearoa New Zealand means that statutory services are ultimately responsible to the voting public. The relationship between the voting public and politicians' willingness to invest in, develop and prioritise statutory services means that public perception of the competence of professionals working within the statutory services is crucial to their on-going operation (Hinings & Greenwood, 1989).

Archetype theorists agree that the main factors precipitating change in the statutory professional organisation's archetype since the mid-1980s have included deregulation and competition as a result of the introduction of new public management and neo-liberalism; as well as technological developments and the globalisation of services made possible through the dominance of the internet (Brock, 2006; Brock, Powell, & Hinings, 2007; De La Luz Fernandez-Alles & Llamas-Sanche, 2008; Mueller, Harvey, & Howorth, 2003; Olsen, 2005; Olsen, 2008; Powell, Brock, & Hinings, 1999). Alongside these factors, client demands for greater accountability and more professional services have also influenced the nature of services from the professional bureaucracy (Powell, Brock, & Hinings, 1999). Professional statutory bureaucracies have been criticised for placing the needs of professionals above those of clients and taxpayers (Kitchener, 1999). The public blamed insufficient monitoring and lack of professional standards for 'inefficiencies' and 'tragedies' within the statutory services (Butler & Drakeford, 2001; Kitchener, 1999; Olsen, 2008). This resulted in calls for greater controls of the professions through audit and accreditation processes (Butler & Drakeford, 2001; Kitchener, 1999; Olsen, 2008). As a result, the 1980s saw a change in the direction of public service provision across the globe. The introduction of the values of new public management and neo-liberalism provided an impetus for change in public service

organisations internationally.[40] The New Right[41], informed by the values of new public management and neo-liberalism, labelled public sector bureaucracy as problematic, costly, inefficient and lacking administrative controls. These reasons were used to justify restructuring the public services and reducing its size and scope (Brock, Powell, & Hinings, 2007; Kitchener, 1999; Olsen, 2005).

The New Right argued that the public sector had much to learn from the practices of the private sector including the introduction of market-based values such as competition, increased managerial control and greater efficiency (Brock, Powell, & Hinings, 2007; Kitchener, 1999; Olsen, 2005). By subscribing to private sector philosophies the public service would increase efficiency, tragedies would reduce and service delivery would improve (Brock, Powell, & Hinings, 2007; Harris, 1998; Kitchener, 1999; Olsen, 2005). A drive for increased efficiency underpinned by cost cutting saw public service organisations reconsidering the way in which they delivered and administered their services (Brock, 2006; Brock, Powell, & Hinings, 2007). [42] The demands for greater accountability placed on the statutory professional bureaucracy by this new political environment placed parameters around professional discretion and autonomy through the introduction of new measures of performance and accountability.

Those involved in implementing new public management across the public sector had two distinct goals: to reduce the role and size of the state; and to implement greater accountability and regulatory control through the introduction of market philosophies and competition (Kitchener, 1999; Olsen, 2008). Private sector managers were appointed to implement new systems of accountability and to regulate professional activity (Foster & Wilding, 2000). Where historically the management structure within a statutory professional bureaucracy fulfilled an administrative role in support of

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[40] It is not the intent of this thesis to provide a comprehensive overview of new public management and neo-liberalism. However, these theories have shaped the nature of the service delivery across the public sector since the 1980s and therefore deserve mention.

[41] The New Right is used throughout this thesis to refer to proponents of laissez-fair economic policies, individualism and minimal state provided welfare.

[42] Dent et al.(2004) in reviewing the implementation of new public management across the health sector internationally noted that New Zealand had embraced this approach as policy makers implemented a neo-liberal approach across the health sector.

professionals, the introduction of tighter regulatory mechanisms, such as audit and accreditation standards, was meant to redirect the balance of power towards the management structure (Kitchener, 1999; Powell, Brock, & Hinings, 1999). Consequently, as the discipline of management has grown and been adopted throughout the public sector managers have needed to shift their focus to take a wider more strategic view of the organisation, with greater responsibility for ensuring efficiency and compliance (Powell, Brock, & Hinings, 1999).

In Aotearoa New Zealand, the influence of new public management was most evident in the introduction of private sector managers into the public health system in the late 1980s, a move highly criticised by professionals and fraught with conflict and tension between clinical and management values (Boston, Martin, Pallot, & Walsh, 1996). Kitchener (1999) studied archetype change within the health system in the United Kingdom following the introduction of new public management that involved similar changes to those implemented in Aotearoa New Zealand. He observed the shift from the professional bureaucracy hospital archetype, which had been characterised by the prominence of professional values and a distinct administrative system, to what he termed a Quasi-Market Hospital Archetype[43], a hybrid archetype that included the introduction of a professional manager role responsible for resource allocation and usage within their own area (Kitchener, 1999). Despite the failure of the full-scale introduction of private sector ideals into the health system in both the United Kingdom and Aotearoa New Zealand, the influence of new public management and corporate values has left a lasting impression (Boston, Martin, Pallot & Walsh, 1996). This legacy is evident in shifts in language including the introduction of the term consumer rather than client and patient as well as altered accountability structures, such as accreditation systems, that place more emphasis on management accountability rather than peer review (Boston, Martin, Pallot & Walsh, 1996; Kitchener, 1999; Powell, Brock, & Hinings, 1999).

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[43] Other variations of this archetype are the quasi-market bureaucracy, the managed professional bureaucracy and corporate bureaucracy detailed in Table 1.

Public and political demand for quality services based on evidence and risk minimisation has led to a re-adaptation or redefinition of the rules and regulations required within a professional bureaucracy (Robbins & Barnwell, 2002). In the original bureaucratic archetype, rules and regulations were used to create structure and to ensure administrative functions were standardised. Today's organisations use Weberian concepts of standardisation, specialisation, worker competence and regulation to define the quality of the services they provide (Healy, 1996). These characteristics are given priority within statutory professional organisations as the assumption is that these standards will ensure that organisations behave in a rational legal manner, that services are developed premised on evidence, that policies are followed, efficiencies maximised and that risk is subsequently minimised (Olsen, 2005).

In summary, this section has examined the environmental conditions that altered the nature of service development and delivery in statutory bureaucracies around the western world including Aotearoa New Zealand. In particular, it has explored the role of neo-liberalism and new public management in restricting the autonomy and discretion of professions across the state sector through the introduction of private sector management techniques including audit and accreditation processes aimed at ensuring greater efficiency and risk minimisation in service delivery.

Critical Appraisal of Archetype Theory

A key task of archetype theory is to explain the nature of professional organisations and the processes that support and impede organisational change within these environments (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999). Classifying organisations based on their archetype requires dual consideration on the nature of the interpretive scheme alongside the structures and systems of the organisation (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). The purpose of this section is to present a

summary of academic debate related to the use of archetype theory to explain change within statutory professional organisations.

Archetype theory is concerned with explaining how consistency and coherence within an organisation's archetype can be achieved. According to this theory, organisational change is about moving from one archetypal form to another. Within an organisational field there will only be one dominant archetype at any point in time (Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). Archetype theory situates the failure to achieve successful archetype transformation in a lack of alignment between proposed changes and the interpretive scheme of the organisation (Hinings & Greenwood, 1989).

Kirkpatrick and Ackroyd (2003a, 2003b) critique archetype theory for its preoccupation with explaining how organisations achieve new organisational forms or archetypes. Their concern rests on the understanding that within archetype theory organisational change is not effective unless there is achievement of a new archetype (Kirkpatrick & Ackroyd, 2003a). Archetype theorists acknowledge hybrid, schizoid or sedimented organisations as only transitory states as the organisation acts to stabilise itself within one dominant archetype (Cooper et al., 1996; Kirkpatrick & Ackroyd, 2003a; 2003b). Kirkpatrick and Achroyd (2003a, 2003b) argue that in reality, hybrid structures are much more common than archetype theory recognises; that political instability and a lack of coherence in terms of the interpretive scheme is commonplace especially in professional organisations.

Archetype studies across the health sector in the United Kingdom and Germany have noted that achieving a new archetype across all organisations within the field is often unrealistic due to the complexity of these environments and the multiple, often contradictory value systems present (Dent et al., 2004; Kitchener, 1999; Mueller, Harvey, & Howorth, 2003). As discussed earlier in this chapter archetype theory acknowledges that multiple, sometimes conflicting values systems can exist within an organisation. However, archetype theory defines change as the achievement of new

service configurations or organisational forms across organisations of the same type and if this cannot be achieved the organisations will revert back to their original form rather than remaining in a state of flux. Dent et al's (2004) study of archetype change within German hospitals found that variations in archetype did exist. In assessing the impact of transitioning from a public sector archetype to the public sector corporation archetype, the researchers found that there could be local differences in how the archetype was interpreted and implemented based on different organisational and institutional contexts such as the culture of the organisation, local politics and personal preferences (Dent et al., 2004). This resulted in a number of variations of the archetype within the organisational field rather than simply one type.

At times, statutory and regulatory requirements can force structural and system changes on organisations (Powell, Brock, & Hinings, 1999). Organisations are required to conform to these dictates in order to ensure compliance and secure ongoing funding. This creates great tension within the organisation as dominant professional values are forced to make allowances for this type of "*technical necessity*" to ensure their on-going survival (Mueller, Harvey, & Howorth, 2003, p. 1974; Powell, Brock, & Hinings, 1999, p. 13). Kirkpatrick and Ackroyd (2003a, 2003b) suggest that archetype theory does not pay enough attention to this type of inter-archetype transformation. They suggest that a loss of social capital and goodwill can occur when service development is imposed on professionals resulting in the changes being only begrudgingly implemented and a growing culture of professional resistance towards management (Kirkpatrick & Ackroyd, 2003a).

While conflict is acknowledged within archetype theory, like the hybrid state, this is seen as a necessary component in terms of shifting to a new archetype and creating better alignment within the environment (Kirkpatrick & Ackroyd, 2003b). Kirkpatrick and Ackroyd (2003a, 2003b) studied social service organisations in the United Kingdom and found the interpretive scheme of the professionals, in this case social workers, was actually in a perpetual state of conflict with that of managers. They found in this situation a new consistent and coherent archetype could not be achieved and yet the

organisation did not shift back to its prior state instead occupying a state of organisational flux somewhere between the two forms (Kirkpatrick & Ackroyd, 2003a; 2003b).

In summary, this section was concerned with a critical appraisal of archetype theory. Archetype theory is primarily concerned with explaining the processes involved in achieving consistent and coherent change across archetypal forms. Archetype theorists do acknowledge hybrid archetypes as transitory states as organisations shift from one archetype to another. This section has explored how the need for archetype theorists to define successful transitions between archetypal forms fails to account for the complexity of organisational environments and the often-conflicting value systems within professional organisations like statutory mental health providers including Living Well.

Conclusion

Archetype theory offers a heuristic device for understanding service development at Living Well and forms the theoretical foundation of this thesis. Archetype theory seeks to address the gap between sociological and management research and analysis on organisations by emphasising an organisation's informal culture alongside its formal structures and systems. It suggests that without alignment between the dominant interpretive scheme of the organisation and a proposed change in service delivery that sustainable change will not occur. Archetype theory explores the complexity of the professional bureaucracy and outlines the role of conflicting value systems of staff and managers within this. It suggests that the complex nature of this environment provides an explanation for the sometimes chaotic and contradictory outcomes resulting from attempts to alter an organisation's archetype. Archetype theory places the conflicting relationship between professional values of autonomy, peer review and ethical practice with management ideals of increased regulation, accountability and efficiency at the centre of this.

The purpose of this chapter has been to provide an overview of archetype theory in order to provide a theoretical framework for this thesis. This has been undertaken through firstly locating archetype theory within the wider body of knowledge on organisational theory; followed by an overview of the different components of archetype theory including the difference between radical and convergent archetype change. The importance of an organisation's informal structure evident in the interpretive scheme and differing levels of staff commitment to change was discussed alongside an analysis of the professional organisation, the bureaucratic archetype and the professional bureaucracy. A critique of archetype theory's reliance on achieving a successful archetype transformation was also presented highlighting that the theory does not accommodate well the complexity and contradictory value systems inherent within professional service organisations like Living Well.

The following chapter outlines the methodology and the methods that informed the research processes for this study including the protocols for gaining access to Living Well, and key phases of the research.

Chapter Three: Methodology and Methods

Introduction

This study was focused on gaining an understanding of the process of service development decision-making within statutory mental health services. It involved an organisational case study of one statutory mental health service in Aotearoa New Zealand, Living Well. The use of an organisational case study facilitated an in-depth examination of the process of service development within its context. This included the organisation's relationship with its external environment as well as the role of its internal systems and structures encompassing the values, beliefs and ideologies that contributed to the organisation's interpretive scheme.

Four research questions framed the completion of this research informing the choice of method including data collection and analysis processes:

1. How are decisions relating to service development made?
2. What are the processes that inform service development?
3. What are the barriers to effective service development?
4. What role do formal planning mechanisms including strategy, policy, reviews and projects play in service development?

The purpose of this chapter is to describe the methodology and method used to complete the study. The chapter begins with a discussion of the rationale for using an organisational case study as the primary approach for this research. Following that, detail relating to the research process is provided, including information about data collection, organisational access, the participants and data analysis processes. The ethical issues related to the study are then discussed. The chapter concludes with consideration of the limitations of the research.

An Organisational Case Study

An organisational case study was the research strategy employed for this investigation, involving an analysis of the process of service development within a statutory mental health organisation, Living Well. The organisational case study method enabled a detailed investigation of the processes related to service development at Living Well. The specific focus on one mental health organisation allowed for depth in the data collected about service development, as well as consideration of the different contextual factors that shaped decision-making within this environment including policies, resources and relationships.

Organisational case studies are an established form of research design emerging from researchers' desire to understand complex social phenomena (Baxter & Jack, 2008; Crowe, Cresswell, Robertson, Huby, Avery, & Sheikh, 2011; Yin, 2012). They provide the opportunity to focus on several aspects of organisational functioning enabling the complexity of the organisation to be elucidated. An organisational case study enables organisational activity to be examined in a holistic and meaningful way (Yin, 2012). This level of examination enables the researcher to gain an in-depth, multifaceted understanding of the processes of the organisation in their natural setting (Baxter & Jack, 2008; Berg, 2007; Buchanan & Bryman, 2008; Crowe et al., 2011; Hartley, 1994; Yin, 1999, Yin, 2003, Yin, 2012). Items for analysis can include all aspects of the organisation's formal and informal structure and systems as well as the nature of service delivery, relationships, the impact of the external environment and the values, ideologies and beliefs that frame the organisation's interpretive scheme (Baxter & Jack, 2008; Berg, 2007; Buchanan & Bryman, 2008; Crowe et al., 2011; Donmoyer, 2000; Gibbert, Ruigrok, & Wicki, 2008; Noor, 2008; Yin, 1999, Yin, 2012). The nature of the research questions posed for this study focused on the process of service development within a statutory mental health organisation and aimed to understand the many factors that influenced this process. An organisational case study was consequently regarded as the most appropriate method for this research due to the depth of data that could be explored and analysed in relation to this issue.

Crowe et al.(2011) identify three different forms of organisational case study: intrinsic, collective and instrumental case studies. Intrinsic case studies involve an investigation into a unique phenomenon within a singular organisation such as an organisation's recovery processes after a natural disaster (Crowe et al., 2011). Collective case studies require the examination of more than one organisation (Crowe et al., 2011). This research is an example of the third type of organisational case study, an instrumental case study, involving the examination of an issue within just one organisation (Crowe et al., 2011). The justification for choosing an instrumental case study lies within the level of detail that can be revealed about the issue under investigation. This enables an in-depth exploration of explanatory factors such as how, what and why as well as facilitating analysis of the causal factors and latent variables that influence the phenomenon under study (Berg, 2007; Baxter & Jack, 2008; Crowe et al., 2011; George & Bennett, 2005). In the case of this research, this method facilitated a detailed examination of the processes related to service development within the real world setting of a statutory mental health service, Living Well.

Organisational case studies typically involve the use of multiple research techniques to ensure the collection of different perspectives and depth of evidence (Baxter & Jack, 2008; Berg, 2007; Yin, 1999, Yin, 2012). Multiple research techniques also provide opportunities for data triangulation. This research involved the use of both primary and secondary data. The primary data included documents sourced directly from the organisation, observation of strategic and operational meetings, as well as interviews with key informants. Secondary data in the form of written sources was also used throughout the research and involved the collection and review of existing literature, research and policy on the topic. The secondary data provided a context within which the primary data could be located.

The Research Process

The research involved a three-tiered approach to the collection of primary data document analysis, analysis of meetings and qualitative interviews. Alongside the fieldwork, secondary data collection including literature, research, policy and external reviews[44] on the topic were collected and analysed. The purpose of this section is to describe the processes of organisational access, recruitment, data collection, as well as to discuss the challenges that arose during this process.

As is always the case when undertaking organisational research obtaining access to an organisation was a critical hurdle in this study. Gaining access to organisations for research is often difficult due to management concerns about confidentiality, protection of reputation, demands on staff time, the potential for the discovery of inefficiencies and poor practice within the organisation (Plankey-Videla, 2012). In securing access to an organisation, gatekeepers nominated by the organisation are typically used to approve the nature and scope of the research potentially making organisational access contingent on a number of criteria (Buchanan, Boddy, & McCalman, 1988; Buchanan & Bryman, 2008; Plankey-Videla, 2012). This research was dependent on access to a District Health Board and was subject to the goodwill of organisational gatekeepers. Securing access to a research site was a difficult process involving approaches to two different District Health Boards.

Prior to gaining access to Living Well, an approach was initially made to another District Health Board through their internal research board. However, this District Health Board wanted to renegotiate the method and purpose of the research, which the researcher felt, considerably altered the nature and scope of the research to such an extent that it negated the original purpose. Consequently, the researcher decided, in consultation with her supervisors, to approach another District Health Board, Living Well.

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[44] External reviews refers to documents produced outside of Living Well, which focus on the development and delivery of mental health services in Aotearoa New Zealand.

The negotiation of access to Living Well occurred through the General Manager, followed by the submission of a research proposal to the Senior Management Team to gain final agreement for the research to proceed subject to ethical approval. The Senior Management Team requested broadening the scope of the research from just adult acute and community mental health to also encompass adult inpatient rehabilitation services to widen the pool of potential interview participants and meetings to be observed that could be included within the research. They also requested a list of potential interviewees and meetings for final approval prior to the commencement of the research. These changes did not significantly alter the intent of the study and the research design was altered accordingly. Alongside this, a further proposal was submitted to the executive group of the Maori Mental Health Service to ensure the research was undertaken in accordance with appropriate cultural processes. Upon gaining approval in principle from both groups, a submission for ethical approval was forwarded to the appropriate Health Ethics Committee.

Following the gaining of ethical approval, the researcher made a request that Living Well nominate a link person to act as an intermediary between the organisation and the researcher. The role of this person was to facilitate access to information, organisational meetings and coordinate the recruitment of interview participants (Buchanan & Bryman, 2008; Buchanan, Boddy, & McCalman, 1988).

The following sections detail the four components involved in the collection of data document analysis, observing meetings, participant interviews and the collection of literature, research, policy and external reviews on the topic.

Organisational Document Analysis

Document analysis involved the collection and analysis of organisational documents produced by Living Well including internal reviews, projects, businesses cases and strategic plans that had relevance to adult mental health produced between July 2002 and April 2006.[45] Appendix A provides a summary of these documents including their goals, the nature of the activity and their recommendations.

Heracleous and Hendry (2000, p. 1258) describe text as "*discourse fixed in writing*". Organisational documents form an integral part of the organisation and are a "*by-product of the interaction and communication of individuals and groups, at all levels, in organisations*" (Hartley, 1994, p. 148). When used alongside data gained through interview or observation, as is the case in this research, organisational texts can provide context, reveal and/or support assumptions within the organisation and provide insights into organisational life (Chreim, 2005; Hartley, 1994; Tsoukas & Hatch, 2001). Documents also provide an analytical or historical reference point against which present accounts can be tested (Hartley, 1994).

Analysis of organisational documents requires attention to be paid to the context and purpose of the particular text. This allowed the researcher to take into account any organisational bias, as organisations are able to sanction the amount and type of information that is included within their documents (Hartley, 1994; Heracleous & Hendry, 2000). They can portray a one sided, false view of organisational reality and can focus content towards the intended audience (Hartley, 1994; Heracleous & Hendry, 2000). The motivations of the author and their position within the organisation were important considerations in the analysis of all organisational documents. The goals and

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[45] The time period of July 2002 to April 2006 was chosen to encapsulate the five year period prior to data collection. Also influencing the selection of this time period was the researcher's knowledge of a Living Well project entitled the Review of Reviews (included in the document analysis and listed in Appendix A) that summarised Living Well's projects and reviews over the period between 1997 and 2004 further extending the period of analysis.

recommendations contained within the documents were regarded alongside other events within the organisation as well as wider strategic and political goals.

In total 28 formal service development documents, with relevance to adult mental health, were located and analysed.[46] The analysis involved listing the reviews chronologically, identifying the type of activity, whether they were generated internally or externally, retrieving details about the processes involved in the activity, as well as the recommendations and outcomes that resulted. This information was tabulated using the headings identified in Table 2 below:

Table 2: Headings for document analysis

When	Name of "review"	Internally or External generated	Type i.e. Review etc.	What it was/ Focus	Summary Recommendations and/or Outcomes

The documents were then thematically analysed to assess the similarities and differences across the activities and triangulated with the data gained from meetings and the qualitative interviews. Chapter Seven presents the discussion related to the analysis of these documents.

Observing Meetings

Another step in the case study involved the observation and recording of operational and strategic meetings that occurred at different levels across adult mental health services at Living Well. The function of meetings at Living Well was a key concern of this research in order to understand how service development intersected with these existing formal mechanisms. The time available to undertake research in health settings is often limited by the gate keepers of the organisation in order to contain disruption to both staff and clients (Morse, 2011). Throughout this study, the researcher maintained a degree of flexibility in terms of the data collection processes in order to meet Living Well's

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[46] See Appendix A for details.

requirements and to be able to extend data collection as the researcher became aware of new events and documentation.[47] The observation of meetings occurred over a period of four weeks in February 2007. This was the time allocated by Living Well to minimise any potential disruption to the organisation. The researcher attended the meetings solely as an observer and did not participate in the meetings. Altheide and Johnson (2011) explain that the use of multiple methods of data collection contributes to validity and reliability. Further to the material gained by recording the meetings over the period of four weeks, minutes from the preceding six months were sourced and analysed. The researcher also made field notes capturing the non-verbal cues and patterns of interaction for all meetings. The recordings, observations, and analysis of minutes were further complemented by interview participants' reflections on their experiences the role of meetings at Living Well. All of these methods combined to provide incremental verification strategies around the role of meetings in service development at Living Well (Altheide & Johnson, 2011).

As noted in the previous chapter, organisations have multiple sometimes competing value systems. Different accounts of events can exist at different levels with each organisational member holding different understandings of the organisation's interpretive scheme and the processes informing service development (Boje, 2001; Buchanon & Dawson, 2007; Chreim, 2005; Rhodes & Brown, 2005; Weick & Browning, 1986). Recording and transcribing meetings at different levels across Living Well enabled a multi-levelled analysis of organisational change and decision-making. This form of data moderates the risks involved in undertaking solely qualitative interviews where there is the potential for the interviewer to impose their definitions of what is important on the data (Gabriel, 1998). In addition, interviews do not necessarily account for the organisation's activity as they are not spontaneously generated, rather they are 'presented and performed' for the benefit of the interviewer they require the interviewee to reflect and make sense of these experiences (Boje, 2001; Czarniawska,

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[47] Examples of this flexibility include extending the number of interview participants from 8 to 9 to ensure sufficient clinical representation and the observation of the development and implementation of the Clinical Governance strategy (discussed in Chapter Nine). In each of these situations organisational and ethical approval was sought and gained prior to their inclusion as part of the research.

1998; Gabriel, 1998). Observing and recording meetings enabled information to spontaneously emerge from within these contexts. This information further triangulated the research data and provided information about interaction and organisational processes from an 'observed' perspective providing opportunities for new insights grounded in the daily activity of the organisation.

In total, 13 meetings from seven different groups, held at different levels across the acute, community and rehabilitation components of Living Well were observed. The aim of observing the meetings was to understand their nature and function, the role they played in service development decision-making as well as to provide insight into the daily operational of the organisation. The meetings included weekly team meetings, quality improvement meetings, service executive meetings and the Senior Management Team meeting and captured meetings across different levels of the organisation, Table 3, p. 71 summarises the meetings attended.[48]

All staff attending these meetings knew about the research prior to its commencement and had signed a consent form to participate. The meetings were recorded and then transcribed; the preceding six months of minutes were also sourced in order to track issues over time. Audio recordings provided the most accurate record for capturing the detail of verbal interactions at meetings removing researcher recall and interpretation issues by providing the researcher with a method to interrogate memory and test the accuracy of observations at a later date (Peräkylä & Ruusuvuori, 2011). The transcriptions, minutes and personal observations from the meetings were entered into an electronic spreadsheet and analysed in the same manner as the interview transcripts.

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[48] Appendix B provides details relating to the meetings attended and minutes analysed as part of this study.

Table 3: Meeting schedule

Meeting	Date Attended	Frequency of meeting[49]
Senior Management Team Meeting	14/2/07 21/2/07	Weekly
Adult General Managers Meeting	27/2/07	Monthly
Acute Inpatient Service Executive (Exec) Meeting	20/2/07 6/3/07	Fortnightly
Acute Quality Meeting	28/2/07 13/2/07	Fortnightly
Community Exec	21/2/07 7/3/07	First and third Wednesday of month
Rehabilitation Exec	14/2/07 28/2/07	Fortnightly
Community Mental Health Team meeting	14/2/07 28/2/07	Weekly

Participant Interviews

Finally, people were interviewed from different levels of the organisation to gain their insights into the processes of service development across Living Well. Participant recruitment involved Living Well's intermediary calling for volunteers through the circulation of information about the research.[50] The Operations Manager, at that time, also had input into the selection of interview participants by nominating individuals whom she felt would offer a useful perspective on the research questions. These people were emailed inviting to them participate. [51] The invitation also included information

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[49] The researcher attended all meetings that occurred during the four week timeframe. While some meetings were scheduled to occur weekly, it was the researcher's experience that meetings were cancelled during the period of data collection. The minute analysis also confirmed the cancellation of meetings on a regular basis due to clinical and operational matters taking priority. The researcher attended all meetings that occurred during the four week timeframe.

[50] Eight of the nine participants volunteered to participate. One participant was invited to participate to ensure sufficient clinical representation.

[51] One potential participant did decline to participate following the consideration of information about the research and the potential time commitment involved.

about the research. Finally, the list of potential participants was sent to the Senior Management Team who approved all of the participants.

The interview participants included: the General Manager; the Service Manager responsible for the Rehabilitation Service; Unit Managers from the Adult Community Teams and the Community Rehabilitation Service; the Clinical Coordinator from one of the Community Mental Health Teams, a nurse from the Acute Inpatient Service; a psychiatrist, a consumer advisor, and a representative nominated by the Maori Mental Health Service to provide a Maori perspective to service development.[52] The interview participants were required to have worked for the organisation for a period longer than two years to ensure they had been able to observe and participate in service development within the organisation.

All except one of the interview participants had been employed by Living Well in excess of 15 years, with six of the nine participants having worked there for over 25 years. Six participants had begun their careers as trainee psychiatric nurses and had fulfilled a number of different roles at Living Well. Three participants still had the primary function of delivering clinical services on a day-to-day basis. The remainder of the interviewees were either working in management, in senior clinical or advisory roles and had portfolios which meant that some of their primary tasks involved service development. A number still carried a clinical caseload as well. The list of participants is provided in Table 4, p. 73.

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[52] In total nine interview participants were involved in this study. The choice of participants was representative of the staffing groups at Living Well. The number of interview participants was capped by the requirements of the Senior Management Team to ensure minimal disruption to service delivery. This number was also considered adequate for data generation when considered alongside the other methods employed for this research.

Table 4: Participant details

Name[53]	Employment role at commencement of research	Length of employment at Living Well	Professional background
Tom	General Manager	25 plus years	Psychiatric Nurse
Jacob	Chair of Clinical Directors	25 years	Psychiatrist
Paul	Service Manager Rehabilitation	25 plus years	Psychiatric Nurse
Geoff	Unit Manager Adult Community	25 plus years	Psychiatric Nurse
Evelyn	Unit Manager Rehabilitation Outpatient Service	35 plus years	Psychiatric Nurse
Carole	Clinical Coordinator for a Community Mental Health team	5 years	Social Worker
Matt	Nurse Practice Consultant[54]	25 plus years	Psychiatric Nurse
Cliff	Nurse in Acute Inpatient service	15 plus years	Psychiatric Nurse
Eliza	Consumer Advisor	15 years	Client

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[53] Pseudonyms have been given to protect participants' identities.

[54] This person was nominated as a cultural representative by the Maori Mental Health service as he had recently stepped down from the role as Clinical Head of this service.

Interview participants were initially asked to participate in two one-hour interviews. Buchanan and Bryman (2008) discuss that within organisational research the researcher should remain open and flexible to new opportunities for investigation as the organisational environment changes. During the first round of interviews in this study, the researcher became aware of the commencement of a major service development initiative. This presented a unique opportunity to observe the process of service development in action and as a result the decision was made to undertake a further interview one year after the initial interview to enable the analysis of an emerging change process. Approval from the Senior Management Team and the Health Ethics Committee was secured to enable this variation in the research to occur. As a consequence of the amendment to the ethical approval, participants participated in a further one-hour interview in April 2008.[55]

The qualitative interviews were framed around a standardised semi-structured interview template that allowed for thematic inquiry (Braun & Clarke, 2006; Czarniawska, 1998; Floersch, Longhofer, Kranke, & Townsend, 2010).[56] Qualitative interviews enable the interviewer and participant to co-construct the inquiry allowing the researcher to gain access to and explore the everyday accounts of the organisation (Czarniawska, 1998; Marshall, 1994). Participants' quotes are cited in this study by using their pseudonym and a number. The number refers to whether the quote was provided in the participant's first, second or third interview.

Secondary Data

Secondary data in the form of literature; research, policy and external reviews was collected alongside the primary data. The collection of secondary data provided a context for the analysis of the data collected as part of the fieldwork. The process of locating secondary data was guided by the research questions and utilised the steps identified by Cronin, Ryan and Coughlan (2008) including determining inclusion or

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[55] Eliza and Cliff did not participate in the third round of interviews.
[56] Appendix C is a copy of the interview schedules used across the qualitative interviews.

exclusion criteria; selecting and accessing literature and research; assessing the quality of the information; followed by data analysis.

Research and literature was sought from a number of different sources including texts, journals, and the internet. Searches were undertaken using resources such as the Ovid database, PsycInfo, Massey University Library Catalogue, Google Scholar, Sociological Abstracts, Index New Zealand, Enigma Publishing On-line, Te Pou, and the Ministry of Health Library Catalogue of on-line resources. Additionally items were located through searching through on-line journals and reference lists of already sourced materials. For each research question a list of key terms and topics were generated. Initial subject, word and keyword searches were then undertaken. The initial searches generated a large number of resources; consequently, these were limited to articles or books produced since 1990 as well as seminal contributions to the topic. A further factor limiting the literature was the availability and accessibility of resources. At this point, the research questions were again applied to the literature alongside questions related to each article's contribution to service development in statutory mental health organisations, the identification of key issues and the lessons that could be learnt from these experiences. All relevant literature and research was reviewed and notes were taken. Key themes were identified and an analysis was undertaken of the content.

Policy and review documents related to mental health care and treatment in Aotearoa New Zealand were also located and analysed. Policy documents were sourced directly through the Ministry of Health and the Mental Health Commission. The primary policy documents which had relevance to this study were *Te Tāhuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan* (Ministry of Health, 2005); *Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015* (Ministry of Health, 2006) and *Te Hononga 2015: Connecting for Greater Wellbeing* (Mental Health Commission, 2007).[57] Further policy documents were identified during the fieldwork component of the research. These items were also sourced directly from their place of publication. Review documents were identified

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[57] Henceforth these documents will be referred to as *TeTāhuhu*, *Te Kōkiri* and *Te Hononga*.

through on-line searches, newspaper reports and through the Health and Disability Commissioner's website at http://www.hdc.org.nz/. These items were either sourced on-line, through Massey University's library, or from Living Well.

Secondary data was located throughout the research process. As new topics of interest became known and themes emerged from within the primary data additional secondary information was sought. The on-going collection of secondary data occurred to ensure that all possible relevant literature, research and policy related to the research questions had been reviewed as part of data analysis thereby further ensuring triangulation of research findings.

Data Analysis

A particular strength of the organisational case study is the careful management and analysis of the rich and detailed data (Baxter & Jack, 2008; Berg, 2007; Jensen & Rodgers, 2001; Yin 2012). Organisational case study analysis can involve the use of different methods and approaches (Yin, 2012). In the current study thematic data analysis was undertaken and as part of the analysis process archetype theory was identified as the theory that had the best fit with the emerging concepts.

Each data source, primary and secondary, contributed to the understanding of service development accordingly the use of different methods of data collection required that the data from the different sources were synthesised as part of the analysis process. Baxter and Jack (2008) note that this process adds strength to the analysis as "*the various strands of data are braided together to promote a greater understanding of the case*" (Baxter & Jack, 2008, p. 554).

This study was an example of exploratory research where the researcher inductively explored service development within Living Well prior to identifying a theory that helped to explain the phenomena. It took some time to find a theory that provided the best explanatory framework for the concepts. Once identified archetype theory was used

as a heuristic device for making sense of service development at Living Well by regarding the organisation as a whole system involving formal structures and systems as well as value systems. This involved utilising the steps involved in identifying and analysing an organisation's archetype described in Chapter Two and included assessing the relationships between aspects of Living Well's formal structure and systems as well as its informal processes represented within the interpretive scheme. Analysis therefore required consideration of both what was said and/or written and the context in which service development occurred. In a similar vein to Baxter and Rideout's (2006) study of nursing student's clinical decision-making, consideration of the context of service development at Living Well provided a fuller account of the elements that informed this process. Service development occurred within a context including the different informal factors influencing the organisation and their relationship with the wider environment. In order to describe and analyse service development these different variables need to be taken into consideration as part of both data collection and analysis (Baxter & Jack, 2008).

Thematic analysis was guided by the research questions and enabled a process of identifying, and analysing recurrent patterns within the data (Braun & Clarke, 2006). The process of identifying and analysing themes was recursive involving a constant moving between the data, the research questions, coded extracts, and the analysis (Braun & Clarke, 2006; Floersch, Lonhofer, Kranke, & Townsend, 2010). The initial process involved considering the raw research data in light of the research questions, identifying interesting and relevant patterns which were allocated codes. These patterns were compared across data sources including secondary sources and sorted into categories based on major and minor themes known as "*umbrella and subthemes*" (Floersch et al., p. 409). Themes were then allocated significance based on their consistency across the research data and their contribution to knowledge about service development within statutory mental health providers. To increase the reliability of the data the same codes were used across all data sources (Floersch et al., 2010).

The thematic analysis aimed to discover aspects of the service development process at Living Well including the organisational processes, contexts and motivations as well as the core characteristics of its archetype. The concurrent analysis of all data sources including primary and secondary sources added to the strength and triangulation of the research findings. The process of data collection and analysis enabled a detailed consideration of service development processes within the organisational environment in which they occurred.

Research Limitations

As noted earlier in this chapter organisational case studies are now an accepted method for undertaking qualitative research (Baxter & Jack, 2008; Crowe et al., 2011). However, a major concern related to the use of organisational case studies is their lack of generalisation and external validity (Crowe et al., 2011; Jensen & Rodgers, 2001; Noor, 2008; Yin, 2003, Yin, 2012). Flyvbjerg (2011) challenges these assumptions as part of the case study paradox that he states has been subject to multiple misunderstandings relating to its credibility as a scientific endeavour. He argues that while not providing for formal generalisation, the knowledge generated through a single case study contributes significantly to the process of knowledge accumulation and theory building within a given field (Flyvbjerg, 2011). Further, Altheide and Johnston (2011) assert that multiple verification strategies such as the different methods of data collection employed for this research contribute both incrementally and interactively to build reliability and validity within the case study.

Yin (2012) emphasises that generalisations from organisational case studies are analytical utilising theoretical constructs rather than statistical generalisations, which have set the standard for replication in quantitative research. In an earlier work Yin (1999) stated that the concerns related to generalisability and external validity in a single case study can be addressed by regarding each case study as an experiment on its own in the same way as a randomised controlled trial is an individual experiment. This provides for replication logic meaning that the single case then becomes an exemplar of the

phenomenon under study that can be tested through replication in additional case studies (Yin, 1999).

This study examines service development within one statutory mental health organisation. It aims to provide a foundation and to become an exemplar for further case studies examining the nature and process of service development in other statutory mental health organisations. It contributes vastly to the body of knowledge on service development within this setting and provides an exemplar that challenges notions of stable archetype transformation and flags the complex, multi-pathed reality of service development within statutory mental health organisations.

Ethical Considerations

Ethical considerations are an essential part of any research. The purpose of this section is to discuss the ethical principles that informed this study as well as the processes used to ensure ethical integrity was maintained throughout.

The discussion and negotiation of ethical considerations must occur in the planning of the research and at the point of gaining access to an organisation (Buchanan & Bryman, 2008; Bulmer, 1988; Plankey-Videla, 2012). It is the responsibility of the researcher to be clear about the purposes and methods of the research and the steps taken to minimise harm to the organisation, its employees as well as its clients (Bulmer, 1988; Plankey-Videla, 2012). It is also important that the research is undertaken in a way which causes the least interruption possible to the activities of the organisation (Beynon, 1988; Buchanan & Bryman, 2008). These are the ethical principles upheld during the course of this research.

As with any research involving human participants consideration was given to any possible risks or costs to those participating in the research (Brewerton & Millward, 2001; Fisher, 1984). Within organisational research, these consequences can potentially include possible disciplinary action, termination of employment, humiliation, changes to

the conditions of employment and/or changes to the employment environment. There could also potentially be adverse consequences for the reputation of the organisation (Bulmer, 1988; Plankey-Videla, 2012). In this research, while Living Well was the subject of the study, the research required the participation from employees within the organisation. This was required at two stages in the research: in the observation of meetings and in the individual interviews.

Obtaining voluntary participation and informed consent from research participants can be difficult when undertaking research within an organisational context (Borgatti & Molina, 2005; Mirvis & Seashore, 1984; Plankey-Videla, 2012). The research participants are the people working within the organisation however, the research contract is with the organisation itself and the organisation is the subject of the study not its employees. Literature debates whether it is possible to achieve full informed consent from employees within organisations (Borgatti & Molina, 2005; Mirvis & Seashore, 1984; Plankey-Videla, 2012). Employees may be obligated or coerced to participate in the research due to the nature of their employment contract; they additionally may feel there could be consequences if they do not consent to being part of the research (Brewerton & Millward, 2001; Mirvis & Seashore, 1984; Plankey-Videla, 2012). Brewerton and Millward (2001) state that to minimise this, both the organisation and participants need to be aware that the research cannot proceed without informed consent from all participants. The nature of the consent form is therefore also important.[58] Consent was gained from all interview and meeting participants prior to the collection of data as part of this research. A further step to ensure the protection of participants was the use of a management disclosure contract. This safeguarded potential interview participants from negative consequences related to their participation in the research as well as protecting their rights to decline to participate or withdraw from the study at any point.[59]

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[58] See Appendix D for a copy of the consent form used during this study.
[59] See Appendix E for a copy of the management disclosure form used as part of this research.

At Living Well, senior management required approval of the list of potential interview participants. Borgatti and Molina (2005) suggest the use of a contract that stipulates the uses of research information as a mechanism to safeguard participants from potential adverse outcomes due to taking part in the research. This "*management disclosure contract*" specifies the rights of the researcher, the organisation and the participants (Borgatti & Molina, 2005, p. 114). It outlines the type of research data the organisation will see, information sharing processes and that participation in the research will not inform any evaluation of employee performance (Borgatti & Molina, 2005). This contract is signed on behalf of the organisation as well as by the researcher and a copy provided to participants along with information about the intent and methods of the research to inform their ability to consent to participate in the research (Borgatti & Molina, 2005). This research involved the use of a contract similar to that developed by Borgatti and Molina, participants were provided with a signed copy of the contract alongside the information sheet, and individual consent forms.

Ensuring that the organisation's identity remains confidential is a key mechanism for reducing the risk of harm to both the organisation and its members (Beynon, 1988; Borgatti & Molina, 2005; Buchanan & Bryman, 2008; Bulmer, 1988; Plankey-Videla, 2012). Every attempt has been taken to keep the identity of Living Well confidential, identifying characteristics such as locality, size, scope of service provision and staffing have been removed or framed in such a way as to conceal the identity of the organisation. All information provided by both the organisation and its employees has been kept confidential.

The data collected as part of this research includes reports from the organisation, minutes of meetings, digital recordings, transcripts and handwritten notes. To ensure confidentiality this information was stored within a locked filing cabinet and on a computer secured with a personal access password. The researcher was the only person to have contact with the data in its raw form. Following collection of the data, any identifying information was removed and pseudonyms provided for participants and the names of organisational departments. An offer was made to Living Well to return

material belonging to the organisation such as reports and meeting minutes following completion of the research; however, the organisation requested that these documents were destroyed. The destruction of the digital copies of interviews will occur after the necessary legal period following completion of the thesis.

Due to the small size and close connections between mental health services, in Aotearoa New Zealand absolute confidentiality may be difficult to ensure. However, every attempt has been made to minimise the risk to the organisation. Living Well was provided with a copy of the research findings prior to the completion of the research and offered the opportunity to correct any information that they believed was inaccurate, to respond or further clarify any information. The Senior Management Team at Living Well approved the findings without any amendments. This was regarded as a key mechanism for ensuring the protection of the organisation against any unforeseen consequences (Beynon, 1988; Borgatti & Molina, 2005; Buchanan & Boddy, 1988; Hartley, 1994). It also provided Living Well with the opportunity to ensure they could not be identified.

The management disclosure contract protected participants' rights to decline to participate in the research. All participants also gave informed consent before meetings were recorded. Prior to the commencement of the individual interviews, participants received reassurance that they did not have to answer every question if they did not wish to; they could decline an interview even if they had previously agreed to one and could withdraw from the research at any stage. Despite the Senior Management Team having approved the list of interview participants prior to recruitment, the content of participants' interviews were kept confidential from the organisation. Participants were also sent a copy of their quotes and gave approval for their use prior to the completion of the study. This enabled them to correct or clarify any information they originally provided, as well as to see the context in which the information was used. Participants were also given the opportunity to prevent information they had provided from being used in the research. The research gave participants confidentiality rather than anonymity as the organisation knew who was interviewed, but not the content of their

interviews. A full explanation of participants' rights occurred prior to the commencement of the research, and were outlined in the information sheet[60] and consent form[61], and at various stages throughout the research process.

Conclusion

The purpose of this chapter has been to describe the research methodology and methods. This study uses an organisational case study to provide an analysis of the process of service development within Living Well, a statutory mental health organisation in Aotearoa New Zealand. The collection and co-generation of multiple forms of data are well aligned with a case study design and facilitate an in-depth understanding of service development within one statutory mental health organisation. This approach also facilitates the process knowledge generation and theory building with regard to archetype transformation in statutory mental health providers.

The research involved the use of both primary and secondary data. Primary data collection and triangulation involved a three-tiered approach, using organisational documents, the observation of meetings and qualitative interviews enabling multiple accounts of service development to be explored and analysed. Secondary data involved written sources related to the theoretical and contextual nature of the research. This provided detailed information related to the archetype of mental health services including its interpretive scheme and raison d'être as well as the more formal systems and structures that shape service development within this environment. Data from all sources were synthesised as part of the analysis process as each data source, primary and secondary, contributed to the understanding of the phenomenon of service development. This provided for data triangulation and supported the internal validity of the research. Thematic analysis guided by the research questions informed the data analysis utilising archetype theory as a heuristic device for understanding the different components of service development within Living Well.

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[60] A copy of the information sheet used for this research is attached in Appendix F.
[61] A copy of the consent form used for this research is provided in Appendix D.

The study involved robust processes to ensure the trustworthiness of data and to promote credible, authentic, transferable findings. The research method included the use of stakeholder checks, data triangulation across collection and the synthesis of data as part of the analysis process. Further steps to verify the veracity of the data also included gaining approval for the inclusion of participants' quotes, and checking with key informants at Living Well about the relevance of the research findings. In addition, the research findings were sent to the Senior Management Team at Living Well to ensure they were satisfied that confidentiality had been protected and the findings reflected their experience of service development within this environment.

The following chapter provides detail about mental health organisations, which are a variant of the professional bureaucratic archetype, discussed in Chapter Two. It presents a discussion of the historical processes of service development within the mental health field both internationally and in Aotearoa New Zealand.

Chapter Four: Changing Trends in Mental Health Care

Introduction

This research is concerned with understanding service development decision-making within statutory mental health services in Aotearoa New Zealand. Chapter Two presented archetype theory as a theoretical framework for understanding professional service organisations including statutory mental health services. The purpose of this chapter is to focus more specifically on the development of statutory mental health organisations. The chapter begins with an overview of the historical context of mental health care with a focus on the role deinstitutionalisation has played in the care and treatment of people with a mental illness. The current nature of the mental health system and the roles of both community and inpatient care are discussed including the function of trends and evidence in service development. The chapter concludes with an analysis of the development of mental health services in Aotearoa New Zealand and provides an overview of the current policy framework informing service delivery.

Statutory Mental Health Organisations: From Institutions to Care in the Community

The history of mental health services in western democracies has been characterised by three main periods of development the rise of the asylum (institutionalisation), the decline of the asylum (deinstitutionalisation) and the reform of mental health services (community care) (Thornicroft & Tansella, 2004). The purpose of this section is to provide an overview of these historical trends, in particular focusing on the changing views and roles of institutional inpatient mental health care.

Since 1970 the number, form and quality of mental health inpatient institutions has changed. Prior to this time, the majority of people with a mental illness spent extended

periods, often their lifetime, in hospital with little hope of recovery, discharge or reintegration back into the community (Bachrach, 1996; Lamb, 1998; Lamb & Bachrach, 2001). During the 1960s, the work of Erving Goffman and Thomas Szasz in the United States, R.D. Laing in the United Kingdom and Michel Foucault in France caused a reconsideration of the role of the psychiatric institution in the care and treatment of people with a mental illness (Bracken & Thomas, 2001; Jones, 1993; Lamb, 1998; Lamb & Bachrach, 2001; Rissmiller & Rissmiller, 2006). Their combined perspectives on inpatient mental health care represented the beginning of the anti-psychiatry movement that paved the way for the movement of long-term mental health clients from institutional settings into the community through a process known as deinstitutionalisation.

These theorists painted a picture of inhumane mental health institutions that denied clients' liberty and self-determination and they argued for therapeutic community care and treatment as an alternative (Bracken & Thomas, 2001; Lamb, 1998; Goodwin, 1997; Rissmiller & Rissmiller, 2006). Goffman (1961) described psychiatric hospitals as "*total institutions*" that institutionalised and isolated people from society for undetermined periods. He believed that within these institutions the prescribed patterns of formalisation, routine and impersonality undermined and discounted an individual's rights to self-determination and autonomy (Goffman, 1961). Writing during the same period Szasz's (1960, 1972) description of mental illness as a myth generated by self-serving psychiatrists caused outrage across the psychiatric profession. Szasz's view was that a psychiatric diagnosis was 'medicalisation' of a social condition that denied people moral responsibility for their own actions. His writings questioned the legitimacy of psychiatry as well as the very foundation and role of psychiatric practice (Szasz, 1960, 1972). Szasz (1960, 1972) asserted that psychiatrists were not actually concerned with treating mental illness, and were rather involved in exerting power and social control over individuals. He also criticised governments for using containment in secure institutions as mechanisms for enforcing 'treatment' on individuals (Szasz, 1960, 1972). Szasz (1960, 1972) believed that involuntary confinement of clients in mental hospitals

was immoral and an instrument of social control that deprived people of their rights to liberty and self-determination.

Laing (1960) and Foucault (1965) argued that mental illness was socially constructed and was a mechanism for disguising the socially unacceptable elements of society in a manner that provided no rights of appeal. Laing (1960) felt that mental illness was an understandable reaction to the persecutory nature of society and established therapeutic communities where clients could voluntarily seek treatment. Foucault (1965) also focused on the nature of psychiatric institutions, describing them as disciplinary institutions that psychiatrists used as a vehicle to exert power over others.

The critiques and therapeutic alternatives proposed to mental health inpatient care, along with the development of a new generation of anti-psychotic drugs, held the promise of improved treatment outcomes and reintegration into the community for clients who had historically spent long periods within psychiatric hospitals (Lamb, 1998; Lamb & Bachrach, 2001; Goodwin, 1997; Nguyen, Brakoulias, & Boyce, 2009; Rissmiller & Rissmiller, 2006; Rosenbloom, 2002). The development and use of anti-psychotic drugs such as Chlorpromazine[62] relieved many of the chronic symptoms associated with schizophrenia and provided hope of recovery for people with this condition (Lamb, 1998; Rosenbloom, 2002). Prior to this time, the medical treatment of psychiatric conditions had been physically invasive including electroconvulsive therapy (ECT)[63] to induce seizures, insulin coma therapy, and surgery including transorbital leucotomy[64] (Rissmiller & Rissmiller, 2006; Rosenbloom, 2002). Orally administered, the new generation of antipsychotic medications were "*70% effective in relieving the hallucinations, delusions and disorganised thought associated with schizophrenia*" (Rosenbloom, 2002, p. 1860). The new drugs offered the possibility that people with psychosis could live their lives outside of institutions.

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[62] Also known as Thorazine, Chlopromazine was first used as a surgical anesthetic to treat sailors in the 1950s.

[63] ECT is still used today to treat clients. Still a contentious procedure it is undertaken as an outpatient procedure under a general anesthetic predominantly for the treatment of chronic depression.

[64] Transorbital leucotomy involves the surgical removal of the front cerebral cortex.

Another strong motivator for deinstitutionalisation was the assumption that care and treatment within the community would be more cost effective than hospital-based care (Bachrach, 1996; Goodwin, 1997; Lamb & Bachrach, 2001). The old psychiatric institutions required ongoing and expensive maintenance; they were often in poor condition as well as being overcrowded (Goodwin, 1997; Joseph, Kearns, & Moon, 2009). The push towards dismantling the old institutions came at a time when governments were considering the cost of the ongoing investment required to maintain institutions and the option of moving people into the community appeared to be a much cheaper alternative (Goodwin, 1997; Joseph, Kearns, & Moon, 2009).

Waning support for long-term care in psychiatric institutions, the promise of improved outcomes as a result of new medications, and the desire to contain costs, came together to create the platform for deinstitutionalisation across the globe (Fisher, Barreira, Geller, White, Lincoln, & Sudders, 2001; Flannigan, Glover, Feeney, Wing, Bebbington , & Lewis, 1994a; Flannigan, Glover, Wing, Lewis, Bebbington, & Feeney, 1994b; George, Durbin, Sheldon, & Goering, 2002; Goodwin, 1997; National Institute for Mental Health, 2002; Tyer, 1998). As a result, mental health services began the process of reducing the use and duration of inpatient mental health treatment and dismantling the old psychiatric institutions.

A key philosophy behind deinstitutionalisation was that a better quality of life and improved mental health outcomes were possible for people with mental illness when treated and supported within the community (Bachrach, 1996; Barry & Crosby, 1996; Goldstein & Horgan, 1988; Goodwin, 1997; Hansson, Middelboe, Sorgaard, Bengtsson-Tops, Bjarnason, Merinder, Nilsson, Sandlund, Korkeila, & Vinding, 2002; Lamb, 1998; Lamb & Bachrach, 2001; Leff, Trieman, & Gooch, 1996; Muijen, 2002; Rissmiller & Rissmiller, 2006; Shepherd, Beadsmoore, Moore, Hardy, & Muijen, 1997; Thomas, 1996; Thornicroft & Tansella, 2004). Deinstitutionalisation was a significant shift in direction of mental health care and treatment. It required the introduction of new therapeutic approaches and treatment modalities that addressed the altered needs of clients with mental illness who were now living in the community.

In terms of archetype theory, the move from institutional care to community care could be characterised as a radical shift in organisational archetype that required significant service development. Figure 1 illustrates the shift in interpretive scheme within mental health institutions from a medical model of treatment premised on the expertise of psychiatrists to a bio-psychosocial model of care focused on short-term inpatient stays for clients with a vision of recovery involving reintegration back into the community (Lamb & Bachrach, 2001). Figure 1 uses the key features of archetypes detailed in Chapter Two, to classify the movement of mental health organisations from an Institutional Archetype to a Community Care Archetype:
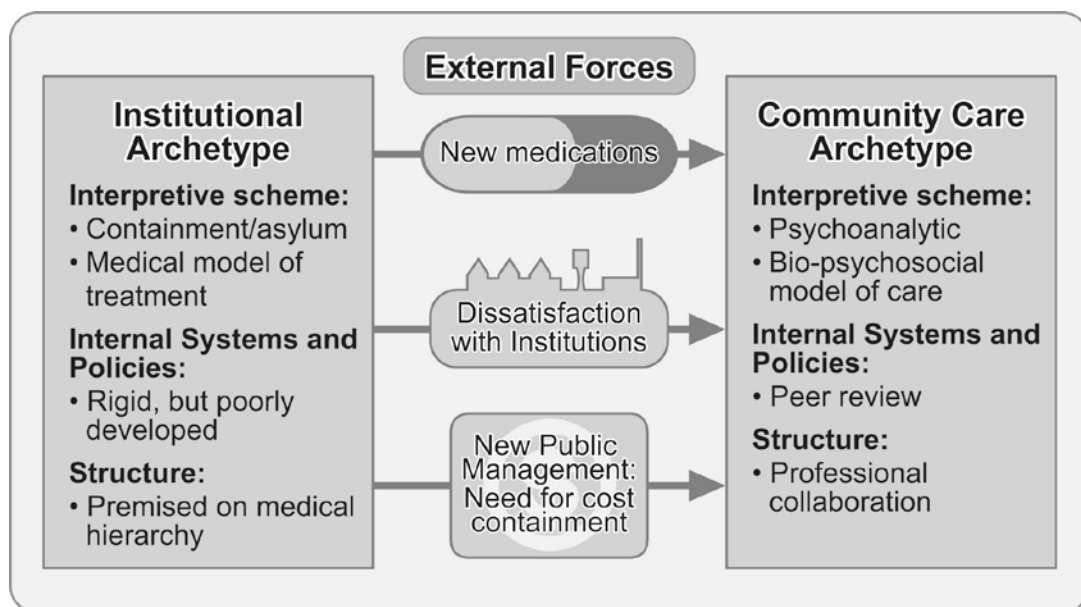
Figure 1: The changing archetype of the mental health bureaucracy

As already noted the Institutional Archetype was the historical model for psychiatric treatment within mental health institutions. The key features of the changed archetype reflected a shift in the predominant values, beliefs and ideologies that underpinned the interpretive scheme driving the provision of mental health care and treatment. The promise community care held was that the interpretive scheme of mental health services would shift from one premised on containment within institutions, where the psychiatrists were seen as the experts to a scheme premised on psychoanalytic and bio-

psychosocial models of care. While the internal systems and policies did not alter significantly, the structure of the organisation was required to move to a model of service delivery based around professional collaboration rather than the medical hierarchy that had dominated the institution.

The process of deinstitutionalisation resulted in a reduction in the numbers of mental health inpatient beds provided internationally and a new priority on the provision of care and support within the community (Flannigan et al., 1994a; Flannigan et al., 1994b; George et al., 2002; Goldstein & Horgan, 1988; Lamb, 1998; Lamb & Bachrach, 2001; Leff, Trieman, & Gooch, 1996; Muijen, 2002; Shepherd et al., 1997; Thomas, 1996). Clients with severe and chronic mental illness were placed on new generation anti-psychotic drugs and discharged into the community with the expectation that services would be developed to meet the many and varied needs of these populations (Braden Johnson, 1990; Lamb & Bachrach, 2001; Rissmiller & Rissmiller, 2006; Rosenbloom, 2002).

In summary, the shift to community care signalled a radical archetype transformation within mental health care and treatment. Premised on changing philosophical beliefs about the nature of mental illness, improved medication options, and a need to contain costs, deinstitutionalisation promised improved client outcomes and a shift from long-term treatment within institutions to recovery within communities. Countries across the western world embraced the process of deinstitutionalisation cutting the number of publicly funded mental health inpatient beds and discharging long-term clients into the community.

The Implications of Community Care

For many long-term mental health inpatients, the process of deinstitutionalisation including the transition between hospital and the community happened smoothly (Lamb, 1998; Nguyen, Brakoulis, & Boyce, 2009). These clients had become, through the process of institutionalisation, accustomed to doing what they were told. Consequently,

when discharged to community care providers they tended to settle in their new placements and accept treatment (Lamb, 1998; Nguyen, Brakoulis, & Boyce, 2009). However, community treatment has not achieved positive results for all and in many areas the number of people with mental illness who remain untreated is high (Butler, 1990; Morrisey, Goldman, & Klerman, 1985; Mullen, 2009; National Institute for Mental Health, 2002; Thomas, 1996). This section reflects on the implications of deinstitutionalisation for clients and statutory mental health services as well as the abilities of communities to respond to the needs of people with all forms of mental illness.

In the latter half of the 20th Century in response to calls for deinstitutionalisation, enthusiastic cuts to bed numbers occurred across the public mental health system (Horsfall, Cleary, & Hunt, 2010; Lamb, 1998; Lamb & Bachrach, 2001). The old psychiatric institutions, while criticised for their restrictive and harsh treatment methods, did provide for 'asylum' as well as a whole range of client needs within one setting including "*shelter, food, clothing, companionship and recreation*" (Butler, 1993, p.117). In order to address all of these needs within the community the development of a comprehensive spectrum of services needed to occur. Unfortunately, the reduction of bed numbers proceeded much faster than the development of the community services intended to replace them (Bachrach, 1996; Butler, 1993; Lamb & Bachrach, 2001; Shepherd et al., 1997; Tyer, 1998). This resulted in a lack of services able to meet the needs of many people with mental illness especially those whose condition was deemed to be severe and chronic who needed high levels of support to be able to function within a community setting (Butler, 1993; Carling, 1993; Lamb, 1998; Lamb & Bachrach, 2001; Lelliot et al.1996; Macpherson, Shepherd, & Edwards, 2004; Morrisey, Goldman, & Klerman, 1985; Mueser et al., 1998).

The assumptions upon which deinstitutionalisation was premised, as with many mental health approaches to service development, had not been empirically tested or validated through scientific research prior to its implementation (Bachrach, 1996; Lamb & Bachrach, 2001). Rather, it was based upon the coming together of two quite different

philosophical perspectives i.e. community care and New Right cost containment (Bachrach, 1996; Lamb & Bachrach, 2001). It quickly became evident that society was ill equipped to deal with the complex needs of the mentally ill within the community. Even today, a large proportion of people with mental illness continue to fall through the gaps and/or occupy inpatient beds for extended periods of time (Braden Johnson, 1990; Butler, 1993; Carling, 1993; Lamb, 1998; Lelliot, Audini, Knapp, & Chisholm, 1996; Macpherson, Shepherd, & Edwards, 2004; Morrisey, Goldman, & Klerman, 1985; Mueser, Bond, Drake, & Resnick, 1998; Nguyen, Brakoulias, & Boyce, 2009).

The question now being asked is whether deinstitutionalisation has gone too far and the numbers of inpatient beds have been reduced below the level of requirement and capacity of the communities they serve (Lamb, 1998; Lamb & Bachrach, 2001). While deinstitutionalisation is often blamed for the failures of the mental health system, Braden Johnson (1990) asserts that the real problem lies in the way in which it was implemented and thinking that "*to initiate the process was to complete it*" (Braden Johnson, 1990, p.255). The reduction in the number of available mental health inpatient beds occurred without significant investment in the development of alternative community services (Butler, 1993; Carling, 1993; Lamb, 1998; Lamb & Bachrach, 2001; Lelliot et al.1996; Macpherson, Shepherd, & Edwards, 2004; Morrisey, Goldman, & Klerman, 1985; Mueser et al., 1998). For the first time in modern history, the community was responsible for the provision of care to people with all forms of mental illness with insufficient resources and without the possibility of long-term hospitalisation (Braden Johnson, 1990; Lamb & Bachrach, 2001). More recently, researchers have cautioned that a significant increase in resourcing and community infrastructure is required prior to implementing further bed reductions (Greengross, Hollander, & Stanton, 2000; Lamb & Bachrach, 2001; Shepherd et al., 1997).

Deinstitutionalisation signalled a change in the way society regarded mental illness as well as how statutory mental health services responded to the needs of people who became mentally ill. This section has identified that the community services required to fill the space left by institutions were slow to develop creating gaps in services for some

of the most vulnerable segments of society, in particular those suffering from severe and enduring mental illness. The pattern of service development undertaken during the process of deinstitutionalisation changed the role and function of inpatient mental health services a topic explored further in the following section.

The Function of Inpatient Care at the Turn of the 21st Century

The role of inpatient mental health care at the turn of the 21st Century has changed from that of an institution that provided for long-term care and treatment of those with mental illness to providing short-term hospital stays for clients suffering from an acute mental health crisis. This section focuses on the nature and demands placed on mental health inpatient services as well as the legacy and implications of deinstitutionalisation for inpatient mental health care.

According to the theory behind deinstitutionalisation, community care and rehabilitation would ideally reduce the need for inpatient mental health services. Despite this, evidence suggests that even in areas where community services are operating efficiently there is still an ongoing requirement for inpatient beds to meet the needs of the most acutely unwell members of society as the number, frequency and level of acuity of clients admitted to inpatient mental health wards continues to increase (Fisher et al., 2001; From Bedlam to Bedsit, 1995; Hopkins, Loeb, & Fick, 2009; Horsfall, Cleary, & Hunt, 2010; Morrisey, Goldman, & Klerman, 1985; Muijen, 2002; Shepherd et al., 1997; Thomas, 1996). Due to the priority given to providing care and treatment within the community, inpatient facilities have increasingly become places of absolute last resort for people experiencing an acute mental health crisis (Muijen, 2002).

In contrast to the long institutional stays within the old psychiatric asylums, today inpatient mental health care is designed to respond to clients when they are acutely mentally unwell with the goal to assess, treat and discharge them back into the community as quickly as possible (Hopkins, Loeb, & Fick, 2009; Horsfall, Cleary, & Hunt, 2010; Mullen, 2009). Criteria for admission may include that the client is unable

to physically care for themselves; presenting as a risk to either themselves or others; and suitable treatment cannot be provided within a community care setting (Hopkins, Loeb, & Fick, 2009; Horsfall, Cleary, & Hunt, 2010). The key functions of inpatient mental health services include providing "*a safe, structured and supportive environment where people can be assessed, where their condition can be stabilised and where they can be appropriately prepared for discharge back to their local community*" (Thomas 1996, p.38).

Internationally, most acute mental health inpatient services are generally full or have an occupancy rate of over 100% (Hopkins, Loeb, & Fick, 2009; Mullen, 2009; Horsfall, Cleary, & Hunt, 2010; National Institute for Mental Health, 2002; Shepherd et al., 1997). Inpatient units operate within a context of concern about their cost, over-occupation and the inadequacy of outcomes from the treatment provided (Goldstein & Horgan, 1988; Horsfall, Cleary, & Hunt, 2010; Hopkins, Loeb, & Fick, 2009; Mullen, 2009; Lamb & Bachrach, 2001; National Institute for Mental Health, 2002; Shepherd et al., 1997; Thomas, 1996). This presents mental health managers with the never-ending problem of rationing their resources in an attempt to provide inpatient treatment for all those requiring it. Goding (2005) suggests that one of the issues with publicly funded mental health services is that in contrast to private companies and organisations, they have a legislative monopoly and therefore need to contain demand instead of increasing it. Rather than creating opportunities for growth and expansion, increased need for public mental health services places additional strain and resource demands on an already overstretched system creating gaps in provision.

Many mental health units have struggled to develop efficient intake systems that would see a reduction in the number of inappropriate admissions. Continued over-occupancy has led to: higher thresholds for admission, increased waiting lists for treatment, increased frequency of leave for clients, more transfers out of area, and clients being assessed and discharged in a shorter period of time (Hopkins, Loeb, & Fick, 2009; Horsfall, Cleary, & Hunt, 2010; Mullen, 2009; National Institute for Mental Health, 2002; Thomas, 1996). These 'temporary' solutions are not viewed as ideal and in many

situations have compromised the quality of care provided (National Institute for Mental Health, 2002). It has become the reality of many mental health settings that the key goal of admission to an inpatient ward is often containment with treatment through medication and the ideals of therapy and rehabilitation are set aside (From Bedlam to Bedsit, 1995; Horsfall, Cleary, & Hunt, 2010; Mullen, 2009).

The process of archetype transition from institutional to community care required, among other things, a shift in resources and the development of alternatives to inpatient admission within the community. The change tracks identified by Hinings and Greenwood (1989)[65], suggest that the process of archetype transformation across mental health services resulted in an unresolved excursion with services torn between two different archetypes, institutional care and community care, in a hybrid or schizoid state. As Shepherd et al.(1997) note simply providing more acute inpatient beds is not the answer. Throughout the process of deinstitutionalisation, service planners and administrators failed to anticipate the extent of community resources required to meet the needs of clients who would have previously spent much of their lives within institutions (Horsfall, Cleary, & Hunt, 2010; Lamb, 1998; Lamb & Bachrach, 2001). For successful archetype transition to community care, investment is required in developing and implementing community alternatives to inpatient care.

This section has discussed the changing role of inpatient mental health care. In contrast to the days of the psychiatric institution, the role of acute inpatient mental health care today is to provide short-term assessment and treatment for clients experiencing a mental health crisis prior to their discharge back into the community. This section has also explored the transition between institutional and community care archetypes, and identified that when viewed through the lens of archetype theory this change from one form to another has not proceeded as anticipated. A failure to adequately develop and resource community care has created gaps in the system representing an unresolved excursion in terms of archetype transformation.

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[65] Change tracks were discussed in Chapter Two.

Patterns of Service Development Decision-Making within Statutory Mental Health Services

This thesis is concerned with understanding the process of service development decision-making within statutory mental health providers in Aotearoa New Zealand. This section discusses historical patterns and trends in decision-making that have influenced the development of services across mental health organisations. This is undertaken to contextualise the current processes that inform the configuration of services in statutory mental health services in Aotearoa New Zealand. In particular, this section explores the complex and often contradictory processes that have informed mental health service development and service configurations, which have tended to defer to trends, politics and perceptions of risk.

Internationally, mental health services have developed in an uncoordinated fashion, meaning that services have been developed in response to perceived need, trends, ideology, political expediency, perceptions of risk and through demands for services (Aarons, Hurlburt, & McCue Horwitz, 2011; Braden Johnson, 1990; Butler, 1993; Callaly & Minas, 2005; Falloon & Fadden, 1993a; Hoge & Howenstine, 1997; Keating, 1998; Norcross, Garofalo, & Koocher, 2006; Panzono & Roth, 2006; Reay, 2010). Some authors argue that the shape of mental health services today more mirrors patterns in politics, beliefs, and economic policy than any clinical evidence of what is required to treat people with mental illness (Braden Johnson, 1990; Butler, 1993; Hafner & An Der Heiden, 1996; National Institute for Mental Health, 2002; Wright & David, nd). Part of the reason for the fragmented development of mental health services is a lack of rigorous, reliable and valid evidence in relation to effective treatment outcomes, therapeutic approaches and service configurations (Beyond the Asylum, 1995; Braden Johnson, 1990; Hafner & An Der Heiden, 1996; Muijen, 2002; National Institute for Mental Health, 2002; Norcross, Garofalo, & Koocher, 2006; Shepherd et al., 1997; The Search for Acute Solutions, 2001). Ideological assumptions and rough estimates of need have instead underpinned service development and service configurations across all

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elements of the mental health system (Hafner & An Der Heiden, 1996). Consequently, the service development and delivery environment has not been planned or organised in a coherent fashion. This approach to service development has resulted in a system of mental health care that involves treatment strategies and service configurations that do not have proven efficacy or even reflect the reality of service providers, clinicians and the needs of the clients they are designed to serve (Braden Johnson, 1990; Butler, 1993; Falloon & Fadden, 1993; Reay, 2010).

'New' ideas for treatment programmes have been developed, and implemented without evidence to support improved client outcomes such as the implementation of wraparound programmes in inpatient settings and hospital in the home programmes (Braden Johnson, 1990). Wraparound programmes were instead originally designed for community settings with research aimed at assessing results within the community rather than inpatient settings. The criteria for adopting services has become that "*it seems like the right approach to take rather than because sound research demonstrates the efficacy of these services*" (Geller, Fisher, & McDermert, 1995, p.897). Ellard (2008), when reflecting on the development of mental health policy in Australia, noted that service development occurred in response to changes in the client population and developments in clinical treatment strategies made by those working pragmatically to respond to the needs of people with mental illness. While lacking a coordinated approach these initiatives have achieved some successes that have resulted in improved outcomes for clients.

A number of authors argue that politics and perceptions of risk across the mental health sector are key determinants of service development meaning that many gaps in service provision and instances of poor service delivery are overlooked until a major incident occurs and/or it attracts the attention of the media (Aarons et al., 2011; Braden Johnson, 1990; Panzono & Roth, 2006). Hoge and Howenstine concur with this finding and state that the historical development of mental health services have been premised on "*the perception of a specific need [which leads to] the creation of a specific programme and the final product is a fragmented ... environment in which clients struggle to access*

assistance from a variety of single purpose agencies that function independently" (Hoge & Howenstine, 1997, p.176). This reactive pattern of service development also means that change and reform to service delivery within mental health services will be ongoing as there continues to be mounting political pressures and calls for safer, more responsive and publicly accountable mental health services (Callaly & Minas, 2005).

Patterns in mental health service development are often cyclical, initiated by therapeutic concerns, which then fall victim to political and/or economic interference (Butler, 1993; Brown, 1985; Callaly & Minas, 2005; Morrisey, Goldman, & Klerman, 1985). Butler (1993) writing about the development of mental health services in the United Kingdom explains that there are very few new treatment or service innovations within the mental health sector. Changes tend to be previous approaches that are simply rediscovered and identified as 'new'. He also notes that problems such as staff shortages, insufficient resources, inadequate training and the public perceptions of the mental health system endure despite changed approaches to service delivery (Butler, 1993).

Professional bureaucracies including statutory mental health providers are slow to adapt to formal change despite the continuous process of examination and audit that occurs within these environments (Blau & Meyer, 1971; Brower & Abolafia, 1997; Matheson, 2000; Olsen, 2005; Olsen, 2008). In situations when evidence-based approaches to practice are implemented the very nature of the mental health service delivery environment means that these take a considerable amount of time to be widely adopted (Minas, 2005; Panzono & Roth, 2006). Panzono and Roth (2006) suggest that this can be in excess of a decade even with the input of extensive financial and workforce resources, attributing this slow pace of change to staff resistance. However, Minas (2005) states that it is a combination of elements within the entire service delivery environment that contribute to the slow pace of change that may include staff attitudes as one of these components. Archetype theory would assert the lack of alignment between the interpretive scheme of the organisation and the proposed service development has created the delay in service implementation (Hinings, Brown, & Greenwood, 1991).

Bureaucrats and administrators have had primary responsibility for shaping the mental health system, as they are responsible for decisions related to funding (Braden Johnson, 1990). Unfortunately, experience would suggest that they lack the expertise or knowledge to administer this effectively and as already noted, decisions related to service development are not always premised on sound evaluation or research evidence (Braden Johnson, 1990). The resulting structures that deliver mental health care and treatment often fail to consider the consequences of client flow, service collaboration and treatment planning (Callaly & Fletcher, 2005). In these situations, the selection of new programmes and services for implementation is based on the fit with an organisation's structures, systems and values rather than on consideration of evidence of what equates with effective care and treatment (Aarons et al., 2011).

The policy framework that informs mental health services does not necessarily assist in creating a responsive and effective system of care. It is overly complex, reflecting political determinants, international conventions and comprising different theoretical and philosophical viewpoints, as well as different treatment standards, approaches, clinical guidelines and service provision frameworks. This creates what Minas (2005) describes as a complex policy web which is meant to inform both clinical practice and service development (Minas, 2005; Thornicroft & Tansella, 2004). These different policies, frameworks, standards and clinical guidelines are intended to provide certainty and systems of accountability around clinical service delivery. The frameworks encourage uniformity thereby minimising the opportunities for error through the creation of accountability frameworks including management structures and audit systems. Yet, the sheer number of policy documents is overwhelming for clinicians, often duplicating existing processes and failing to acknowledge the reality of the service delivery context (Minas, 2005; Thornicroft & Tansella, 2004).

There is scarce evidence that a coordinated system of care for clients with a mental illness exists due to a lack of a unified set of clearly defined goals for mental health services. Bachrach (1996) suggests that each organisation or therapeutic programme

focuses on the immediate needs of their clients and ignores the long-term consequences. Once the client has left their programme there is typically no obligation on behalf of the mental health provider to provide long-term follow-up and the person then has to navigate the rest of the mental health system on their own (Falloon & Fadden, 1993). The failure of mental health providers to consider concerns outside of their locus of control further contributes to a fragmented mental health system, creating gaps and overlaps in service provision (Falloon & Fadden, 1993).

This section has emphasised the range of factors that influence the process of service development in statutory mental health services. It has discussed how often ideas, trends, politics and perceptions of risk are prioritised in service development rather than consideration of evidence. Contributing to the uncoordinated approach to service development across the mental health system is the complex policy framework involving multiple policies, frameworks, standards and clinical guidelines. There is also a lack of consistency regarding what constitutes effective care and treatment alongside disagreement about the efficacy of research into mental health treatment and the development of new therapeutic approaches. The following section further explores the role of evaluation and evidence in service development in statutory mental health services.

The Place of Evaluation and Evidence-Based Service Development

Service evaluation and the implementation of evidence-based practice approaches by mental health services occurs infrequently outside of required funding and contractual obligations (Thornicroft & Knudsen, 1996). Literature has identified the need to provide a more coordinated and systematic approach to mental illness and a related need to ensure that therapeutic practices are premised on evidence (Callaly & Mias, 2005; Minas, 2005; Norcross, Garofalo, & Koocher, 2006; Panzono & Roth, 2006; Reay, 2010; Traver, 2011). Evaluation is used to "*synthesize what is already known, unearth false assumptions, debunk myths, develop new information and explain the implications*

of this information for future decision making" (Nixon, 1997, p.3). Evaluations and evidence can make a positive contribution to the development of mental health services. The purpose of this section is to explore the role of evaluation and evidence within statutory mental health services including its frequency of use, functions and the barriers to its effective utilisation in order to understand the contribution it makes to service development.

Evaluations can assess if services are meeting the needs of clients[66]; their clinical and cost effectiveness; whether there are any gaps in the service delivery continuum; as well as whether delivery is in accordance with specifications (Bachrach, 1996; Falloon & Fadden, 1993; Nixon, 1997). This information can then be reintegrated back into services to enable them to adapt and enhance their programmes in response to the changing needs of the community (Falloon & Fadden, 1993). The benefits of service evaluation include incremental service and practice improvement as well as the potential to influence mental health policy and ultimately to address the fragmented nature of the mental health system (Falloon & Fadden, 1993; Sullivan, 1996; Wing, 1996). Service evaluation when it is a routine part of service delivery enables services to remain responsive to the needs of their clients, identifying successes and emerging problems enabling the implementation of change at the earliest possible opportunity (Falloon & Fadden, 1993). Nixon (1997) writing about routine programme evaluation within child and adolescent mental health states that this contributes to a solid foundation of knowledge about how best to meet the needs of their client population.

Mental health care and treatment takes place in multiple environments involving many aspects of a client's life. Measuring outcomes is often subjective, data collection unreliable and expertise for analysing the results is often lacking (Aarons et al., 2011; Butler, 1993; Hafner & An Der Heiden, 1996). Gkeredakis, Swan, Powell, Nicolini, Scarbrough, Roginski, Taylor-Phillips and Clarke (2011) suggest that it is difficult to assess the reasons behind the underutilisation of evaluation across the health system as

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[66] This should include consideration of cases that are still to be identified as well as those already known to hospital-based and primary care services (Falloon & Fadden, 1993).

evaluation theories and models do not allow for the unpredictability of the service delivery environment.[67] There is also "*substantial variation in clinical perspectives, case conceptualisation, epidemiological understanding and clinical decision making*" influencing the reliability and validity of evaluation across mental health organisations (Reay, 2010, p.97).

Wing (1996), suggests five tools that can assist with the evaluation of mental health programmes and aid in subsequent service development decisions. These include adopting an integrated system including clinical audit[68]; case registers; mental health information systems; clinical data sets as well as controlled and quasi-controlled experiments (Wing, 1996). Wing (1996) asserts that effective programme evaluation within mental health services should occur as part of routine service delivery, making use of already established monitoring systems and having acceptance from managers, clinicians as well as clients. Wing's approach, like many other evaluation or evidence-based initiatives, is reliant on the use of technology to capture and analyse client data. Advances in technology have aided the ability to collect and store client information. Unfortunately, the advent of the individual client record has been criticised as being ill-suited to clinical use as well as service evaluation as "*it tends to be incomplete, difficult to access and slow to retrieve*" (Bachrach, 1996, p.8).

Alongside the development of individual client records has been the establishment of national mental health collection systems with data warehouses aimed at producing information that can inform mental health policy, service development and evaluation (Wing, 1996). Instead of contributing to a process of routine service evaluation and the implementation of evidence-based practice strategies, in many instances computerised records have achieved the opposite effect being cumbersome and requiring experts to retrieve and analyse the data (Wing, 1996). These developments have predominantly focused on care and treatment within inpatient settings and have neglected the wider

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[67] Gkeredakis et al.(2011) research examined the gap between knowledge and practice in the National Health Service in the United Kingdom, including mental health services.
[68] Clinical audit is described as being similar to scientific research except clinical guidelines are substituted for a control group (Wing, 1996).

context of care in the community provided by non-government organisations. They focus on one aspect of an individual client's mental health journey, the inpatient stay, rather than contributing to knowledge about the extent of service use across the mental health sector. These databases have also been criticised for their development by bureaucrats and policy analysts who are out of touch with the reality of clinical practice (Bachrach, 1996).

There is growing acknowledgement across mental health services of the need to measure client outcomes with tools developed to enable this to occur (Sullivan, 1996). National outcome measurement programmes are already in place in the United Kingdom, Australia and in Aotearoa New Zealand[69], among others. The aim of these programmes is to provide reliable tools for assessing client treatment outcomes for use in individual treatment planning. This is only one aspect of programme evaluation and to date there is little reliable evidence to demonstrate the integration of client outcomes in routine service/programme evaluation and service development, and replicable system and treatment outcome tools are still to be developed (Sullivan, 1996).

In line with international trends, Aotearoa New Zealand created a national mental health data collection system (MHINC) in 2000, with the goal of measuring mental health service utilisation across the country. In 2009 MHINC data was combined with the local District Health Board Mental Health Standard Measures of Assessment and Recovery (MH-SMART) to create a new national data base for mental health called PRIMHD (PRIMHD, 2012). Since the establishment of MHINC, there have been ongoing concerns voiced by District Health Boards related to the integrity and reliability of the data collected by MHINC and provided in PRIMHD (Jarmey, 2011). This is consistent with international experiences where databases have had significant problems related to data integrity and criticism of the use of the information for furthering management priorities and purchasing requirements (Wing, 1996).

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[69] The Aotearoa New Zealand outcomes measures programme is called Mental Health Standard Measures of Assessment and Recovery (MH-SMART).

As mentioned earlier in this chapter, funding premised on ideological and political factors has historically dictated the need for service development. The identification of gaps within the current spectrum of service delivery is difficult due to a lack of evaluation processes or the routine use of evidence-based decision-making pathways outside of routine financial audit, measurement of service delivery targets and other contractual requirements (Bachrach, 1996; Sullivan, 1996). Politically popular questions and measures of utility such as bed occupancy motivate audits for funding and contractual purposes meaning that instances of creative and effective service provision are often overlooked (Bachrach, 1996; Braden Johnson, 1990). Consequently, there is frequently no comprehensive system level assessment or clinical evaluation of clients' need resulting in duplication and gaps in service delivery (Bachrach, 1996; Sullivan, 1996).

Mental health literature has shifted focus since 2000 from consideration of the role of service evaluation to a closer examination of evidence-based practice. The discussion of evidence-based practice sits within implementation literature and talks to the characteristics and processes required to support the successful adoption of evidence-based practice approaches in mental health organisations (Aarons et al., 2011; Gkeredakis et al., 2011; Norcross, 2006; O'Connor & Kotse, 2008; Panzono & Roth, 2006; Proctor et al., 2011; Toney, Bond, McHugo, & Swain, 2011). Reflecting some of the key tenets of archetype theory the implementation literature suggests that for successful adoption of evidence-based approaches services need to take into account the value system of the organisation, clinical as well as administrative leadership, workforce development, practice reinforcement as well as the organisation's attitude towards risk (Aarons et al., 2011; Gkeredakis et al., 2011; Norcross, 2006; O'Connor & Kotse, 2008; Panzono & Roth, 2006; Proctor et al., 2011; Toney et al., 2011).

The implementation literature provides frameworks to assist mental health services to adopt and implement empirically tested and valid treatment approaches (Aarons et al., 2011; Gkeredakis et al., 2011; Norcross, 2006; O'Connor & Kotse, 2008; Panzono & Roth, 2006; Proctor et al., 2011; Toney et al., 2011). What this literature does not do is

address the current dilemma about what constitutes validity of results in mental health, the lack of measurement tools for many of the treatment approaches as well as how to align evidence-based strategies alongside the current array of less empirically valid tools currently in use. In addition, it fails to acknowledge the autonomous nature of practitioners or the politically charged nature of the delivery environment, the very characteristics that define a professional bureaucracy and reflect the nature of mental health organisations.

This section has outlined the role of evaluation and evidence-based approaches in mental health services. It has discussed the challenges presented by the nature of the clinical environment and difficulties in implementing these approaches. There is a lack of rigorous processes for evaluation or the use of evidence in developing treatment approaches across mental health services. There are also conceptual and methodological issues around what constitutes a valid measure. Attempts have been made to develop data collection systems and outcome measures, but to date they lack integrity and validity. The absence of clear processes for assessing and developing services creates potential for politics, the management of risk and ideological as well as value assumptions to be the main determinants of service development.

The Development of Mental Health Services in Aotearoa New Zealand.

Thus far, this chapter has provided an analysis of the development of mental services internationally. It has discussed the role of ideological beliefs and trends pertaining to the care and treatment of people with mental illness as well as the often fragmented and uncoordinated approach to service development that has prevailed across mental health services. This research is concerned with understanding service development within statutory mental health organisations in Aotearoa New Zealand. Therefore, this chapter now moves to discuss the development of mental health services in Aotearoa New Zealand reflecting on similarities in approaches between local and international patterns of service development.

The literature addressing the history and development of mental health services in Aotearoa New Zealand is relatively small. That which does exist recounts the individual stories of different mental health services such as Cherry Farm in Otago and Sunnyside in Canterbury (Barton & Barnett, 1981; Brookes, 2001; Kavanagh, 1996; Seager, 1987). In addition to these institutionally-based documents, media and government accounts of the history and development of mental health services chronicle the activities and concerns with regard to the inability of mental health services to meet the needs of those with mental illness.

In Aotearoa New Zealand, the development of mental health services occurred after European settlement and mirrored services delivered in the United Kingdom (Brunton, 2005). Prisons provided the location for the first mental health treatment with the first 'lunatic asylums' in Aotearoa New Zealand built during the 1860s in response to concerns about "*civic improvement*" [70] (Joseph, Kearns, & Moon, 2009, p.82).

Throughout their history, mental health services in Aotearoa New Zealand have been criticised for inadequate resourcing, the condition of the physical environment, overcrowding and the difficulty of retaining good quality staff (Brookes, 2001, Kavanagh, 1996). Even when the first psychiatric institutions were built in Aotearoa New Zealand mistakes were made including forgetting to build facilities for the superintendent and the sewerage system at Sunnyside hospital in Christchurch (Barton & Barnett, 1981; Seagar, 1987). Seacliff in Otago was poorly constructed, on the side of an unstable cliff into which it eventually collapsed and Cherry Farm had ongoing problems with its sewer system (Brookes, 2001; Kavanagh, 1996). These factors all contributed to making conditions intolerable and quality staff recruitment and retention difficult (Kavanagh, 1996).

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[70] "Civic improvement" involved removing less desirable people from society and placing them in institutions away from public scrutiny (Joseph, Kearns, & Moon, 2009, p.82).

The first psychiatric hospitals built in Aotearoa New Zealand were essentially self-contained communities (Barton & Barnett, 1981). They grew their own produce, had their own cattle for milk and beef production, as well as their own morgues (Barton & Barnett, 1981). Once admitted clients did not leave the facility and often worked maintaining the grounds of the institution (HealthLink South, 1990). The first mental health legislation was introduced in 1911 and stayed in force until 1969 (Joseph & Kearns, 1996). The Mental Defectives Act renamed lunatic asylums as psychiatric hospitals and created the ability for people to receive care voluntarily (Joseph & Kearns, 1996).

The period from the early 1900s until 1948 saw advances in mental health treatment including insulin coma therapy, electroconvulsive therapy and in some extreme cases surgical options such as pre-frontal leucotomy (Brooker, 2001). During this period, the resident population of psychiatric hospitals rose dramatically with poor client-staff ratios and few options for treatment or discharge from these facilities (Brookes, 2001). Mental health care and treatment mirrored international approaches where clients with mental illness were hospitalised for extended periods, with little ongoing contact from mental health services when discharged back into the community (Barton & Barnett, 1981). The psychiatric hospitals' population eventually peaked in 1965 at 10,492 clients (Department of Internal Affairs, 2007).

In the late 1960s, again following the international trend towards deinstitutionalisation[71], the government devolved responsibility for mental health services to local hospital boards (Barton & Barnett, 1981; Brooker, 2001; Kavanagh, 1996). Mental health care and treatment in Aotearoa New Zealand has been criticised as lacking a coordinated approach since its inception and the devolution of services to local hospital boards further contributed to this fragmented approach as each local board determined the extent and nature of mental health services provided within their region (Joseph, Kearns, & Moon, 2009). This step also saw the beginning of the process of deinstitutionalisation

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[71] The philosophical and practice arguments for deinstitutionalisation have been discussed earlier in this chapter.

as hospital boards, pressured by the government to decrease costs, regarded community care as being a cheaper alternative to treatment within psychiatric institutions (Barton & Barnett, 1981; Brooker, 2001; Kavanagh, 1996).

From the 1960s, the clinical focus in terms of mental health care and treatment began to shift from long-term hospital admission to clients being admitted to hospital for shorter periods of time, being discharged and maintained within the community, still able to access hospital care as, and when, necessary (Barton & Barnett, 1981). The first visits by psychiatric community nurses as part of this model occurred in 1967 (Barton & Barnett, 1981). These visits involved ward nurses working on a part-time basis to visit past inpatients who were now living in the community (Barton & Barnett, 1981).[72] Despite this innovation, the 1969 Mental Health Act predominantly focused on standards of care within hospitals and provided very little reference to community care (Joseph & Kearns, 1996; Moon, Joseph, & Kearns, 2005).[73]

The number of people within psychiatric hospitals fell dramatically from the 1960s to approximately half the number 20 years later (Barton & Barnett, 1981). The experience at Sunnyside Hospital in Canterbury is typical of many other institutions around the country with numbers peaking at 1042 clients in 1969 and falling to a client population of 663 people in 1978 (Barton & Barnett, 1981). Despite the decrease in numbers, in 1982 over 7000 people were still resident in mental health institutions across Aotearoa New Zealand and inpatient mental health care still consumed the vast majority of the allocated mental health budget (Department of Internal Affairs, 2007; Joseph, Kearns, & Moon, 2009; Joseph & Kearns, 1996; Moon, Joseph, & Kearns, 2005).

Concern about the quality and nature of mental health services over the latter part of the 20th Century focused on the way in which the country embraced the process of deinstitutionalisation. Joseph and Kearns (1996, p.180) describe this process as lacking

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[72] Now fulfilled by clinicians working in community teams, this community treatment model is still the dominant model of treatment used today.
[73] This legislation was updated in 1992 to the Compulsory, Treatment and Assessment Act which includes strict regulations around the use of compulsory care in both the community and inpatient settings.

coherence and resembling an ad-hoc process based on "*loosely related measures*". An example of the lack of coherency is evident in the accelerated speed of deinstitutionalisation during the 1980s alongside the government's neo-liberal agenda of cost cutting, health sector reform and dismantling of the welfare state (Joseph & Kearns, 1996; Joseph, Kearns, & Moon, 2009).[74] Joseph, Kearns and Moon (2009) state that the dominant neo-liberal discourse underpinned by new public management theories simply reduced models of mental health care and treatment to their organisational and financial characteristics [75] in order to justify their closure.

In 1993, reflecting the neo-liberal agenda, health services adopted a quasi-market structure that separated out the funding from the provision of services (Ashton, Mays, & Devlin, 2005). This involved the creation of Regional Health Authorities (RHAs) with responsibility for purchasing services and the transformation of Area Health Boards into Crown Health Enterprises (CHE) essentially becoming profit-making organisations responsible for delivering health services (Ashton, Mays, & Devlin, 2005). The move to a business structure for delivering health care accelerated the pace of deinstitutionalisation as CHEs viewed institutional mental health care as an unnecessary cost. The arguments around the benefits of community based care and treatment provided a ready rationale for closing psychiatric hospitals (Joseph, Kearns & Moon, 2009). In the hurry to close hospitals, planners failed to account for the need to develop and resource community based approaches (Joseph & Kearns, 1996; Joseph, Kearns, & Moon, 2009; Kavanagh, 1996). Kavanagh (1996) asserts that economic rationalism had dictated an accelerated programme of deinstitutionalisation during the 1990s which had not been translated into the development of appropriate levels of care and support in the community. Essentially reductions in inpatient bed numbers occurred with the expectation that market forces and/or the voluntary sector would address the gap in care and treatment (Joseph, Kearns, & Moon, 2009). Alongside the process of reducing the number of inpatient beds provided in mental health hospitals, CHEs also stopped investing in the upgrading and maintenance of the old institutions resulting in decreasing

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[74] As discussed in Chapter One.

[75] Organisational and financial characteristics refers to the cost benefit analysis of service delivery against the value of tangible assets such as land values.

quality of the physical environment within these buildings which created a further impetus to close their doors permanently (Joseph, Kearns, & Moon, 2009).

The implementation of the quasi-market approach to health care marked a change in mental health organisations. While mental health organisations had begun the process of transition from the institutional archetype, described earlier in this chapter, to a community care archetype, this process was not complete prior to the introduction of the neo-liberal reforms of the 1980s. What resulted was a hybrid archetype comprising elements of the community care archetype with the new values of accountability and efficiency embodied within the quasi-market reforms of the health sector.

Figure 2, p.111 highlights the main characteristics of the hybrid quasi-market/community care archetype. The interpretive scheme of statutory mental health organisations post the reforms of the 1980s, involved a complex mix of community care[76] and management values that struggled to achieve a balance in terms of which value system predominated.[77] The internal systems and policies of the organisation consequently shifted from the traditional medical hierarchical model to a dual system of clinical directorates and management roles which provided oversight for the internal systems of the organisation with peer review processes still informing clinical care. The structure of the organisation also changed from centralised financial management to individual clinical units having responsibility for their own financial and resource budgets alongside clinical delivery. Despite the introduction of programmes of care premised on professional groupings working together as multidisciplinary teams the medical hierarchy headed by psychiatrists prevailed due to their role as the responsible clinicians meaning they had the ultimate responsibility for client care across the mental health service.

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[76] Community care involves the combination of psychoanalytic and bio-psychosocial treatment modalities translated from the 1980s hybrid community care archetype.

[77] The conflicting value systems of clinicians and managers as well as the consequence of this for service development was a key finding of this research and is discussed further in the analysis sections of this thesis.
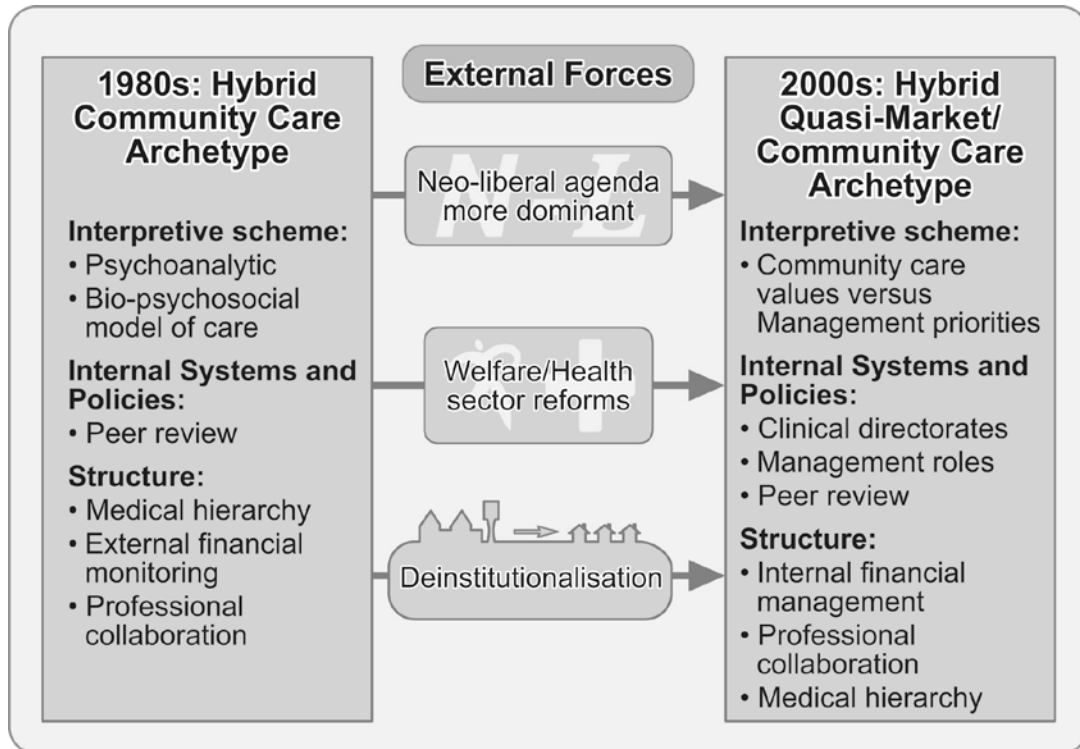
Figure 2: The new quasi-market archetype of mental health services

Brunton (2005, p.2) summarises Aotearoa New Zealand's approach to mental health policy development as reflecting a pattern of "*alternating bursts of policy development and funding interspersed with long periods of quiet incremental change, indifference, or even stagnation*." This pattern is evident in Aotearoa New Zealand's approach to deinstitutionalisation as despite the perceived speed and vigour with which the policy makers and administrators embraced deinstitutionalisation in reality many of the 'old' psychiatric institutions were still open in the late 1990s (Department of Internal Affairs, 2007; Joseph, Kearns, & Moon, 2009).[78] It was not until this time that care in the community became the dominant form of treatment for clients with mental illness (Joseph, Kearns, & Moon, 2009).

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[78] Examples of institutions still open in the late 1990s include: Tokonui in the Waikato which closed in 1999; Lake Alice in the Rangitikei closed in 2000; Seaview established in 1872 only closed in 2001; Kingseat in Auckland first opened in 1932 closed in 1999; Ngawhatu in Nelson closed in 2000; Sunnyside in Christchurch and Porirua reconfigured into new inpatient facilities (Department of Internal Affairs, 2007; Joseph, Kearns, & Moon, 2009).

Mental health services in Aotearoa New Zealand have a long, chequered history with numerous inquiries into poor client treatment and the failure of the government to adequately resource the sector (Barton & Barnett, 1981; Department of Internal Affairs, 2007; Joseph, Kearns, & Moon, 2009; Joseph & Kearns, 1996; Kavanagh, 1996; Moon, Joseph, & Kearns, 2005). Concerns about inadequate resourcing, overcrowding, and lack of qualified staff continue to mirror the trends experienced internationally and detailed earlier in this chapter. In the 1990s, mental health services further came under the spotlight with a series of national reviews looking at the gaps in service delivery culminating in the *Mason Inquiry into Mental Health Services* in 1996. [79] The concerns, raised in these investigations and reviews, caused the government and Ministry of Health to rethink the oversight of the development and delivery of mental health services across Aotearoa New Zealand.

A consequence of the *Mason Inquiry* (1996) was the establishment of the Mental Health Commission. The Mental Health Commission was set up as an independent body to be a 'watchdog' for clients of mental health services as well as to provide advice to the government on the extent to which mental health services were meeting the needs of those with mental illness (Mental Health Commission Act, 1998). At the time of its establishment, the Mental Health Commission was given a finite life span of just five years (Mental Health Commission Act, 1998).[80]

The first task of the Mental Health Commission was to develop the *Blueprint for Mental Health Services* (1998). The *Blueprint* presented a plan for mental health services premised on the recovery philosophy aimed at improving the involvement of mental

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[79] Reviews and inquiries since 1994 include: Mason 1994 (*Matthew Francis Inquiry*); Mason 1996 (*The Mason Inquiry*); Cull 1997 (*Jacko Paki Inquiry*); Mental Health Commission 2002 (*Auckland Services Inquiry*); Cull and Robinson 2003 (*Paul Ellis Inquiry*); Health and Disability Commissioner 2002 (*Southland DHB, Burton Inquiry*); Department of Internal Affairs 2007 (*Confidential Forum for former inpatients – response to Lake Alice Court case*). See also Brunton, 2005 for a review of the role of inquiries into mental health care between 1858 and 1996. In 2005, the government established the *Confidential Forum for Former In-Patients of Psychiatric* Hospitals to enable former staff, clients and their families to talk about their experiences of psychiatric treatment in the years prior to 1992 (Department of Internal Affairs, 2007).

[80] The current National government have indicated this will end in 2015 (Mental Health Commission Amendment Act, 2007).

health clients in their care as well as increasing their life satisfaction (Reed, 2006). At the same time, the government, represented by the Ministry of Health, was developing the first Mental Health Plan entitled *Moving Forward* (1997). The *Blueprint* and *Moving Forward* attempted to address many of the failings and gaps in the mental health system that the *Mason Inquiry* had identified and resulted in a significant injection of funding over the next ten years.

In the period post 1996 there have been significant infrastructure and resource developments within mental health services, shifts in philosophy away from containment to recovery and a focus on delivering the best care possible in the least restrictive environment (Brunton, 2011). The establishment of District Health Boards in 2000 and the introduction of the Primary Health Care Strategy saw a further change in philosophy with the belief that statutory mental health care should focus on those with severe mental illness and those with mild to moderate[81] should receive care from their General Practitioner and other non-statutory services (Brunton, 2011). Between January 2006 and January 2007, only 8% of people who accessed statutory mental health services received inpatient care (Brunton, 2011). There is still ongoing concern about the ability of statutory mental health services to meet the needs of people with mental illness (Brunton, 2011).

This section has provided an overview of the development of mental health services in Aotearoa New Zealand. In general, service development has followed international trends and moved from treating and caring for clients within institutions towards providing care within the community. Mental health services in Aotearoa New Zealand have been criticised for a lack of coherence and an ad-hoc approach to planning. Since their establishment mental health services have been plagued with concerns related to inadequate resourcing, poor environmental conditions, problems with staff recruitment and retention as well as lack of foresight in terms of planning and development. Despite

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[81] The definition of what constitutes mild to moderate mental illness is typically a subjective measure determined by the assessing practitioner. It is a clinical assessment related to the prevalence of the disorder, its recurrence over the preceding 12 months and the level of disability experienced by the client (Oakley Browne, Wells, & Scott, 2006).

the closure of old psychiatric institutions, the advancement of medical and philosophical approaches to mental health treatment as well as the changing location of service delivery, the problems related to mental health care first identified in the 19th Century still pervade the service delivery environment today. Instead of taking a coordinated approach to the development of mental health services, policy makers have responded to issues as they have occurred or made changes in policy direction in response to wider health sector reforms.

Aotearoa New Zealand's Mental Health Policy Framework

Following on from *Moving Forward* and the *Blueprint*, overarching documents produced by the Ministry of Health and the Mental Health Commission continue to inform the policy framework for the delivery of mental health services in Aotearoa New Zealand. The intent of the policy framework is to provide leadership and national coordination across mental health services. The purpose of this section is to introduce the current mental health policy framework that informs service development and delivery in Aotearoa New Zealand.

The Ministry of Health, through its Mental Health Directorate, plays a key role in overseeing the provision of mental health services across Aotearoa New Zealand through the development and monitoring of *Te Tāhuhu* and *Te Kōkiri* as well as other policy and guideline documents in areas including suicide prevention, the treatment of co-existing substance disorders and mental illness, forensic services among others. *Te Tāhuhu* (2005) is the government's current vision for mental health services and outlines what it hopes the sector will achieve during the period of the plan. The document identifies 10 key strategic/priority areas for the mental health and addiction sector until 2015. These include: Promotion and Prevention; Building Mental Health Services; Responsiveness; Workforce and Culture; Māori Mental Health; Primary Health Care; Addiction; Funding Mechanisms for Recovery; Transparency and Trust; Working Together (Ministry of Health, 2005).

Te Kōkiri according to the Ministry of Health, sets out the programme of action to achieve this plan (Ministry of Health, 2006). It provides further detail with regard to the strategic framework, speaking of the ideals that the government's policy aims to address and provides high-level overviews and targets with regard to expected roles of the key participants in the mental health sector.

Alongside these two key strategic documents sits *Te Hononga 2015* a vision for the mental health sector created by the Mental Health Commission in 2007. In 2004 the Mental Health Commission drafted a vision for mental health services called *Our Lives in 2014: A Recovery Vision for People with Mental Illness* the purpose of this document was to inform the development of the second mental health plan. Following the publication of *Te Tāhuhu*, the Mental Health Commission updated this document and subsequently released *Te Hononga 2015*. *Te Hononga 2015* reaffirmed the Mental Health Commission's vision for the Mental Health Sector. It is framed by a health promotion philosophy[82] and a desire to reduce the prevalence of mental illness and/or addiction within New Zealand society. The document focuses on 10 key values that the Mental Health Commission believes should underpin the mental health sector by 2015. These include: Putting people first; Well-being for everyone; Recovery; Affirming rights and autonomy; Building strengths and resilience; Responding early; Connectedness/Te Hononga; Right responses; Collaboration; and Services in communities (Mental Health Commission, 2007).

The mental health plans, *Te Tāhuhu*; *Te Kōkiri* and *Te Hononga*, developed by the Ministry of Health and Mental Health Commission provide the framework for the delivery of mental health services across Aotearoa New Zealand. In this way, these organisations provide overall governance for the sector and set the agenda for the national coordination of mental health service development. As well as being high level strategy documents, they provide detail around how the sector is expected to demonstrate compliance with the plans and as a consequence the documents act as the

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[82] A health promotion philosophy encourages people to be healthier, by gaining greater control over their health and provides a focus on the prevention of illness and maintenance of wellness through healthy living initiatives (http://www.who.int/topics/health_promotion/en/).

government's mechanism for ensuring guidelines are provided around the vision and scope of mental health services nationally.

As noted in the introductory chapter of this thesis, in Aotearoa New Zealand, each District Health Board is responsible for overseeing the scope of mental health services required by their region's population. Population need determines the allocation of funding and it is the expectation of the government that services will provide quality mental health services. Since 2001, the government has allocated funding for health services on a needs-based funding model. The needs-based allocation system has resulted in mental health services differing in the nature and scope of service delivery across the country. While individual District Health Boards decide on the priorities for their own region, the key philosophies and targets provided by the Ministry of Health guide the service delivery environment.

The Ministry of Health is responsible for providing overall strategic vision across the mental health sector as well as monitoring the performance of District Health Boards' delivery of efficient and effective mental health services. As already noted the Ministry of Health creates national policies, goals and objectives around the delivery of mental health services in each District Health Board's area. It is then the responsibility of District Health Boards to interpret the policy and implement it. The implementation of policy may differ across the country as each area allocates different priority to each of the components of mental health policy, continuing the fragmented approach to service delivery that has characterised the patterns of service development in Aotearoa New Zealand. The key tension for policy makers consequently becomes balancing national consistency with the need for regions to remain responsive to the needs of their client populations.

The purpose of this section has been to outline the current mental health policy framework in Aotearoa New Zealand. While the Ministry of Health and the Mental Health Commission are responsible for providing overall strategic direction for mental health services, in reality the fragmented approach to service delivery which has

dominated mental health care continues through the nature of the service delivery environment where District Health Boards allocate priority and determine the scope and nature of services within their region. This framework provides the national context for service development and delivery within Living Well.

Introducing the Archetype of Living Well

Living Well was the site for this research. Living Well is a professional organisation delivering statutory mental health services across both urban and rural settings in Aotearoa New Zealand. As noted in the introductory chapter, Living Well is a large regional mental health service located at the site of an historic psychiatric hospital. Its services mirror the scope of other large statutory mental health services around the country and include the full spectrum of general mental health services across community and inpatient settings.[83] This study specifically focuses on service development across the Adult General Community, Adult General Inpatient and Rehabilitation Services of Living Well and where relevant also considers elements of the wider management structure.

Living Well's archetype at the time of this research encompassed the key characteristics of the hybrid quasi market/community care archetype detailed in Figure 2, p. 111 and is presented again in Figure 3, p.118.

Living Well's core function or raison d'être guided all aspects of service development and delivery and was premised on the delivery of responsive mental health services. This raison d'être also aligned Living Well with the archetype of the professional bureaucracy where the core focus of the organisation emanates from the professional expertise of its staff in the delivery of services directly to clients (Brock, 2006; Powell, Brock, & Hinings, 1999).[84] Further, the work undertaken within Living Well was highly discretionary, based on the skill and knowledge of highly trained clinicians with the

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[83] See Appendix G for a copy of Living Well's organisational chart detailing the full spectrum of services delivered and their location within the organisation's structure.
[84] Chapter Two introduced the professional bureaucratic archetype.

prevalence of mental health disorders ensuring that the services provided were in high demand from the community.

Living Well's Archetype

Raison D'être
• Delivery of responsive mental health services

Interpretive scheme:

Community Care Values vs. Management Priorities

- Ethic of care
- Autonomy
- Clinical expertise

- Policy and strategy
- Risk management
- Accountability
- Efficiency

Internal Systems and Policies:
• Clinical directorates
• Management roles
• Peer review

Structure:
• Internal financial management
• Professional collaboration
• Medical hierarchy

Figure 3: Living Well's archetype

The structure of Living Well was divided into different functional units under the umbrella of one senior management team.[85] Like other professional bureaucracies, Living Well was a composite organisation encompassing both management and clinical values. The organisation had a hierarchical management structure with a parallel clinical leadership structure. A manager and clinical leader oversaw each functional unit and clinical directorates including the nursing directorate and allied health group, provided further professional leadership across the organisation.[86] Psychiatrists typically fulfilled clinical leadership roles and a Chief of Psychiatry position existed alongside the General Manager, providing Living Well with medical leadership. Services were delivered

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[85] Appendix G presents a copy of Living Well's organisational chart.
[86] The role of psychiatrists at Living Well is discussed further in Chapter Eight.

directly to clients by clinicians while management provided oversight for the operational concerns of the organisation.[87]

A key feature of the professional value system at Living Well, as well as its raison d'être was an ethic of care. Underpinned by professional values, an ethic of care includes a responsibility to act and respond to clients based on their needs and includes an investment from professionals to ensuring client welfare (Barnes & Brannelly, 2008; Woods, 2011). Woods (2011) describes an ethic of care within nursing as involving a moral commitment and social investment in caring for others irrespective of the circumstances in which the need for care arises. For mental health clinicians working at Living Well, an ethic of care translated into giving priority to the clinical concerns of clients irrespective of the operational, strategic and wider environmental concerns of the organisation.

Living Well's interpretive scheme consequently involved a complex system of values with clinicians prioritising the immediacy of clinical demands by utilising clinical expertise, autonomy and peer review[88] and management priorities reflecting daily operational priorities balanced alongside concerns about the external environment including the priority given to policy and strategy, risk management, accountability and cost efficiency.[89] The value systems were evident throughout all aspects of the research. Exploring and analysing the nature of Living Well's archetype including the values contributing to its interpretive scheme, the interplay with the formal structures and systems as well as their contribution to service development is a key focus of the discussion chapters that follow.

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[87] Clinical demand refers to the level of acuity of clients and the clinical interventions required to meet the needs of these people. Operational refers to the management and administrative responses required to deliver mental health services on a daily basis. For further explanation see the definitions provided in Chapter One.

[88] The role of professional values in service development and delivery is explored further in Chapter Five.

[89] Management concerns related to the operational demands of running Living Well are discussed in Chapter Five.

Conclusion

The purpose of this chapter has been to provide an analysis of the development of mental health services both internationally and within Aotearoa New Zealand. This has been undertaken through a discussion of the history of mental health service development including the critical process of deinstitutionalisation and the move to provide care in the community. The transition from an institutional archetype to a community care archetype has been explored alongside the changing role and function of community care and inpatient treatment. The gaps and conflicts evident across the development of mental health services have also been discussed including the underutilisation of evaluation and evidence-based practice to inform decision-making. Finally, the chapter concluded with an overview of the process of mental health service development in Aotearoa New Zealand, the current shape of the service delivery environment within this context and the nature of Living Well's archetype.

It was the intent of this chapter to develop a foundation of knowledge for the reader on the topic of mental health organisations to provide a context within which this research can be located. The chapter has highlighted the complex nature of service development which is shaped by changes in philosophy including the movement from institutional to community care as well as different ideological and political forces such as neo-liberalism and new public management. In Aotearoa New Zealand, mental health services have followed international trends in service development. The result of this fragmented approach has left a legacy of concern about the nature and quality of mental health services. This research aims to utilise archetype theory to explore service development in one organisation in order to contribute to the body of knowledge on the process of service development within statutory mental health services within Aotearoa New Zealand. A central concern of the research is to explore the nature of the interpretive scheme embedded in statutory mental health services today alongside the systems and processes that inform service development.

The chapters that follow report on the research findings related to the process of service development at Living Well. They draw on elements of archetype theory, as well as literature and policy to analyse how decisions related to service development within statutory mental health services occur.

Chapter Five: Running the Business

Introduction

The research questions that framed this study aimed to explore the process of service development within Living Well. This included examining how service development decisions were made; analysing the processes and barriers to service development; as well as assessing the role of formal planning mechanisms including strategy, policy, reviews and projects. This chapter examines what is required to run a mental health service on a daily basis. It begins by discussing the function of the business structure including how service alignment can create barriers to service development and delivery. It addresses the functions of risk and financial management in terms of shaping or constraining everyday service delivery as well as longer-term service development. This chapter also analyses the complexity of the interpretive scheme at Living Well, which struggled to balance the different and often competing priorities of clinicians providing services with managers overseeing the operation and management of resources. It concludes with a discussion of the priority given to the delivery of acute mental health care within the Acute Inpatient Unit.

Mental health organisations are complex organisations, constantly struggling to balance competing demands from both internal and external factors (Minas, 2005; O'Connor & Kotse, 2008). Archetype theory stresses the need to analyse an organisation's structures and processes alongside its interpretive scheme, which is a core focus of this research (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999). As discussed in the previous chapters mental health organisations have complex structures, which are in a state of perpetual service planning and development, dominated by short-term planning cycles and the need to exercise caution in terms of service development and risk management. Service development within Living Well is an example of convergent archetype change involving service adjustment within the current

organisational archetype. A major factor influencing the process of service development at Living Well was that clinicians and managers gave priority to the everyday demands of service delivering in accordance with their raison d'être of delivering responsive mental health services. The central concern of this chapter is to analyse the impact of the day-to-day operation of Living Well on service development, which begins with a discussion of the business structure.

The Business Structure

Living Well is a large organisation with a complex business structure. The formal[90] business structure of Living Well is hierarchical, encompassing different service areas each with their own clinical focus and priorities in terms of both service development and delivery. Living Well's service development processes were complicated and often contradictory, with services frequently identifying different priorities and directions for service development. Despite the hierarchical nature of Living Well's formal business structure, in reality it operated as a set of fragmented units with a diffuse power structure as staff's daily work and priorities rested within their individual unit. It consequently took a lot of effort on the part of management to have the whole organisation working together which most of the time did not occur. The purpose of this section is to provide an analysis of Living Well's business structure to assess whether this provided mechanisms, justification and barriers to service development. The section begins by exploring the functional elements of Living Well's business structure. This is followed by a discussion of the role and tensions embedded within the symbolic elements of the business structure as part of service development processes at Living Well.

Callaly and Minas (2005) state that in order for clinicians to be able to deliver effective clinical services to clients, they need, among other things, a well functioning business

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[90] Formal is used here to refer to the written business structure dictating the functional aspects of Living Well including the location of services, referral processes and lines of accountability.

structure. For this structure to work well and support clinical service delivery there also needs to be a process of ongoing reflection, evaluation and improvement so that it aligns with the organisation's raison d'être and the values of its interpretive scheme. The business structure of a mental health organisation provides for elements of both functional and symbolic significance (Callaly & Fletcher, 2005). The functional aspects of the business structure dictate the actual physical location of services, the creation of boundaries between services including who accepts which clients, referral processes, reporting lines as well as fulfilling accounting requirements. The symbolic aspects of the structure include elements of service belonging, loyalty and collegiality that link with vision and strategy and are embedded within the organisation's interpretive scheme (Callaly & Fletcher, 2005). This may reflect the groupings of different operational units under the titles of Community Services or Rehabilitation Services meaning that staff employed within these units, while not necessarily physically located together, identified and aligned with each other as a service area.

The Functional Aspects of Living Well's Business Structure

Across Aotearoa New Zealand the business structure of large statutory mental health services are complex and typically mirror the structure across the rest of the District Health Board. Living Well's organisational chart captured in Figure 4, p.125 conveys the scope and nature of the formal business structure.[91]

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[91] Changes were made to the business structure during the period of this research due to the implementation of the Clinical Governance Strategy, discussed in Chapter Nine.

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                        ┌─────────────┐
                        │  GENERAL    │
                        │  MANAGER    │
                        └─────────────┘
              ┌────────────────┴────────────────┐
       ┌─────────────┐                    ┌─────────────┐
       │  CHAIR OF   │                    │ OPERATIONS  │
       │  PSYCHIATRY │                    │  MANAGER    │
       └─────────────┘                    └─────────────┘
                        ┌──────────────────────────────┐
                        │ SENIOR MANAGEMENT TEAM: CLINICAL DIRECTORS,
                        │ SERVICE MANAGERS, DIRECTOR OF NURSING
                        └──────────────────────────────┘
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| ADULT INPATIENT SERVICE | ADULT COMMUNITY SERVICE | MAORI MENTAL HEALTH | FORENSIC SERVICES | INTELLECTUALLY DISABLED PERSONS HEALTH | REHABILITATION SERVICES | SPECIALTY AND ADDICTION SERVICES | CHILD, ADOLESCENT & FAMILY SERVICES | QUALITY ASSURANCE & BUSINESS UNIT |
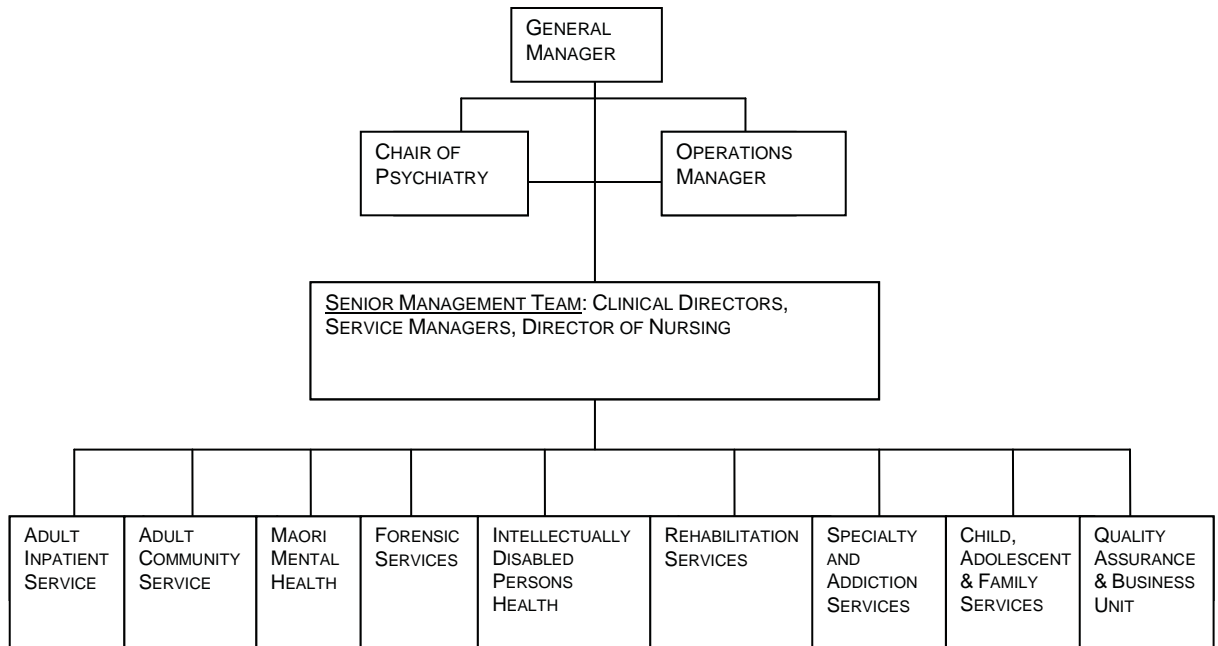
Figure 4: Living Well's 2006 Organisational Chart

In Weber's original typology of the bureaucratic organisation an organisation's structure gave meaning to the process of rational legal administration through a hierarchical authority structure, where employees were appointed and selected based on merit with clear lines of accountability (Beetham, 1987). At Living Well, the formal business structure, as depicted in Figure 4, was hierarchical; the various levels allowed for the coordination of the overall tasks of the organisation and provided for oversight and accountability of staff. At the commencement of this research, the Senior Management Team reported to the Chair of Psychiatry and Operations Manager, who in turn reported to the General Manager. Adding to the complexity of the reporting structure was the fact that the Chair of Psychiatry, Operations Manager and General Manager were also members of the Senior Management Team. The Senior Management Team then oversaw the operation of approximately ten different service areas broken down into general and speciality services across adult, child and youth services as well as other auxiliary business functions such as training, research and clinical support. Each of these service areas then contained numerous smaller operational units that were organised into clusters based on a number of different elements including: geography in the case of

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Adult Community Mental Health Services; service focus such as inpatient and outpatient; or length of treatment including short and long-term rehabilitation services. The size and scope of the service areas varied as did the business processes of each. Each of the smaller units had their own set of values, beliefs and ideologies about how work should be undertaken dependent on their service focus, client needs and staff composition. Carole spoke about the business configuration and the need to differentiate between service areas:

> *There is the Child and Adolescent service and there is the [adult] inpatient service and there is the [adult] outpatient service, you know each of those do have specialist components, you can't really realistically in a city this size have an adult and a child service merged together because those groups do have different needs.* (Carole, 3[92]).

Despite these differences between units, the analysis of documents, meetings and interviews established that there was a degree of coherence across the organisation in terms of the raison d'être of providing responsive mental health services. The convergence around the raison d'être could be seen in the priority allocated to this in meetings, the aims of reviews and projects[93] as well as in the tenor of participant interviews. Although each of the operational units and professional groups held different views with regard to how to achieve this raison d'être.

A number of operational units were realigned into different service areas during the course of this research and a number of projects over the years including the Best Use of Beds Project, the Community Integration Project, Resectorisation Project, the Clinical Pathways of Care Project and Understanding the Patient Journey had been focused on examining the relationship between services in order to address how services could

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[92] The number included after the participant's name refers to the interview sequence where the quote occurred.

[93] Appendix A provides detail related to each project and reviews' aims included in the document analysis for this study.

better work together to improve client flow through the system as well as breaking down service barriers.[94] Participants were asked to think about the function of the business structure of Living Well in particular the role of the configuration of services. Participants reported that changes to the formal business structure of Living Well over time may have altered referral pathways, internal reporting lines or intake criteria, but clients were unaware of the actual configurations of services and the impact this had or potentially could have on their care. Paul, as the Operations Manager of Living Well, spoke about the nature of the business functions of the organisation stating:

> *The business processes include: is this funded for? Is that enough FTE [full-time equivalent staffing positions]? Is the forecast in your budget for the next five years going to be appropriate? Is there going to be more FTE needed to continue the service? But if it makes any difference to [client] outcomes I don't think it does.* (Paul, 3).

His view was that there was very little relationship between business planning and client outcomes with business planning focused on operational tasks required to deliver mental health services on a daily basis including staffing; bed availability; maintenance concerns; risk minimisation and audit; information technology; human resource concerns; and budgetary requirements.

Geoff's belief was that despite the service configuration changing fairly frequently it was not perceptible to clients: *"I would be surprised if I went to [any client] and said what changes have you noticed whether there is much on the ground that he would have noticed"* (Geoff, 3). This was a view also shared by Evelyn who was frustrated at the continual process of senior management "*tinkering*" with the location of services and scope of management responsibilities:

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[94] Appendix A contains detail relating to these projects.

I don't know whether a lean business structure or a no meat on the bones business structure is going to look like for [clients] 10 years down the track? Whether that is going to filter through to them, but I don't think it does at this point in time. (Evelyn, 3).

Jacob agreed with both Geoff and Evelyn stating that clients were unaware that a business structure existed to organise services. These participants consequently felt that the business structure served an operational focus in order to simplify the process of managing services, rather than being aligned with clinical outcomes or the nature of clinical care.

The Symbolic Aspects of Living Well's Business Structure

The symbolic aspects of the business structure involve the invisible boundaries and relationships of staff within service areas associated with feelings of belonging, loyalty and collegiality as part of membership of different professional, operational and service groupings (Callaly & Fletcher, 2005). It reflects the values, beliefs and ideologies of staff and is part of the organisation's interpretive scheme. The symbolic business structure consequently plays an important role in service development. This section addresses the role of the symbolic aspects of the business structure in service development at Living Well including the barriers and lack of flexibility embedded within this structure.

The nature of the symbolic aspects of Living Well's business structure influenced organisational belonging with staff locating their belonging to their small, individual unit rather than the organisation as a whole. Hinings, Brown and Greenwood (1991) discuss that a lack of a centralised power structure within an organisation means that ideas can be filtered and reinterpreted many times over making the process of securing consistent support for an initiative and its implementation incredibly complicated as the organisation negotiates its way through the different professional value systems that dominate service provision. The symbolic aspects of the business structure at Living

Well placed parameters around staff's locus of care and focused their attention on their individual unit as the priority when delivering services.

The diffuse nature of power across an organisation's business structure can result in units being dislocated from the rest of the organisation and lacking overall organisational belonging as there is little communication and connection between the different components (Beetham, 1987; Kirkpatrick & Ackroyd, 2003a; Mouzelis, 1967). While staff gave priority to client care, their focus was mostly upon the clients in their own units. They did not typically pay attention to wider organisational issues unless there were direct impacts on their ability to deliver care. In this way relational boundaries reflected operational boundaries and this made it difficult to get cross unit initiatives established. An example of the difficulty involved in getting teams to work together was the Best Use of Beds project.[95] This project involved participation of staff from across Living Well with one goal of the project being to create better systems for working cooperatively across the organisation. An outcome of the project was the development of an interface model to improve communication and collaboration. Despite support and agreement from staff and management, individual units' concerns about the potential impact on their own clients, workload and resources meant that the interface model was not implemented.

As evident in the outcome of the Best Use of Beds Project, interview participants felt that the nature of the business structure at Living Well meant that often services worked in isolation created what they described as a "*silo mentality*", meaning that it was difficult to gain support for projects that focused on Living Well as a whole or on client flow through the service delivery continuum. Jacob commented on the conflict that arose as a result of the difficulty gaining agreement between services: "*we have got a huge number of specialist teams. Every time you set up a team you set up boundaries and boundaries mean there are going to be disputes – you know they don't belong to us, yes they do*" (Jacob, 3). Consequently, operational units were reluctant to engage in any service development that had the potential to alter the nature or scope of what they did.

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[95] Information related to the Best Use of Beds project is contained in Appendix A.

Carole gave an example from within her area of work where some referral processes were changed and the other teams ignored this:

> *We have just revised the policy about where clients go and that's been interesting. I don't think it was a project, but it … established these are the rules about where clients who are known to the service will re-enter the service…it's been a bit problematic because not all of the [teams] have stuck to the rules.* (Carole, 2).

Here the impact of organisational identity issues can be seen alongside the impact of the symbolic business structure. Carole's view was that Clinical Coordinators disregarded the change as it affected their ability to predict their intake, thereby threatening their autonomy, an important part of their professional value system.[96]

The nature of the symbolic business structure and the priority staff gave to their individual unit contributed to a lack of cooperation between units. A number of participants spoke about the difficulties presented by the perceived inflexibility of the business structure and staff's lack of willingness to work across service boundaries. Jacob felt that this unit or service focus manifested itself in a failure to communicate between areas noting: "*Why have two services that have so much in common miles apart, different staff and different resources and one refers [a client] to the other and basically all they get is a bit of paperwork from each other, not even a phone call*" (Jacob, 3). He believed simply sending a paper referral without a follow-up phone call reflected a general pattern towards a lack of communication across services. Jacob found this very frustrating and unnecessary given that all units operated as part of the one organisation and yet did not take the time to talk with each other.

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[96] The role of professional values in service development and delivery is explored further later in this chapter.

A lack of flexibility and failure to communicate across units made attempting to achieve consistency across services difficult and reflected the strength of the symbolic aspects of the business structure in creating alignment as well as barriers between services. The dislocation enabled areas of a large organisation such as Living Well to operate without concern for the organisation as a whole and created the potential to serve goals, that were in conflict with those of the wider organisation. Tom discussed the impact of the individual unit focus at Living Well as he spoke about the lack of outcomes from the Best Use of Beds project:

> *I wonder whether we took a too internal focus about that and people came along with their views of the world [reflecting the priorities of their individual unit]? Acute inpatient services … view of the world was we just want to empty our beds and make life better for us because we are terrible and no one understands us, [the inpatient rehabilitation service] were saying we don't want a lot of acute people sent over here, we want to help manage... and then we had forensics saying we are not a part of this... And [long-term inpatient rehabilitation services] just watched the world go by.* (Tom, 2).

Tom's quote demonstrates how each unit protected their 'patch' and focused on their individual priorities, which he felt undermined the capacity of organisation-wide projects such as the Best Use of Beds project to produce results.

Service alignment refers to the symbolic nature of the business structure where operational units were grouped together with 'similar' services. The impact of service alignment included feelings of belonging, loyalty and collegiality across services that were grouped together under a specific service title such as Adult Community or Rehabilitation Services. Evelyn felt that the service alignment created by the business structure also created barriers for clients moving between services:

The barriers from one service to the next basically impacts on the [client]. Because for example, our service provision says that for each service this is the criteria you have to fit for us, right? And so, where it doesn't benefit [clients] is where they don't fit in that gap, you know this service ends here and that service's criteria end there. (Evelyn, 3).

She believed services defending their boundaries had a detrimental impact on clients as units placed their own needs above those of clients and the organisation as a whole, influencing the flow of clients across the care continuum[97].

The symbolic aspects of the business structure became solidified in operational factors including resource constraints and high workload pressures. These elements made it more difficult for the different operational units to work together because of staff concern that clients from other units might be re-allocated to them, or that they might lose resources to other units, both of which would intensify the pressure on workloads. The ability of clinical staff to have autonomy and exercise discretion in the nature of the work they undertook was an important part of the clinical value system that impacted on services attempting to work together. Carole had witnessed units fighting to protect service boundaries and their own discrete area of work by refusing to accept clients who did not exactly meet their intake criteria or who would place additional resource demands on their unit due to the complexity of the individual client's needs: *"I just feel that some of that silo thinking prevents a client from accessing the best care that they should be entitled to because through no fault of their own they are rendered ineligible for that specialist treatment"* (Carole, 1). Gaps were consequently created between services across Living Well. An example of this was that at times units placed their area's needs before the needs of certain high and complex need clients. Refusing to accept these clients because of the potential for additional resource or workload burdens on their unit, meaning that these clients either were ineligible for care or did not receive

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[97] Care continuum refers to the movement of clients between units from outpatient services, to acute inpatient care, to rehabilitation services and then back into the community.

the quality of care they required. The needs of these clients created the impetus for the Best Use of Beds Project; the Community Integration Project, Resectorisation Project and the Clinical Pathways of Care Project.[98] These projects examined service boundaries and involved developing mechanisms such as referral processes to ensure units could work together in the best interests of clients. They all involved the establishment of working groups, comprehensive consultation with staff and clients as well as the piloting of new transfer processes. Yet over time participants reported there were few outcomes or changes implemented as a result of these projects and barriers between services continued to persist perpetuating the individual unit focus of the symbolic business structure.

Geoff reflected that the 'silo' attitude across units also had the potential to sabotage new service development initiatives as units protected their own service area at the expense of others:

> *An area will see something gaining direction, a particular idea gaining direction, and they will see that that doesn't suit where they are at and they'll subvert it or they'll slow it down. Or if you get a couple of people that'll combine and just shoot the idea down and in fact what is the best direction won't be achieved because a couple of smaller services are enough to sink it.* (Geoff, 1).

Paul explained that this was a standard approach to decision-making at the Senior Management Team[99] meeting and described this process:

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[98] Information about all of these projects, except the Community Integration Project, can be found in Appendix A. The Community Integration Project occurred outside the timeframe for document analysis as part of primary data collection, but was included as part of secondary data for this study.
[99] Membership of the Senior Management Team at Living Well included the Service Managers, Clinical Directors from across the service, plus senior clinical representatives from the main professional groups, as well as the Operations Manager and the General Manager. The role and function of the Senior Management Team is discussed in greater depth in Chapter Six.

Say we want to change [my unit] around. Quite often people at [the Senior Management Meeting] haven't thoroughly been involved in the project so we usually put it to the vote. So if that silo wants to do that, and it doesn't seem to affect my silo, then I'll say yeah right-e-o. But if it does affect my silo I might say no, no, no, you can't do that. (Paul, 2).

Tom, like other participants, felt that the both the symbolic and functional aspects of the business structure acted together to contribute to the creation of boundaries between services. In Tom's view this meant that services, which essentially performed similar functions operated differently and delivered different programmes because of their views about where they were located within the functional business structure. He cited examples of similar community services located in different parts of Living Well's business structure one within Adult Community and the other within the Rehabilitation Service:

I think about the quality, the nature of how our community mental health teams work because they are under a certain business structure versus ... an equivalent team that is located in another service area and hasn't got the acute end of it. I believe they probably behave completely differently about how they manage the people with enduring mental illness. (Tom, 3).

As the General Manager, Tom had different views about managing the business structure than the other participants. He considered that the functional business structure of the organisation provided certainty for staff around tasks, roles and responsibilities. Tom believed that service alignment was not about the business structure, but rather about breaking down barriers to create pathways for clients that did not take into account the service boundaries:

I spend a large amount of my time angsting over have you got the right configuration. Have we done this just purely as a business model of just purely slicing up the services, or have we got the best service alignments so we are ... forever dropping one service configuration and dropping it into another because it is about service alignment rather than anything else. That I think is particularly important as that's where boundaries get created because you have got service people regardless of how integrated you want to be, people still subscribe to the business model they'll still behave in terms of the business model because our system is still very hierarchical. (Tom, 3).

Tom's view was that due to elements of symbolic service alignment staff saw the business structure and the way services were delivered as being the same thing. Staff therefore resisted attempts to change the business structure because of the impact on themselves personally, on the workload for their unit and their need to protect their professional autonomy. These were valid concerns for staff and the way out of the impasse that this created was, in Tom's opinion, to focus on services working together.

Jacob, Geoff and Paul suggested that an alternative approach to addressing fragmentation across the organisation was to regard each service separately as per the symbolic structure and implement the functional business structures based on each service's need. Jacob provided the strict adherence to the age criteria placed on Youth Services and Adult Community as an example to illustrate this scenario. He felt that it was in clients' interests to have more flexible boundaries with overlaps in service admission criteria and gave an example from Melbourne to support this suggestion:

They are in the same building and actually have an overlap in age so that each group: Youth Specialty and First Episode Psychosis Services in Melbourne, will overlap in the ages that they take so you have got a much more flexible system. Where if

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> *Youth Specialty thinks somebody should stay in their service until 19, they'll keep them there. Here they are booted out at 18 years and one day. And the Melbourne First Episode Psychosis Service starts seeing people at 15 and they are in the same building so they, I think that is a much more sensible approach which again deals with this boundary I was talking about before.* (Jacob, 3).

Jacob believed that in this instance the Melbourne mental health service had got it right by overlapping the age criteria. However, at Living Well the inflexibility created by the symbolic business structure exemplified in staff's lack of willingness to work across service boundaries made implementing this type of initiative difficult.

This section has argued that the business structure at Living Well created internal boundaries and service alignment, which while serving functional and symbolic purposes for staff, was essentially invisible to clients. The business structure did affect the flow of clients across the care continuum as each service preserved the integrity of their area by rejecting or accepting clients based on the perceived resource and workload impacts. Services were therefore constrained by their locus of care, defined by their location in the business structure as well as a desire to maintain the 'integrity' of their area. Project attempts[100] to improve cooperation and communication between units had been unsuccessful as staff did not fully engage with wider organisational issues unless they had a direct impact on their ability to provide care within their unit.

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[100] Including the Best Use of Beds Project, Improving the Patient Journey, Resectorisation, the Clinical Pathways of Care Project and the Inpatient and Community Integration projects. Appendix A provides detail relating to these projects.

Management Priorities of Risk Management, Accountability, and Efficiency

To guarantee Living Well was able to continue to receive funding and deliver services on an ongoing basis, management needed to ensure that the organisation was able to meet audit and accountability standards as well as manage their financial resources effectively. Alongside addressing operational concerns such as staffing and bed availability there was also a need for continuous service improvement and the consideration of quality initiatives, which generated ideas and proposals for service development. The purpose of this section is to outline how the management of risk, accreditation and financial controls to improve efficiency influenced service development. In particular it explains the additional demands placed on staff to implement new initiatives and the need to prioritise the findings of sentinel events so that Living Well remained responsive to what was required to deliver safe mental health services.

The nature of political and accountability factors were influential in the process of service development and important priorities for management at Living Well. [101] Paul explained the tasks of management at Living Well: "*mostly business processes include accountability, data collection, rationalising what you need to do and making sure that you get the right information to the Ministry [of Health] to ensure that they think you are doing a good job*" (Paul, 3). Jacob, a senior clinician at Living Well, discussed management priorities in relation to the changing nature of the service delivery environment that required the organisation to continually adapt and adjust in order to remain current in terms of policy and funding frameworks: "*there is a wider process going on of …development and it is something that will never stop, it is a continuous process and every area, every division has to keep looking at it all the time in response to what is changing around them*" (Jacob, 1). Jacob's view was that being cognisant of

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[101] The role of political factors in influencing policy and strategy is discussed in greater depth in Chapter Six.

these external factors contributed to Living Well remaining responsive to the changing needs of the community, but created uncertainty in terms of planning services. It was the role of management at Living Well to attempt to coordinate these external factors, to ensure that services were delivered within budget constraints and fulfilled the necessary audit requirements.

Chapter Two outlined the changing nature of the professional bureaucracy and noted that, following a series of crises in the 1980s and growing dissatisfaction with the inefficiencies of the public sector, governments across the western world required tighter controls over professional autonomy and new regulations were brought in to ensure efficiency and accountability across the health sector (Butler & Drakeford, 2001; Kitchener, 1999; Olsen, 2008). Clinical guidelines were tightened, new audit and accountability criteria introduced and managers given more responsibility to oversee the costs as well as the quality of service provision (Olsen, 2008). Jacob spoke about the implications of this for service delivery:

> *I think probably there's a degree that people are more risk averse than they once were and the attitude of the public towards professions has changed so doctors are not held in the high esteem that they used to be and I'm not sure that is a bad thing at all. And so it is a different environment altogether from 20 years ago.* (Jacob, 1).

Jacob saw the need to respond to risk as part of the changing service delivery environment as well as public expectations about the quality of clinical care.

Responding to risk including serious or sentinel events were key triggers for service development at Living Well as change was required to meet statutory requirements and coronial recommendations. At Living Well services immediately responded to coronial findings, media pressure or Ministry of Health requirements, following a critical or

sentinel incident/event as well as the perceived risk of such an incident occurring as Matt noted:

> *I would like to think that not all change is generated in terms of a response to something that has gone wrong. But there is no doubt that some projects do arise in terms of we didn't do too well in this, so how can we do it better.* (Matt, 1).

Despite being formal service development activities, serious or sentinel events were unpredictable and could not be planned for, only occurring following a perceived failure in client care. Serious or sentinel events typically involved the input of external bodies such as the Coroner, the District Inspector for Mental Health, the Director or Deputy Director of Mental Health, as well as clinicians, clients and their families/whanau. Evelyn spoke about the priority clinicians gave to service changes resulting from sentinel events:

> *One big way is if something has gone wrong and then you know it goes upwards and then comes back down with recommendations, so that brings about change. This is quite a powerful way of bringing about change because you have got some good examples and because people don't want to do things wrong you know and so they respond to that quite well.* (Evelyn, 1).

This type of event has a high public profile and mental health services are required to make changes to ensure that all reasonable steps are taken so that such events do not occur again. Living Well had assigned priority to responding to sentinel events and systems had been put in place which facilitated a swift response and analysis of the situation as Jacob explained:

> *Certainly with adverse events we have got quite a robust system now where we have clear policies and procedures. In fact, that was really just finalised a few months ago with the sentinel event review policy and so there have been lots of improvement in how we deal with those I think, how we look for systemic issue, problems go back to the units and say "look, what about this, this and this?". So we look for what can be learned about adverse events and are there any continuing risks, those two things.* (Jacob, 1).

Chapters Six and Seven discuss that formal service development and the implementation of strategic plans take time, cost money and occur within the context of ongoing service delivery. Clinicians felt that accreditation, audit, long-term strategy and national policy implementation intruded into their clinical time with clients as commented on by Paul: "*What my unit struggle with is meeting the demands of [Living Well] to get their accreditation while they are trying to do clinical care*" (Paul, 1). The consequence of this was that it had become difficult to engage clinicians in audit and accreditation processes as they saw it as taking them away from clinical service delivery, Carole explained:

> *We are also in a very risk averse environment, which on the one hand is entirely understandable, but on the other actually consumes a significant chunk of a clinicians' time to make sure that every body's back's covered really. And that can perhaps take more focus away from client time so we are more concerned about covering our arses than we are about sitting down with the family.* (Carole, 1).

As reflected in Carole's quote, clinicians felt that another factor influencing service development was that Living Well had become a fiscally and risk management driven service which halted initiative in service delivery. This reflected international and

historical patterns of service development within mental health services (Bachrach, 1996; Braden Johnson, 1990; Butler, 1993; Falloon & Fadden, 1993; Thornicroft & Knudsen, 1996). Jacob discussed that pressures created by prudent financial management limited his ability to plan and address needs within in his area: *"we have to consider that all our service development has to occur within the current budget at the moment, so I might have ideas for rebuilding this unit or that unit, but I've got to be realistic"* (Jacob, 1). Carole reflected a similar sentiment in terms of the financial constraints of the organisation, she felt this undermined attempts to be client centred in terms of service planning:

> *I suspect a lot of it is budget driven. I think that huge amounts of the decisions must be because they have got to meet this budget cut or that budget cut or whatever so, it's unfortunate that I think we are in a world where often the financiers are ruling the decision making process really. And possibly that's not leading to better services for clients really.* (Carole, 1).

Geoff concurred stating that while managing risk and accreditation did fulfil an administrative purpose it did not always lead to improved services or improved outcomes for clients: "*I mean if you do this, this and this you will get all of those boxes ticked, it doesn't actually mean you will provide a better service*" (Geoff, 1). Eliza gave an example illustrating the way in which the Senior Management Team responded to issues of gender safety in the intensive care ward of the Acute Inpatient Service. Eliza, as Consumer Advisor to the Acute Inpatient Service, had been involved in setting up a group looking at gender safety issues involving staff and clients from the units for a period of about a year. It had highlighted issues of concern and proposed mechanisms for addressing these but there had been no action from the Senior Management Team to ensure the mechanisms were put in place. Yet following a recent incident:

> *There has just been an edict passed that [the intensive care ward] is going to be male and female, gender specific and I*

think that is good, however I think the decision has been made
in haste and the planning hasn't gone into it. You know it was
decided on in early January that it would be gender specific by
the end of January. (Eliza, 1).

Eliza's concern was that an operational response was decided very quickly by members of the Senior Management Team to resolve the presenting problem. She felt the decision-making process lacked full consideration of the implications of the changes for staff and client care across the rest of the unit as well as the work that had already been undertaken exploring solutions to gender safety problems.

The views of Eliza, Jacob, Carole and Geoff all convey the frustration experienced by clinicians of risk and resource constraints imposed by management on behalf of the organisation to ensure its ongoing viability. The findings of this study support previous research on the relationship between management and clinicians with the increased workload resulting from service development contributing to a culture of resistance towards management driven service development (Denis et al., 1999; Kirkpatrick & Ackroyd, 2003; Mueller, Harvey, & Howorth, 2003).[102]

Living Well responded quickly to both internal and external political factors related to risk management and accountability, including the findings from sentinel reviews, audit and accreditation. It has been noted elsewhere that professionals reluctantly accepted this type of change as necessary to ensure the organisation's long-term viability and to show compliance with regulatory and audit requirements (Mueller, Harvey, & Howorth, 2003; Powell, Brock, & Hinings, 1999). Clinicians make allowances for this type of "*technical necessity*" to ensure their ongoing survival even when it does not align with their value systems (Powell, Brock, & Hinings, 1999, p.13). This concurred with the experience of those working at Living Well, who while they resented these reluctant incursions on their clinical time, did not question the validity of responding to sentinel

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[102] Clinical resistance towards management imposed service development is discussed further in Chapter Eight.

events, the requirements of ongoing audit and review, or the need to continually change or develop. They just accepted that it was part of what needed to happen and considered it normal within this environment. Archetype theorists posit that over time the changes implemented as part of these reluctant incursions become part of the organisation's interpretive scheme influencing the values, beliefs and ideologies of the different professional groups and creating opportunities for further archetype transformation (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999).

The purpose of this section has been to explain how the management priority given to elements of risk and accountability such as responding to sentinel events alongside efficiency controls reinforced management practices with regard to focusing on operational issues and factors related to clinical demand. Clinicians made changes that were in the interest of their clients even when this placed an additional burden on them. The lack of access to additional finances to develop services created an imposition for staff as they had to take on additional tasks on top of already busy workloads without recompense, which reinforced clinical suspicion towards management driven service development. Unfortunately, additional tasks on top of already overstretched workloads ate away at clinical goodwill and meant that clinicians were less willing to participate and embrace other planned service development activities.

Clinical Values: An Ethic of Care, Clinical Expertise, Autonomy and Peer Review

Living Well was staffed by clinicians from a variety of professional backgrounds including psychiatrists, nurses, and allied health professionals[103] who made up the majority of the workforce. Each of these professional groups approached the treatment and care of clients with a mental illness from a different perspective, using different

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[103] Allied health professionals include social workers, occupational therapists, psychologists, physiotherapists, speech language therapists, pharmacists and dieticians; typically, a registered health professional that requires a tertiary qualification to practice.

approaches informed by their tertiary education base, professional value system and practice experience. It is beyond the scope of this research to describe in detail each of the different professional perspectives informing the delivery of care and treatment to clients at Living Well. The intent of this section is to outline the overarching values of the professional groups as they relate to the provision and development of services at Living Well highlighting the priority given to the immediacy of clinical demands governed by an ethic of care, the importance of clinical autonomy, expertise and peer review.

While each professional group at Living Well had its own set of professional values, they came together to deliver services as multidisciplinary teams. Cliff spoke about the value of working with others in multidisciplinary teams as he discussed his role and the need to engage with others:

> *We strategise to support things, we bounce ideas of each other. It is an opportunity for people, it's about planning a day; what we are going to do, and how many people we are going to have and how we are going to manage those people, what resources we need, what assistance we may need or may not need.* (Cliff, 1).

As Cliff reflected, the multidisciplinary dialogue determined the nature and scope of clinical services delivered to clients and informed the interpretive scheme for service development and delivery at Living Well.

As noted in Chapter Four, an ethic of care was a key element of the interpretive scheme of Living Well. Underpinned by professional values, an ethic of care includes a responsibility to act and respond to clients based on their needs and includes an commitment to ensuring client welfare (Barnes & Brannelly, 2008; Woods, 2011). An ethic of care was reflected in Carole's vision for a mental health service that was be underpinned by:

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A shared philosophy of client centred care. Client including not just the individual that is receiving the service but also their significant supports whether that is family or community housing or whatever so that we are all working together to optimise their best health outcomes. (Carole, 1).

Carole's view emphasised that the priority for professionals, across all service areas and professional groupings, was about the universal delivery of quality mental health services to clients. Participant interviews reflected this raison d'être through the tenor of conversations, the focus on client need and priority given to clinical care. Additionally, the goals of formal reviews and projects such as Improving the Patient Journey and the Knowing the People Planning Projects reflected this ethic as they focused on improving accessibility and the quality of services.[104]

Clinicians' value systems informed the overall interpretive scheme at Living Well. The process of registration and membership of professional bodies underpinned the different professional philosophies of clinicians at Living Well providing ethical guidelines, processes for peer review, ongoing professional development and was a contributing factor to their value system. Formal professional registration is required for most occupations working in statutory health services by either their profession such as psychiatrists, or under the Health Professionals Competency Assurance Act 2003. Other groups such as social work have voluntary registration, but at Living Well registration was a requirement of employment in these roles. Clinicians' professional values and the priority given to peer review informed all aspects of their practice. Jacob discussed his area of responsibility stating that the core question of service delivery should be about: *"how do we configure those[services] to provide a more humane service, that can enhance the flow of people so that people can leave hospital when they are ready to leave and not when someone is ready to take them?"* (Jacob, 2). Jacob's view conveys the priority for clinicians in terms of service development, which was focused on using

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[104] Appendix A contains details related to these projects.

their clinical expertise to develop and provide mental health services to those clients under their care.

Professional autonomy was another important component of the value system of clinicians at Living Well. The nature of the work undertaken within professional service organisations like Living Well is highly discretionary and rests on the expertise and abilities of clinicians (Brock, 2006; Powell, Brock, & Hinings, 1999; Mintzberg, 1979). Historically, professionals regulated themselves through peer review and had autonomy and discretion over the nature and scope of their work rather than on regulatory mechanisms and hierarchical authority pathways (Olsen, 2008). Consequently, clinicians viewed service development initiatives as structural changes that did little to alter their delivery of professional services (Hinings, Brown, & Greenwood, 1991). The discretionary nature of professional practice meant that the nature of clinical engagement was a defence against managerial intrusion (Mueller, Harvey, & Howorth, 2003). Clinicians protected their autonomy and saw membership of their professional organisation as part of this (Olsen, 2008). Peer review processes were an integrated part of Living Well formal systems through Clinical Directorates, the provision of clinical supervision and clinical review meetings.

Archetype theorists highlight the importance of professional autonomy stating that members of organisations only follow rules and adapt to administrative or managerial demands when it is in their interest to do so (Denis et al., 1999; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). Any changes that threaten to undermine professional autonomy are challenged and likely to fail, even if dictated by an altered organisational context as powerful groups resist attempts to change (Denis et al., 1999; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). An example of this at Living Well was a proposal aimed at reviewing the role of Clinical Directors across the service. The purpose of the review was to facilitate consistency in the way the role operated and create alignment across services. The Clinical Directors viewed the proposal as being a direct attack on their autonomy and authority. Meetings were set up by management to try and appease this professional group as Tom, the General Manager

acknowledged: *"they are absolutely critical to any success in service development and the health system so what you've actually got to get alongside them and their representatives as early as possible"* (Tom, 3). Despite the attempts at engagement, the feedback to the proposal from clinicians, especially psychiatrists, signalled their contempt for the project and therefore the proposal did not proceed.

Archetype theory argues that successful service development requires alignment between the proposed initiative and the interpretive scheme of the organisation or that it at least does not pose a significant threat to it (Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999; Denis et al., 1999). Without support from clinicians a service development proposal is unlikely to be successful (Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999; Denis et al., 1999). On the other hand, when professionals understand the reasons for change, see value in its implementation and it aligns with their professional values of clinical expertise, autonomy and peer review, then, it is likely that it will proceed (Denis et al., 1999). The interpretive scheme of Living Well involved a complex web of value systems representing the values, beliefs and ideologies of clinicians; the different service areas across the organisation; management; clients; families/whanau; and Maori. Within this scheme, there were inconsistencies, contradictions, and conflict between the different value systems contributing to a slow pace of service development across the organisation and a resulting focus on operational or clinical demand. The focus on operational or clinical demand is legitimised if it meets clients' needs, however the findings of this research emphasise that the consistent focus on short-term priorities created gaps and fragmentation in service planning and development.

In summary, at Living Well an ethic of care dominated all aspects of service delivery and was an important part of the organisation's interpretive scheme. The interpretive scheme at Living Well consisted of multiple value systems with clinicians forming the most significant stakeholder group. Clinicians' value systems placed priority on delivering quality mental health care with the overall goal being to improve mental health outcomes for clients. Maintaining clinical autonomy was also an important part of

the clinical voice and any service development that threatened to undermine the discretionary nature of clinical work was unlikely to be successful. Threats made to clinical autonomy over time had contributed to clinicians being suspicious of the motives behind management driven service development. The value systems of clinicians at Living Well focused on service delivery, consequently the goals that underpinned clinical participation in service development were about improving client outcomes based on clinical expertise rather than on management demands.

The Tension between Management Priorities and Clinical Values

Managers at Living Well, while having responsibility for financial, audit and business control mechanisms, had discretion in terms of determining the alignment of services and their location within the business structure. The purpose of this chapter is to explore what is required in running a mental health service on a daily basis. This section begins by discussing the backgrounds of those in management roles and structures at Living Well highlighting the priority of clinical values as part of this. It further addresses the ongoing tension and sometimes competing priorities of the business focus of managers who oversee the operation and manage the resources with clinicians delivering services, providing examples as to how the conflict diverted attention and delayed planned service development processes.

At the time of this research, all of the managers within Living Well were former clinicians, typically ex-psychiatric nurses, who had risen through the roles of clinician, Clinical Coordinator to Unit Manager and then Service Manager. Olsen (2008) explains that managers in professional bureaucracies are influenced by their past professional experience, which provides guidance in terms of ethical behaviour, and priorities for service delivery. The General Manager and Operational Manager at Living Well were ex-psychiatric nurses who began their professional careers with the organisation and had well in excess of 20 years experience working in both clinical and managerial roles.

Alongside the management hierarchy was a clinical leadership structure made up of Clinical Directors, with a Chair of Clinical Directors appointed to oversee the leadership of this group sitting alongside the General Manager and Operations Manager. Each service area had a Clinical Director and across the entire organisation these positions were primarily occupied by psychiatrists with only one non-psychiatrist, a nurse, occupying the role.

Within professional bureaucracies like Living Well, management has historically served a simply administrative function in support of the work undertaken by clinicians rather than determining the nature of services and assessing the quality of service delivery (Kitchener, 1999; Powell, Brock, & Hinings, 1999). The philosophies and values underpinning the management of health services, including mental health, since the 1980s have been influenced by neo-liberalism and new public management and are premised on individualism, accountability and efficiency. In Aotearoa New Zealand, the move to introduce private sector managers and management techniques in the public hospital system was a contentious move, but a new impetus to ensure greater accountability and regulation has endured (Aldridge, 1996; Boston, Martin, Pallot, & Walsh, 1996; Cheyne, O'Brien, & Belgrave, 2008; Gauld, 2001; Kelsey, 1997). These 'new' management values conflict with the professional values of discretion, autonomy and peer review that have historically dominated health care provision under the umbrella of the professional bureaucracy (Barnes & Brannelly, 2008; Tronto, 2010; Koggel & Orme, 2010; Woods, 2011). As a consequence, those working within 'helping roles' have felt that their contribution, autonomy and discretion has been questioned and undermined by the new managerialism promoted by new public management (Woods, 2011). Paul reflected on the struggles he faced as a manager running a mental health service in the current political environment, which demanded greater accountability and efficiency:

> *Recruitment, financial responsibility and basically the constant inquiries and meeting media demands and sentinel event reviews inhibit planning because you are so busy doing the*

operational side of it and really answering the queries and dealing with the financial issues that, basically; the strategic development stuff goes on the back burner. (Paul, 1).

The focus on accountability and audit according to Paul had resulted in an operational and risk management focus to the tasks of delivering mental health services rather than strategic planning which he struggled with as a past clinician.

The dominance of clinical or professional values at a management level meant that the formal management structure at Living Well was preoccupied by ongoing tension between the two competing value systems of clinicians with their focus on clinical care framed by the values of professional discretion, autonomy and peer review with management's need to fulfil regulatory and audit requirements. The lack of consistency and cohesion between the two systems resulted in what Denis et al.(1999) termed "custodial" or "diluted" management where the focus within the organisation became on addressing operational issues and tinkering with minor service development rather than on addressing long-term service planning issues. Callaly and Minus (2005) suggest that an operational approach to service development is characterised by an over reliance on aspects of productivity, structural arrangements, financial restraints, human resource demands and other risk and accountability demands. The focus on implementing the daily operational tasks of running the business was a result of the clash between the value systems of professionals and managers with professionals resenting the intrusion of management into areas that were historically the sole responsibility of clinicians. The culmination of this was that management at Living Well struggled to maintain a purely management approach to delivering and planning services rather deferring to the values that underpinned their clinical backgrounds. This tension between management and professional values played out in various settings at Living Well evident in the analysis undertaken as part of this study including in the content, processes and dynamics of meetings, the inability to maintain a focus on strategic goals and projects in the long-term. It was also present in a preoccupation with dealing with immediate issues related to clinical care such as staffing and over occupancy.

Participants reported that attendance at meetings across Living Well varied[105] and different priorities and agendas came into conflict making consensus about service development very difficult and time consuming to achieve. Interview participants cited that a meeting that some people viewed as being a place for decision-making was viewed as a discussion forum by others. Conflicting interests were particularly evident in meetings where psychiatrists and managers attended, with the goals of these two groups often being markedly different causing projects to stall and as a result many meetings failed to reach any concrete solutions. A key example of this was the functioning of the Senior Management Team[106] meeting as Paul commented:

> *Normally [issues] are just like a ball tossed around and some, especially the medical fraternity in [the Senior Management Team], they like to just sort of discuss things whereas service managers tend to want an outcome... And they just sit there quietly and wait until the discussion is over and then say what are we doing? And that's a problem. The doctors [psychiatrists] say it will probably need more discussion. We get into that bad cycle of over discussing. And then we are into a cycle whereby somebody comes in and says well I wasn't at your strategic meeting but I think we should do this as well, so do you want to bring it up at the next strategic meeting? (Paul, 2).*

Paul's quote illustrates the different goals and interests of managers and clinicians, highlighting the frustration experienced by all parties and the subsequent delay to service planning and decision-making that occurred as a result.

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[105] Reasons for varied meeting attendance included each meetings perceived priority or value and other demands on staff time including the priority given to clinical service delivery.

[106] The Senior Management Team at Living Well was made up of Service Managers, Clinical Directors from across the service, plus senior clinical representation from the main professional groups, as well as the Operations Manager and the General Manager.

The conflicting values, beliefs and ideologies across Living Well and the priority given to professional values across the organisation made the service development decision making process very complicated, a view commented on by Jacob:

> *I think all my colleagues and I struggle with our own areas' difficulties and have to listen to other areas' difficulties and it is about people; well it is a very long process getting people to agree to major changes and whether it is more difficult in mental health than other areas I don't know. But it is about how we operate as humans and our own sort of strengths and weaknesses and the biases we have got towards our own areas, how we view our work differently.* (Jacob, 1).

Jacob's view was that attempts to come to compromised solutions were negotiated in what was often very time consuming and protracted processes. Geoff described the relationships between professional groups across units as being like "*interdisciplinary turf wars*" reflecting the influence of the symbolic structure of the organisation. In this situation, operational and risk factors driven by personal interests could easily dominate this process.[107]

Mueller, Harvey and Howorth (2003) researched archetype change in Hospital Trust Boards in the United Kingdom. They found that in situations where managers and clinicians consistently failed to reach agreement on matters of strategy and service development management often adopted a pragmatic response by focusing on immediate and short-term problem resolution to minimise conflict and provide a basis for some level of decision-making (Mueller, Harvey, & Howorth, 2003). Similar to the findings of Mueller, Harvey and Howorth's (2003), the Senior Management Team meeting at Living Well had become very focused on problem solving related to the ongoing operation of Living Well, including issues that could be agreed on quickly

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[107] The role of individuals in co-opting the service development process is further discussed in Chapter Eight.

rather than addressing long-term service planning and development which required further discussion to reach agreement. The make-up of the Senior Management Team exemplified the tension between professional values informing the nature and quality of the clinical focus of the organisation with a strict business approach emphasising administrative and managerial controls. The Operations Manager designed the format and structure of the meeting and the nature of the agenda lent itself towards finding solutions for issues quickly. By controlling the amount of discussion at meetings a tight rein was kept on behaviour and discussion was focused on the areas that the Operations Manager felt were a priority. Participants in this meeting were required to raise their hands prior to speaking and the Operations Manager terminated discussion when she found it irrelevant.[108] The agenda was divided by type either for decision, for discussion or for information and time was allocated for each. Items were prioritised based on their relevance to the daily operation of the service. Briefing forms were completed for each item and circulated prior to the meeting. The minute analysis reflected that while the structure of the meeting aimed to direct the nature of the items towards resolution through decision-making this did not actually occur. The most frequent actions noted as emerging from this meeting included that information would be circulated to service areas and senior clinicians for feedback or alternately the item was to be deferred to a future meeting for discussion, both essentially fulfilling the same function of avoiding making decisions. During one of the meetings attended as part of this research, a long discussion occurred about staff recruitment, an operational issue. This allowed all participants to voice opinions but the Operations Manager very tightly controlled the conclusions and actions drawn from this towards the development of a plan for providing staff cover and filling current vacancies.

The need to continually seek further feedback and have more discussion around matters raised at the meetings highlighted the difficulty of achieving consensus across the roles and different perspectives represented at this forum. It also reflected the dominance of professional values around democratic processes and consensus decision-making as well

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[108] This convention had been adopted over time to prevent members talking over each other, which according to the participants had limited effective participation in the meeting.

as the need for collegial processes as part of the service development process. The main decisions made at the meeting were related to pragmatic operational concerns such as staffing, occupancy, Christmas cards and medication error reports rather than long-term planning reflecting Mueller, Harvey and Howorth's (2003) finding that pragmatic change becomes a way around all the difficulties related to implementing strategic change.

The purpose of this section has been to provide an analysis of the tension that existed between the priorities of managers and the value systems of the different professional groups. This tension dominated the service development process at Living Well as well as underpinning the interpretive scheme of the organisation. Ongoing debate and discussion between clinicians and managers dominated service development processes in meetings as well as across all formal service development activities including projects and reviews. The tension between clinicians' and managements' values evident at Living Well and the priority given to operational and clinical demand resulted in a focus on what was required to deliver services by adopting a more pragmatic approach to service development and focusing on operational tasks that supported clinical activity. Nowhere was this more evident that in the ongoing operation of the Acute Inpatient Service.

Acute Demand

The management of the Acute Inpatient Service is an example of an area at Living Well dominated by concerns with regard to clinical demand and the operational requirements of the unit. It provides an exemplar with regard to the complexity of running the business on a daily basis and the consequent difficulty of prioritising service development within this environment. Issues of over occupancy, high levels of acuity, staffing demands such as shortages and burnout, inadequacy of the physical environment are common across acute mental health settings and were key features of Living Well's Acute Inpatient Service (Butler, 1990; Morrisey, Goldman, & Klerman,

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1985; National Institute for Mental Health, 2002; Shepherd et al., 1997; Thomas, 1996). This section uses the Acute Inpatient Service at Living Well to highlight the problems of planning and implementing service development in an environment dominated by issues associated with high clinical demand and the acuity of clients. The Acute Inpatient Service at Living Well had dedicated significant staffing and financial resources to understanding the nature of service delivery problems and instigated numerous projects in order to develop services to address these issues. The nature of mental illness and the continuing demand for services meant that problems related to service delivery took priority as the service struggled to provide responsive mental health services on a daily basis.

Chapter Four addressed the function of acute inpatient care as part of the discussion on the changing trends in mental health care. Clinical care within an acute inpatient mental health unit is reactive responding to the needs of clients as they present (Hopkins, Loeb, & Fick, 2009; Horsfall, Cleary, & Hunt, 2010; Mullen, 2009). Client stays in the unit focus on assessing and treating mental illness where clients are typically very unwell and have a myriad of complex factors impacting on their ability to be discharged (Hopkins, Loeb, & Fick, 2009; Horsfall, Cleary, & Hunt, 2010). The nature of the acute inpatient mental health ward is that presenting issues must be addressed as they emerge and in their daily work clinicians are focused on client needs rather than concerned about long-term planning and strategy (Goldstein & Horgan, 1988; Horsfall, Cleary, & Hunt, 2010; Hopkins, Loeb, & Fick, 2009; Mullen, 2009; Lamb & Bachrach, 2001; National Institute for Mental Health, 2002; Shepherd et al., 1997; Thomas, 1996). The approach to service development in the Acute Inpatient Service at Living Well reflected an immediate and demand driven focus. It emphasised working pragmatically by responding to operational demands and placed less concern on issues of long-term strategy, service planning and development.

The characteristics of acute care and the pragmatism required in delivering services informed the context of service development and delivery within the Acute Inpatient Service at Living Well. The experience of the acute environment at Living Well mirrors

international experience as mental health managers continually face the challenge of balancing the resourcing demands of the unit with the need to provide high quality care (Goldstein & Horgan, 1988; Horsfall, Cleary, & Hunt, 2010; Hopkins, Loeb, & Fick, 2009; Mullen, 2009; Lamb & Bachrach, 2001; National Institute for Mental Health, 2002; Shepherd et al., 1997; Thomas, 1996). The response to problems presented by the Acute Inpatient Service typified the dominance of operational and risk factors in service planning and delivery at Living Well with short-term and temporary solutions adopted to address presenting concerns including sleeping clients over in other units, using respite care, and shifting clients out of the district to address the peaks in demand for beds. These issues were perpetual and linked with the risks and nature of this type of environment, as Matt explained:

> *...certainly in acute mental health inpatient units if anyone is going to harm themselves in any kind of you know, in any kind of area I would imagine next to being in a war that's the most likely place where you are going to get hurt, because that is the nature of the people. People are in a small unit and the majority of them are over there because they are a risk to themselves or they are at risk to some one else so in some ways it is not surprising some people do get hurt.* (Matt, 3).

Since moving into a new building in 2000 many projects, reviews and evaluations had examined the problems presented by the acute inpatient environment including the Best Use of Beds project, the Community Integration project, the Seclusion project, the Intensive Care Unit project, a gender safety project, and Home Based Treatment, among others.[109] A huge amount of staffing resource and clinical expertise was called on to complete these activities. In his initial interview, Paul noted that pressing issues like those in the Acute Inpatient Service always shifted management's focus to concerns other than service development initiatives:

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[109] Appendix A contains detail relating to these service development initiatives.

When the Acute Inpatient Service is under crisis with like they have been over the last three weeks with 95/96 people in with only 65 beds, they are basically just sending them home to their families themselves with no treatment and then coming back the next day and reassigning them, hoping and waiting... I don't know because we are too busy trying to move people out that we are not actually dealing with the issue which is the care in [the acute setting] and good care to meet the needs of the [clients]. Are we using drugs correctly, are we using seclusion and restraint correctly, are we treating the symptoms quick enough to get them out or do people get lost because they are just numbers and huge numbers? (Paul, 1).

As Paul's comment reflects, over time the issues related to acute demand continued to be unresolved and despite the investment in projects to address these issues the priority of simply delivering day-to-day care meant that the findings were never implemented while others had been implemented only for a short period of time. An example of this was the Community Integration Project, undertaken following the opening of the new Acute Inpatient Service in 2000. The project aimed to have clinicians working across the inpatient and community services in an attempt to manage client admission and discharge more effectively. Paul spoke about the Community Integration Project:

[It established] doctors working across teams or some worked inpatient and some worked outpatient but they both worked for their [Community] team...What happened is the doctors would go and see the most seriously unwell first and so the [clients] who were sitting there just humming along were seen late in the day and therefore no decision was made. When you look back, all of a sudden you had these [clients] with huge lengths of stay and they had actually been well for six

months, but because they weren't as important as the ones that had just come through the door with psychosis, who were really unwell, they got left for a little bit. So we drifted into having teams in the Inpatient Service to manage these clients and we forgot about the community... It was also on the Community Teams to send their Nurse Case Managers in every day to see their [clients] and that started to falter, people didn't go in. (Paul, 3).

The example of the Community Integration Project illustrates staff's willingness to work together initially in the best interests of clients. Unfortunately concerns related to client length of stay, and acuity slowly undermined the project's outcomes. Overtime these pressing immediate issues meant that clinicians were unable to maintain focus on the long-term goals of the project.

In 2003, another project had been set up and was repeated over a number of years called the Understanding Acute Demand Project.[110] This project analysed inpatient activity in order to identify client characteristics, patterns in admissions including time and frequency, as well as the prevalence of alcohol and drug disorders. The project, last undertaken in 2007, provided useful evidence intended to inform service development. The ability to do this was limited due to ongoing operational issues and reluctance on behalf of the clinical team to spend the time considering the implications of the research for service delivery while they were dealing with the pressures of the acute environment. Cliff a senior clinician also spoke about the dilemmas of managing an acute mental health inpatient service saying:

Too many people not enough beds...that means that our workload increases, our environment is crowded, we don't do the things that we should do, we don't do good discharge

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[110] Appendix A contains detail about the Understanding Acute Demand Project.

planning, we tend to sleep people in lots of different environments. You know, if you are an inpatient you're an inpatient who doesn't have a bed or who sleeps in a completely different site from the one you are in even though you could be acutely unwell. And it is kind of extremely difficult making those decisions or having to make those decisions. (Cliff, 1).

This focus on acute need meant that having the time to consider the implications of research for service delivery was limited.

In 2007, following two suicides and one other incident resulting in the injury of a client an external inquiry looking at the quality of acute inpatient care at this facility was commenced.[111] Tom's view was that these events were symptomatic of a service not working properly:

Acute inpatient environments are never going to be easy places ever and I think we have to accept that, but we can make them a lot better and so the recent number of events that we have had must be evidence of a system that is not working or has some dysfunction about it. (Tom, 3).

Tom's comment reflects a desire to improve the quality of acute inpatient care and concern about how best to do this.

The purpose of this section has been to examine the requirements, pressures and priorities involved in running a mental health service on a daily basis and to consider their implications for service delivery. The Acute Inpatient Service typifies the complexity of the service delivery environment and the priority given by clinicians to delivering responsive mental health services. Practitioner focus within the Acute

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[111] As noted elsewhere in the thesis external inquiries are frequent occurrences within mental health services across Aotearoa New Zealand. This inquiry was one of many looking at issues in mental health care in 2007.

Inpatient Service was about managing very unwell people with complex needs in an environment which was not always ideal due to problems related to over demand, staffing shortages, high client turnover and a lack of support from other areas across the organisation. Service development initiatives were additional burdens on top of their already overstretched workload. Clinicians were concerned about improving the quality of client care and looking at processes to address this, with the focus across the service being on meeting the demands presented by clients on a daily basis.

Conclusion

The purpose of this chapter has been to analyse the complexity of the service delivery environment at Living Well and to explore the factors that influenced what is a complicated and sometime contradictory process of service development. The chapter discussed how daily pressures and the organisation's raison d'être of delivering responsive mental health services meant that daily operational and clinical issues especially those related to risk management and acute demand took priority over planning and developing services. It also explored the tensions and contradictions between the priorities of managers and the value systems of clinicians at Living Well. The need to balance clinical values of professional discretion, autonomy and peer review with management requirements of risk management, accreditation and efficiency controls was also identified. The tension between these conflicting perspectives meant that priority was given to issues related to operational and clinical demand in order to support professionals in their daily delivery of mental health services.

Archetype theory states that an organisation's raison d'être or domain of activity is a key feature of its archetype. Living Well's raison d'être was the provision of responsive mental health services. Mental health services need to be responsive to the complex, chaotic, unpredictable and at times irrational nature of mental illness and to understand what is required to deliver services to clients who are either acutely or chronically unwell. Traditional approaches to understanding organisational change as a series of

rational steps do not reflect the reality of those working within mental health services, nor the complex factors influencing and driving change as well as the multiple participants and value systems involved in working in this environment.

The following chapter shifts from the day-to-day functioning of Living Well to consider the role of government policy, politics and strategic planning in service development.

Chapter Six: The Role of Government Policy, Politics and Strategic Planning in Service Development

Introduction

Service development within statutory mental health services such as Living Well happens in different ways, triggered by events, policies and personalities both internal and external to the organisation. The purpose of this research is to gain an understanding of the process of service development within statutory mental health organisations. This chapter explores formal service development pathways as a product of government policy, politics and strategic planning. It provides an analysis of the wider policy framework and its relevance to service delivery. A discussion on the impact of the political nature of mental health service development alongside the role that Aotearoa New Zealand's electoral cycle plays in the ability of services to plan new initiatives is then explored. This is followed by consideration of the relevance of local strategic planning to service development at Living Well including how strategic vision can be maintained in the long-term.

The rational bureaucratic approach drives all formal processes in relation to mental health services from a national level down to service delivery ensuring clear lines are drawn from plans, to decisions, to actions. Politicians, public servants, members of the public, staff and even clients expect organisations like Living Well to behave in certain ways, following formal processes in order to ensure accountability for public money, efficient outcomes and equity in the treatment of clients (Blau & Meyer, 1971; Pandy & Bretschneider, 1997; Weber, 1947). At a national level government policy and strategies, provide the framework for the operation of services, defining key targets, scope of service provision, overarching principles and audit frameworks among other things. At a local level, the function of strategy and policy involves planning service delivery as well as putting in place risk minimisation frameworks, accountability

structures and processes that outline the rules and regulations around the delivery of services.

The consideration of the role of government policies, politics and strategic planning in service development involves assessing the complicated and often contradictory role that these elements play within statutory mental health services. Government policies, politics and strategic planning processes are part of the structure and systems that make up the purpose and function of these organisations (Brock, Powell, & Hinings, 2007; Olsen, 2008). The values embedded within the interpretive scheme of the organisation give meaning to these formal systems and processes (Brock, Powell, & Hinings, 2007; Olsen, 2008). Consequently, assessment of the role of government policies, politics and strategic planning needs to include consideration of Living Well's interpretive scheme and the different value systems that contribute to this.

The purpose of this chapter is to explore the role of government policy, politics and strategic planning in the service development process at Living Well. It makes links between the core aspects of Living Well's archetype and the actual process of service development in this environment. It further examines the complex and sometimes contradictory relationship between Living Well and its stakeholders including politicians, the public, clients, and staff.

The Role of the Ministry of Health and National Strategic Frameworks

Government policy and frameworks are designed to guide the formal processes of service development and delivery at Living Well to ensure risk minimisation, accountability and efficiency. Chapter Four discussed the piecemeal, fragmented pattern that has dominated mental health service development in Aotearoa New Zealand. The results of this study indicate that the need for service providers to respond to client need reduces policy and strategy to the role of idealised value frameworks rather than

practical resources informing the nature and scope of service development. This section discusses the role of the Ministry of Health's and Mental Health Commission's policy framework at Living Well. It further highlights the tension evident in the relationship of service providers with the Ministry of Health.

Staff at Living Well knew about the roles of both the Ministry of Health and the Mental Health Commission. They were also aware of the existence of the current national policy documents: *Te Kōkiri*, *Te Tāhuhu* and *Te Hononga*[112]. They supported the values and vision contained within these and believed they were designed to create a framework and structure for mental health services informing strategy and governance. Participants, including Evelyn and Jacob, spoke about the role of the documents: *"The Ministry of Health is very much guiding where we are going. They are all guiding documents which sort of help us in our work, work out which path we are of proceeding along"* (Evelyn, 3). *"The framework is important because it does provide a framework, a structure, a reference point for developing our approach here" (*Jacob, 3*).*

Geoff, was more ambivalent about the Ministry of Health's actual role beyond just providing a broad policy framework and implementing political imperatives. He spoke about it in very general terms supporting the notion of the documents informing a value system rather than a service development framework, but then qualified this by saying "v*alue system might be a bit grand to call, but I do think they are more relevant [to service delivery]"* (Geoff, 3).

Participants said that the high-level language and jargon used in the mental health plans conveyed something about the Ministry of Health's relationship with the service delivery environment. They were particularly disparaging of the first mental health plan: *Moving Forward: The National Mental Health Plan - for More and Better Services* released in 1997. They criticised its relevance to the sector and the lack of connection to direct clinical practice. Participants said that *Te Kōkiri*, the second mental health plan, was easier to interpret than the previous plan and they felt that it could be more relevant

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[112] *Te Kōkiri*, *Te Tāhuhu* and *Te Hononga* were discussed in Chapter Three.

to clinicians. Tom summarised his thoughts on both the previous and current mental health plans saying:

> *We now have a blueprint effectively for delivery of services...*
> *So where for a long time we were trying to interpret Mason and*
> *all of those things and the earlier mental health plans of*
> *Moving Forward etc, we've now got a far more detailed*
> *prescriptive document and a picture for what things might look*
> *like.* (Tom, 3).

Despite participants' belief in the intent of the documents, they felt there was a lack of fit between these overarching frameworks and funding priorities. The lack of fit represented a disconnection between the Ministry of Health and the direct service delivery environment evident in the differing priorities for service development initiatives held by both. According to participants, the Ministry of Health's plan caused conflict in the relationship between funders, providers and the Ministry of Health ultimately creating gaps in the system. Paul summarised what he thought were the core issues creating tension in the relationship between the Ministry of Health and providers:

> *[The Ministry of Health] contract according to what they want*
> *to do in their strategy document to funding and planners, and*
> *they have very broad statements about patient journey and treat*
> *the patient in the right time, right place, right ... And then the*
> *funders fund different organisations. There is then a missmatch*
> *between what the ideal is and the theory is and what you can*
> *practically do with the money and or the contract you have been*
> *given. Therefore, a lot of the tension I believe comes in trying to*
> *meet the demand of what's actually required for the individual.*
> (Paul, 1).

As noted by Paul, when high-level documents did not fit well with local approaches to service delivery or the nature of local need this caused tension between clinicians and the Ministry of Health. In addition, Paul said that the Ministry of Health often required funders to build service specifications around national level priorities which providers then had difficulty fitting into their local frameworks:

> *We had to produce plans through Funding and Planning to meet our population… but quite often what they [the Ministry of Health] are sending us in policy is something that has happened [elsewhere] that doesn't suit our plan and we have to instigate something that is not an issue for us.* (Paul, 3).

Evelyn provided another example of the Ministry of Health's implementation of its policy and funding frameworks, which had caused tension in their relationship with Living Well. This involved using intellectual property from a funding proposal made by Living Well to fund the same initiative in another area:

> *Living Well puts in a proposal, doesn't get it of course, because [another] place has got a higher suicide rate especially in young Maori men and things. They get it, but they use Living Well's knowledge to decide how they are going to apply it in [that area]. And while that's good for the people in [that area], they get the better knowledge; it is actually a slightly devious way of going about it.* (Evelyn, 3).

In this example, the Ministry of Health's failure to recognise Living Well's contribution as well as not allocating funds contributed to ill feeling and a lack of trust from Living Well staff directed towards the Ministry of Health.

Participants felt that the Ministry of Health had an ethical responsibility to oversee consistency not just in terms of the policy framework, but also in terms of service

configuration, programme delivery and practice standards across the sector. The lack of fit between service development decision-making and the wider policy framework was commented on by Jacob, who felt it was important to view wider sector development separately from Living Well's service development. It was his view that the role of the Ministry of Health was to outline the wider sector issues, but service configuration and programme development was actually the responsibility of individual service providers such as Living Well. Evelyn also reflected on this when she commented on the scope and nature of service delivery provided by Living Well: *"I think that there is certainly unmet need in the people that use the service, but whose responsibility it is I'm not sure really."* (Evelyn, 1). However, another participant, Tom, noted that the Ministry of Health itself, felt conflict between providing a strategic policy framework for the sector and its need to control the details of service delivery:

> *I find that they [the Ministry of Health] move across that continuum quite a bit, sometimes they want to know what you are doing in a supportive way and in my experience have been quite punitive. I haven't found the Ministry to be consistently helpful … because I don't know if they consistently know what they are supposed to be doing. Yes they manage the Mental Health Act very well that's a statutory requirement, but in terms of service development and those sorts of things they seem to be participating in, rather than leading.* (Tom, 1).

Tom's observations suggest that in the ten years since the *Mason Inquiry* which criticised a lack of leadership, vision and coordination across the mental health sector, there appears to have been little movement in the translation of national strategy into "*a vision statement into a fully functioning, prestigious service*" (Mason et al., 1996).

Whether participants felt that achieving consistency across the country was a realistic task for a policy provider was unclear, however there was a level of dissatisfaction directed towards the Ministry of Health throughout the interviews linked with not

fulfilling the expectation of consistent service coordination across the sector. It was felt that by not ensuring consistency in the nature of service delivery including the names of services[113] that the Ministry of Health was not meeting its obligations and contributing to further fragmentation across the sector.

In summary, *Te Kōkiri*, *Te Tāhuhu* and *Te Hononga*, provide the overall national policy framework for mental health service across Aotearoa New Zealand and form part of the secondary data analysed as part of this research. The Ministry of Health has a statutory role in overseeing the implementation of these documents including allocating funding and monitoring providers. A consistent theme throughout the research was that there was a degree of uncertainty about the Ministry of Health's ability to carry out its role effectively due to its failure to address the complexity of the service delivery environment, a topic explored further in the following section. Tension existed between Living Well and the Ministry of Health evident in a lack of trust, fragmentation across the sector, and a concern about a lack of national leadership.

Using Policy and Strategy to Inform and Shape Service Development

The government, general public, staff and clients expect mental health services to develop in a coordinated rational fashion, making the most of formal service development pathways guided by the policies and frameworks designed to support them. At Living Well, the reality was that formal policies and frameworks bore little direct relationship to the process of service development. The purpose of this section is to explore the connection between national policy and local service delivery at Living Well as well as to examine the barriers to implementing the national frameworks.

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[113] An example being Crisis Mental Health Services which vary in name and referral processes across Aotearoa New Zealand with names including Crisis Assessment Team, Psychiatric Emergency Service, Crisis Mental Health Services among others.

The intent of the Ministry of Health was to provide national frameworks and guidelines that had direct relevance to current service delivery decision-making in statutory mental health organisations like Living Well. Participants emphasised that Living Well placed priority on being seen to implement Ministry of Health policy and directives in order to minimise risk and fulfil political obligations. Ministry of Health directives and programme developments were therefore a key concern and consequently important to management when considering the strategic direction of Living Well. However analysis demonstrated that the link between and relevance of service development and the wider political and policy framework was only vaguely articulated by staff at Living Well and rarely practically implemented. There was a conflict in what participants said about the adherence to policy and the actual act of using policy to inform and shape service development. Living Well's management and staff provided lip-service to the role government policy should play in service development. Rather than informing the service development process directly, instead policy became a framework for service delivery to rationalise existing service development as a form of post-hoc justification.

The release of the new framework documents: *Te Kōkiri*, *Te Tāhuhu* and *Te Hononga*, coincided with the commencement of the fieldwork component of this research. Staff were enthusiastic about the plans when first released, but as time progressed the content of the documents struggled to hold their focus due to the priority of delivering clinical mental health services. The clinical and operational demands presented by delivering a mental health service shifted priorities and diverted attention from the more general vision of the mental health sector contained in those documents to the daily requirements of responding to people who needed the support of mental health services.

In actuality, four key sets of pressures within Living Well took priority over implementing the policy framework: operational and clinical demands as well as

political and audit requirements.[114] Ellard's (2008) and Butler's (1990) analysis of the mental health systems of the United Kingdom and Australia have noted that policy lacked a connection with the practice environment and changes in practice did not result from the detail of strategic policy documents but, instead from clinicians working pragmatically to find solutions to the challenges they faced locally in their clinical work. Paul noted a similar pattern in service development at Living Well stating: *"The trouble is the [policy] direction is very broad and when you want any specifics around it that is where the difficulty comes from"* (Paul, 1). Paul felt that because of the lack of specifics in national policy documents clinicians had no other choice than to come up with responses to service delivery problems on their own. The reality of integrating the policy framework into service development and delivery on an ongoing basis meant that it essentially became an idealised system of values to inform rather than a set of criteria that would guide service development.

The lack of an explicit connection between national policy and the decision-making processes of Living Well was evident across all aspects of this research including participant interviews, document analysis and meeting observation. Service development reflected a pragmatic and responsive approach to operational and clinical demands rather than a broader strategic vision. This mirrors the pattern observed by Aarons, Hurlburt and McCue Horwitz, (2011) who noted that programmes within mental health services are selected based primarily on fit with the organisation's structure, roles and priorities embedded within its interpretive scheme as opposed to following a policy direction or framework. This point was also noted by Paul when talking about the identification of strategic priorities at the Senior Management Team level:

> *I think we decide what we need to do practically and then put it*
> *into the theory, that is in the District Annual Report rather than*

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[114] These pressures explains the seeming relevance of the new policy frameworks upon release in the first interview and that as time went by the significance of goals set at this higher policy level diminished as trends across the sector changed and new priorities were identified. This was noted in the changing views of participants between the first and third interview with regard to the significance of the new policy framework documents: *Te Kōkiri*, *Te Tāhuhu* and *Te Hononga*.

the other way round. [Policy] doesn't really guide you. It may say you may have to do more for Pacific Island people and so we might have a plan about how we are going to do that, but more or less it is sort of driven more by the [practicalities] than the theory. (Paul,1).

As already noted, participants believed that there was a lack of fit between the national policy framework, clinical service delivery and localised service development. However, they did see a relationship between the funding of services and trends in terms of service delivery frameworks. The analysis of review documents also demonstrated that over time services within Living Well's region were developed and funded because of trends and popular opinion rather than consideration of evidence or policy objectives including the disestablishment and reestablishment of middle managers.[115] These results are consistent with those of other studies where service development funding decisions reflect a cyclical pattern in which previous programme initiatives or service configurations are often rediscovered or reinvented based on trends in ideologies and treatment approaches internationally (Butler, 1993; Brown, 1985; Callaly & Minas, 2005; Morrisey, Goldman, & Klerman, 1985).

Archetype theory does not identify a direct relationship between national policy and strategy and archetype transformation. Rather, the theory regards national policy documents as creating the conditions for archetype change through a process of introducing new standards and frameworks for services that undermine and may eventually destabilise the organisation's ways of working embedded within its existing interpretive scheme (Brock, Powell, & Hinings, 2007). This pattern of national policy indirectly informing service development was evident at Living Well as some of the principles contained in local service development documents including responsiveness, primary health care, working together and the recovery framework were themes from

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[115] Appendix A includes information related to these review documents.

within the national policy documents.[116] These principles from the national policy documents therefore informed the philosophy of service delivery. Geoff summarised his thoughts with reference to the overarching role of the policies: *"Well clearly they outline the standards and the focus in an overarching sense, promoting recovery as a philosophy and the models that flow from that"* (Geoff, 1). Jacob felt similarly saying: *"I wouldn't say they are in our mind day to day, but they are up there as a necessary framework of reference"* (Jacob, 3). The analysis of review and project documents as well as meeting minutes undertaken as part of this research similarly identified that the national policy documents received little attention as part of routine service development and delivery, but the key concepts and principles were repeated in local strategic aims and project goals.[117]

Participants felt that the lack of connection between national strategy and current clinical service delivery presented a barrier to effective service development as it created fragmentation across services, a lack of clarity related to funding requirements and reflected a lack of national leadership across mental health services. Paul related this to a top down approach from the Ministry of Health in terms of directing service development:

> *I mean what we should do is present to Funding and Planning the groups of clients that we have got and the needs of the groups of clients and then they go to the Ministry and say these are the groups of clients we have in our area of [Living Well] and these are the needs of those clients and what needs to be funded. Rather than work off a philosophy at the top direct the money … and then have got gaps in the system at the bottom which we continually have to answer for.* (Paul, 1).

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[116] These themes were evident in the interviews with participants, projects and review documents, Living Well's strategic priorities and activities as well as agenda items and discussion at meetings.
[117] Appendix A contains details related to projects and reviews undertaken at Living Well.

Addressing the lack of connection between national strategy and clinical service delivery was consequently important to achieving consistency in the quality of services delivered across the sector. For example, senior managers were aware of the disconnection between the framework documents and service delivery and felt they had an obligation to try to translate this into something more meaningful for clinicians. Tom felt that in order to address the dislocation between policy and service delivery Living Well should focus on how the documents could be implemented as part of strategy: "*So let's not spend a lot of time navel gazing ourselves around strategic planning processes. What we should be looking at now is around strategic implementation.*" (Tom, 3). His view was that there needed to be a shared vision on what the Ministry of Health's priorities meant in terms of service delivery as well as the translation of these principles into a strategic plan that was relevant to the needs of clients and staff.

This section aimed to explore the role of national policies, strategies and frameworks in service development at Living Well. There was an often conflicting and sometimes contradictory role between what staff thought should be the role of the Ministry of Health and its framework documents, and the actual function they played in the service development process including the desire for the documents to be specific and detailed coupled with resentment at a local service delivery level to being told what to do by policy makers. While priority was given to the ideas contained within these documents in reality this was more by coincidence and out of pragmatism rather than planning, and demands related to service delivery actually drove the service development process. Consequently, national policy and framework documents fulfilled the role of supporting the strategic vision of Living Well rather than driving the shape and nature of service delivery.

Ministry of Health Programme Priorities for Local Service Development

The Ministry of Health does not have a specific, clearly articulated role with regard to local service development. They can become involved in service development through the promotion of national standards and directions as well as through the implementation of funding and audit requirements allocated to specific policies such as the *Pacific Health Strategy* and *Primary Health Care Strategy* that encourage District Health Boards to adopt and then implement the programmes. The Ministry of Health can also approach individual mental health providers asking them to pilot initiatives prior to providing funding across the sector. This section provides some examples of programmes that the Ministry of Health proposed and implemented locally with differing levels of success in order to examine the tensions in the relationship between the Ministry of Health and service providers such as Living Well. It suggests including the need to be flexible and responsive to each other when developing services.

Archetype theory suggests that for any change to be successfully implemented the proposed initiative needs to align with the interpretive scheme of the organisation (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999).[118] Paul criticised the Ministry of Health's approach to programme development related to strategy and policy such as the *Pacific Health Strategy, the National Mental Health Information Strategy* and *Tauawhitia te Wero – Embracing the Challenge: National Mental Health and Addiction Workforce Development Plan*, as being too generic. He felt that the Ministry of Health required mental health services nationally to dedicate service components and resources to specific areas that were not relevant given the different demography of District Health Board regions nor the particular interpretive scheme of mental health organisations. Paul felt that the generic nature of these targets

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[118] The core characteristics of Living Well's interpretive scheme include consideration of both community care and management components underpinned by professional values and bio-psychosocial philosophies of care. These elements were introduced in Chapter Four.

did not allow for the diversity of the sector and cited the lack of relevance of components of the *Pacific Health Strategy* as an example due to the low Pacific Island population in some areas of the country. Paul stated that the Ministry of Health required District Health Boards to: *"target Pacific Islanders ... and they are not the groups we are actually dealing with when we could be putting the resource in a better area."* (Paul, 3). Paul's view provides a further example of the complex relationship that providers had with the Ministry of Health where they wanted leadership and consistency across the sector yet believed that the national standards created to achieve this did not reflect the needs providers saw at a local level, thereby failing to align with their interpretive scheme.

In order to ensure the successful adoption of national priorities Paul felt that the secret to the success of the Ministry of Health programmes such as those detailed in *Te Kokiri*, lay in piloting the initiative first and then being able to adapt the service specifications locally based on an evaluation of the pilot. This meant that the Ministry of Health would initiate the change at a project level, but then allow some scope for the programme to be adapted to meet local need. The Watch House Project, which involved locating mental health clinicians within the Police Service's watch house, had been highlighted by Geoff, Tom and Paul as an example of just such a successful initiative at Living Well over the past year.

The Watch House Project was developed in response to a Ministry of Health programme request. The Ministry of Health's initial proposal reflected a lack of connection with the interpretive scheme of Living Well and with the needs of clients. It prioritised the policy goals of the Ministry of Health without consideration of local needs. The ability to pilot the project first meant that Living Well had been able to adapt the service specifications to be more responsive to the needs of clients and therefore more reflective of the interpretive scheme at Living Well. Paul described the process:

> *The Ministry thought we were going to capture a lot of people*
> *and send them into residential alcohol and drug programmes*

very early on. We found that they were repeat offenders in there who didn't want any sort of services they would just come back again the next night drunk. They were living in [the centre of town] and they were homeless and had all sorts of other issues. But what we did find out was the Police, just by classing people as alcohol and drug, were missing things like suicidality and depression and those are the things that we actually picked up on and we could then say "hey that person is not a risk to you we think they are a huge risk to themselves for these reasons." So we actually picked up some really interesting stuff around people we could probably catch very early on so our relationship with the Police has improved out of sight with that and it is more of a partnership. (Paul, 3).

The Ministry of Health's original goal of the project was around the assessment and treatment of people with alcohol and drug issues, however for Paul the benefits of the project included a better working relationship with the Police and an improved ability to identify people at risk of harming themselves. If the Ministry of Health had not shown flexibility in terms of the project specifications based on local assessment then the benefits of the project would not have been realised.

In contrast, Paul went on to cite the Ministry of Health's Relapse Prevention Plan directive as an example of an initiative that had not been piloted and did not work well as each District Health Board had a different idea of what should be implemented. Here, in contrast to the Watch House Project, Paul believed that local diversity created fragmentation across the sector: "*So some of those where they have not trialled them are really difficult to implement as you are not comparing apples with apples sort of thing.*" (Paul, 3). Paul's quote highlights the complexity of the relationship between mental health service providers and the Ministry of Health. It further illustrates how difficult it is to coordinate and develop services across the country as each mental health service translates project parameters into services and programmes that meet their local needs

and interpretive scheme. Unfortunately, this has the flow of effect of resulting in a lack of consistency in terms of service development across the country.

In summary, the relationship between mental health providers and the Ministry of Health is an important determinant in the development and successful implementation of projects. As with all archetype change, including service development, successful implementation was related to the degree that a proposed change aligned with the interpretive scheme of those implementing the initiative. The Watch House Project was a successful example of the Ministry of Health and Living Well working together to ensure that the project met the needs of clients and aligned with the value system of clinicians. In situations where there was a lack of cooperation between providers and the Ministry of Health, there was reluctant implementation of projects (convergent archetype change) that often resulted in tension and a lack of coordination in the delivery of services.

The Role of Politics in Service Development

The national policy framework created by the Ministry of Health and the Mental Health Commission is just one part of the broader political framework that informs mental health service development. This section aims to explore the influence of the electoral cycle and the media upon service development decision-making and day-to-day clinical service delivery.

Accountability is a key term in the delivery of any government funded service. Both the government and the public have expectations that the resources provided to fund mental health services will be used in a manner which meets the needs of people with mental illness (Blau & Meyer, 1971; Pandy & Bretschneider, 1997; Weber, 1947). The government has a role to play in balancing the public's expectation around social control, which emphasises containment rather than community care, with the need to provide quality mental health services in an environment that leads to positive

outcomes. Every time a case about someone who has a mental illness makes it into the media, this balance is questioned and accountability is sought as Carole noted: "*it seems to me that it is becoming more of a blame culture*" (Carole, 3). In this situation, the mental health system is seen to fail and questions are asked about the quality of service delivery and the robustness of accountability structures. Certainly, the *Mason Inquiry* undertaken in 1996 highlighted that in the period between 1987 and 1996 over 67 inquiries had been conducted into the failings of mental health service provision in Aotearoa New Zealand (Mason et al., 1998) a pattern which continues today with a review being commenced in mid 2011 looking into clinical errors and leadership problems at Hutt Valley Mental Health Service (Newton & Ash, 2011).

The relationship between politics and mental health service development has been well documented in other countries (Aarons et al., 2011; Braden Johnson, 1990; Butler, 1993; Hafner & An Der Heiden, 1996; National Institute for Mental Health, 2002; Panzono & Roth, 2006; Wright & David). These external environmental conditions can constrain the nature of any archetype change including service development by placing pressure on the organisation in terms of the scope and nature of the services it provides (Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989). Certainly, the priority given to political factors such as fashion, ideology, political expediency, and perceptions of risk and need have contributed to mental health services internationally developing in an ad hoc fashion that often fails to include a considered analysis of client need and the services that are required to address the continuum of care across mental health services (Aarons et al., 2011; Braden Johnson, 1990; Butler, 1993; Callaly & Minas, 2005; Falloon & Fadden, 1993a; Hoge & Howenstine, 1997; Joseph, Kearns, Moon, 2009; Keating, 1998; Norcross, Garofalo, & Koocher, 2006; Panzono & Roth, 2006; Reay, 2010). As discussed in Chapter Four, mental health services in this country have followed a similar pattern of development to other similar countries. This development can be characterised by a "*consistent picture of piecemeal approaches*" to the provision and development of the mental health system (Joseph & Kearns, 1996; Joseph, Kearns, & Moon, 2009; Moon, Joseph, & Kearns, 2005).

As already noted, numerous national reviews and inquiries undertaken in Aotearoa New Zealand have highlighted gaps in mental health service provision at a local level as well as more general fragmentation across the mental health sector.[119] These reviews have contributed to an incremental process of service development exemplified by changes in government, different political priorities and agendas; the ongoing need to ensure risk minimisation as well as remaining responsive to those requiring services (Joseph & Kearns, 1996; Joseph, Kearns, & Moon, 2009; Mason et al., 1996; Moon, Joseph, & Kearns, 2005). At times, organisations like the Ministry of Health can impose change including structural, policy and process adjustments on organisations (Powell, Brock, & Hinings, 1999). Organisations implement these changes to ensure compliance and secure ongoing funding. Matt described this process:

> *[The Ministry of Health] has demanded that we look at how we do things and perhaps in some cases alter the way that we do things so that we are changing our processes so that they meet the expectations, in an attempt to meet the standards that are required of us.* (Matt, 3).

Matt's quote draws attention to a process of pragmatic adaptation, where the organisation has to adapt and adjust out of "*technical necessity*" to ensure its ongoing survival (Mueller, Harvey, & Howorth, 2003, p.1974). Part of the complex relationship that service providers like Living Well had with the Ministry of Health was that they need to adhere to national policy and framework targets in order to receive ongoing funding. While the Ministry of Health targets for service development fulfilled a government expectation, as noted earlier in this chapter, they were criticised by staff at Living Well as not reflecting the reality of the service delivery environment and values of the organisation represented within its interpretive scheme.

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[119] These reviews and inquiries included: *1993 Inquiry under section 47 of the health and Disability Service Act; 1996 Mason Inquiry, 1993 Paul Ellis Inquiry; 2001 Burton Inquiry –Report into Southland District Health Board Mental Health Services; Mental Health Services of Public Hospital 2001; 2004 Consultant Psychiatrist, Dr C, A Rural Hospital: A Report by the Health and Disability Commissioner; 2005 Registered Nurse, Ms C, Capital and Coast District Health Board: A Report by the Health and Disability Commissioner Psychiatrist; Dr C & Psychiatrist, Dr D, Canterbury District Health Board: A Report by the Health and Disability Commissioner 2009*; among others.

Chapter Two discussed the platform for archetype change that occurred across statutory organisations as a result of the adoption of new public management and neo-liberalism with its focus on accountability and cost efficiency. The need for mental health services to ensure accountability and value for money in their delivery of clinical care placed priority on the consideration of national standards and targets. Essentially District Health Boards have to be seen to implement policy in order to receive ongoing funding and at Living Well these factors had been translated into reporting requirements to the funder and accountability reports to the Ministry of Health, as Paul noted:

> *Most of the business processes are accountability, data collection, rationalising what you need to do and making sure that you get the right information to the Ministry to ensure that they think you are doing a good job.* (Paul, 3).

Despite the importance given to meeting audit and funding requirements the immediate needs of clients at Living Well still drove clinical service development and delivery. At times, the Ministry of Health could direct that a particular service be developed, established or altered and consequently service providers like Living Well had to respond irrespective of other priorities. An example of this was the Day Programme Review, which resulted in the closure of this programme at Living Well. Living Well initiated the review in response to policy directives and subsequent funding changes made by the Ministry of Health concerned about the scope of rehabilitative services delivered by statutory providers.[120] A further example was a decision made by the funding arm of the District Health Board to shift funding Primary Health Liaison roles from Living Well to the NGO sector in accordance with the Ministry of Health's political imperatives. The current study found a relationship between the frequency with which the Ministry of Health dictated the nature and scope of service delivery, their requirement to manage risk and the stage of the electoral cycle factors, which are explored in the next section.

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[120] Appendix A includes details about the Day Programme Review.

The Electoral Cycle

This research set out with the aim of understanding the process of service development in statutory mental health organisations. The three-year length of New Zealand's electoral cycle places pressure on statutory services to meet their political obligations such as policy implementation targets, audit requirements and addressing accreditation frameworks within short time-frames. This section explores the role of the electoral cycle in Aotearoa New Zealand in shaping service development within Living Well.

Aotearoa New Zealand's three-year electoral cycle is short in comparison to other Western countries such as the United Kingdom and France at five-years, as well as Germany, and Sweden at four-years (Reed, 2006). Participants at Living Well felt that the short electoral cycle created instability because it undermined the ability of the government to provide consistent leadership as well as creating reluctance on behalf of funders to invest significantly in the strategic framework and vision for the sector. Matt reflected on this by saying:

> *The timing is important, I mean, it does have an influence … we're in an election year and we are not sure where it is exactly we are going to go politically speaking. There is stuff going on and whether we like it or not those things affect us and they will affect any kind of major proposal or service kind of change or policy.* (Matt, 3).

This political uncertainty, Matt felt, contributed to an inconsistent approach to service development, ongoing fragmentation and lack of coordination across the mental health sector.

An organisation's perception of risk, especially in today's neo-liberal environment, plays an important role in whether they will support or adopt new service development

initiatives (Aaron et al., 2011). Reed (2006) commented upon the way that the short-election cycle constrains the health sector's willingness to take service development risks in organisations like Living Well. He noted that the short electoral cycle in Aotearoa New Zealand meant that reform across the entire health sector occurred frequently, punctuated by major changes in approaches and philosophies as the governing parties wanted to demonstrate to their electoral constituencies that they were keeping their election promises. This was evident at Living Well as rather than adopting a considered approach to service development, strategies were sometimes developed and adopted in response to political whim and changing ideologies dependent on the stage and nature of the electoral cycle, as noted by Tom:

> *The danger of our election cycle … is it is a real challenge for the delivery of best mental health services as different ideologies come into play and different challenges and our services get sensationalised.* (Tom, 1).

Participants commented that with each election cycle[121] especially when there were changes in government, the priorities of service development and delivery changed including the move to shift more services to primary care and focus statutory mental health services towards acute service delivery for the most unwell. At Living Well this was exemplified in the closure of the Day Programme and the disestablishment of the Family Mental Health service which were targeted towards rehabilitation and therapy for those with mild to moderate mental illness. Participants felt that this made it difficult to create a consolidated framework for mental health services. The electoral cycle focused the government's attention dependent on whether the government was newly elected (first year), consolidating its platform (second year) or entering a new election cycle (third year). According to participants, Living Well's Board was unlikely to invest in contentious projects that would take time to see results or take any potential risks in service development or delivery because of the risks that an election would see a change in direction. Tom, General Manager of Living Well, explained that the short electoral

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[121] Both at a District Health Board and national government level.

term made the District Health Board particularly risk averse because of the political spotlight placed on them whenever an election was drawing closer. Tom explained:

> *When we're in an election cycle and [especially when] we are likely to see a change in government that puts an edge on both the inquiring minds of media and also the defensiveness of governing bodies like our Board etc.* (Tom, 3).

Consequently, District Health Boards were less inclined to invest in new service development opportunities without real assurance and evidence that the outcomes would be positive.

District Health Board elections occur every three years alongside local body elections and do not coincide with the national election.[122] Both the funder and provider arm of the District Health Board report to the Board on a regular basis and require their ongoing support to continue to deliver services. The factors discussed with regard to the national election are also relevant to the District Health Board local body elections, as the District Health Board's willingness to take risks and invest in service development opportunities varies alongside their electoral cycle.

Services such as Living Well needed to consider the stage of the electoral cycle when considering service development in order to maximise the chance of gaining support for new service development initiatives. The service delivery environment in mental health does not allow for such consideration, as clients require the delivery of services on an ongoing basis irrespective of political priorities and agendas. The changing government priorities and philosophies have therefore shaped the wider health sector adding to the inconsistent approach to planned service development and the fragmented nature of mental health services.

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[122] Local body and DHB elections last occurred in 2010 and will next occur in 2013. The national election occurred in 2008 and 2011.

The Role of the Media

Another external environmental factor that affected service development at Living Well was the role the media played in portraying the nature and quality of mental health services. Most members of society have an emotive response to mental illness which is influenced by media reports of people who are not well committing crimes (Mason et al., 1996; Nairn, 2007). The public do not consider clinical research outcomes, information about the recovery model and community treatment approaches when thinking about the type of care provided to people with mental illness. The media acts as a political agent in the development of mental health services because they highlight instances of poor practice and gaps, as well as placing a microscope over all aspects of service delivery. In this study, participants felt that the media played a role in shaping public perception of mental health services and consequently the District Health Board's willingness to invest in service development activities. The media attention adds to the cautious nature of the mental health environment where District Health Boards and service providers, such as Living Well, are unwilling or unable to show creativity and/or take further risks in service development and delivery. Paul highlighted that responding to the media was a major pressure, distracting from the task of planning and delivering services. He stated: "*we work in a difficult system where we're under media focus all the time and it is then very hard to work.*" (Paul, 1). The pressure created by the media focus was due to the potential for unforeseen errors resulting in unwanted attention across all aspects of service delivery.

Geoff discussed public and media expectations as being unrealistic: "*I think you have a population and a media focus out there that doesn't seem to believe it needs its own filter and it can ask for everything and clearly we are not going to be able to [meet that]*" (Geoff, 1). During the period of this research, the media highlighted two suicides and a self-harm event that had occurred within the Acute Inpatient Service at Living Well. As discussed in the previous chapter, this attention triggered an external inquiry into the operation of the entire Acute Inpatient Service, essentially halting the process of service development at that time as the reviewers looked to further analyse the system

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and identify potential gaps within this. This was evident in the analysis of minutes from the Acute Inpatient Service which reflected more of a focus on operational issues in the period just prior to the review commencing with service development projects put on hold until the review was completed. Examples of service development initiatives put on hold within the Acute Inpatient Service included a project looking at gender safety[123] and a review of therapeutic programming.[124]

Media portrayals of mental illness play a significant role in the ongoing stigmatisation of mental illness and mental health services (Nairn, 2007). The 1996 *Mason Inquiry* also highlighted the focus of media attention on gaps in mental health services as being part of the initial impetus for the inquiry (Mason et al., 1996). Matt felt that the media created a particular view of things that was not helpful to those providing care in this type of environment stating:

> *I mean when you look at what has happened recently in the media and the resulting external inquiry that we are about to go through, I think that it's important that people understand what the situation is all about. It is very easy I suppose for the media to take a segment of something and without the proper explanation as to what's going on. People or the public, can rightfully given the information they are fed by the media come to some alarming conclusions.* (Matt, 3).[125]

This perceived pressure to ensure positive outcomes all of the time further influenced the District Health Board's willingness to take risks and limited the ability of service providers to dramatically alter the nature and scope of service provision.

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[123] The project examining gender safety involved assessing the implications of the current gender configuration on the inpatient ward.

[124] The review of therapeutic programming involved assessing the content of the scheduled clinical programmes run for clients within the inpatient unit. The programmes included daily living skills and activity programmes. They were run as group sessions facilitated by occupational therapists, physiotherapists or nursing staff.

[125] Chapter Five provided a more in-depth focus on service development within the acute inpatient service and the difficulties associated with this.

Carole, in particular, described the role of the media as being a political agent in the provision of mental health services, that failed to acknowledge the nature of the service delivery environment where Living Well was providing services to very unwell people with a limited availability of resources: *"there are some media and some members of the public who seem not to appreciate that nothing we are ever going to be able to do will prevent every human error and human tragedy"*. (Carole, 3). Carole's contention was that Living Well was providing the best service they possibly could, given the constraints of the environment and the knowledge that existed in this area. Further, that what the media, public and politicians failed to appreciate was that there were no guarantees or absolute safeguards when working with people with mental illness.

In summary, a key factor in service development and delivery at Living Well was balancing public expectations with developing quality services that would improve the quality of life and treatment outcomes of people with mental illness. A tension lay in the ability of the organisation to balance the socially constructed beliefs of society with the organisation's interpretive scheme surrounding the care and treatment of people with mental illness. At Living Well, the political spotlight meant that the potential for negative attention tempered service development decision-making to ensure it was politically and publicly acceptable.

The Relevance of National Strategy and Policy to Clinicians

Clinicians' involvement in interpreting and implementing policy is incredibly valuable in terms of decreasing the gap between policy development and implementation. However, this involvement takes busy clinicians away from the core tasks of their roles. The role of clinicians in the service development process and the priority given to clinical care is discussed further in Chapter Eight. The first part of this chapter explored the role of national policy, strategy and frameworks in terms of service development. This section further investigates the significance of these elements to clinicians who are involved in providing care and treatment to clients with mental illness on a daily basis. It

also discusses the importance of balancing the involvement of clinicians in policy implementation with the reality of service provision, presenting some suggestions as to how this could be resolved.

Participants in this study were mostly senior staff members with many years of clinical and managerial experience.[126] While they understood the relevance of Ministry of Health documents for strategic planning, they believed that these framework documents lacked relevance to the vast majority of clinicians working directly with clients as noted by Geoff and Matt:

> *It is easy to see their application to what we are doing, well certainly to my level of what we are doing. I guess it is my challenge to make sure that the next two levels down to shop floor also have some understanding of why we are doing what we are doing.* (Geoff, 3).

> *It's a big picture thing really because as a clinician working, say with someone in [a unit], you don't necessarily see the direct relevance or the connection between a national policy and what you are actually doing when you are working with someone. Or at best you might have an awareness of it.* (Matt, 3).

As discussed in Chapter Five, clinicians from a range of different professional groupings were the biggest stakeholder group at Living Well and they were important contributors to the organisation's interpretive scheme.[127] In accordance with archetype theory, at Living Well ultimately all plans and ideas needed to align with the value system of clinicians in order to be implemented (Brock, 2006; Brock, Powell, & Hinings, 2007;

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[126] Refer to Table 1 in the methodology chapter for a breakdown on length of service of the participants in this research.

[127] Chapter Five provided further discussion regarding the different professional groups contributing to Living Well's interpretive scheme.

Callaly & Minas, 2005; Goding, 2005; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999). Consequently, for service development to be successful clinicians needed to play an integral part in its development and implementation (Callaly & Minas, 2005; Goding, 2005). Participants acknowledged this, and reflected on how to improve the connection between strategic policy and the practice environment. Jacob thought the secret lay in communicating and demonstrating the utility of the Ministry of Health's policies to all clinicians:

> *I think policies aren't all that useful unless they are disseminated to all the people they need to go to and explained. I think we don't do enough of that, but we spend endless hours writing policies and some staff don't know where they are or what they're about or their purpose.* (Jacob, 3).

The need to ensure the utility of national policies to clinicians was a view shared by Tom: *"I think the critical relevance to clinicians is to actually be able to see that they have got outcomes and encouraging them to look at the information"* (Tom, 3). Carole discussed that it was not until her role changed recently from a clinical position to part of the management structure that she actually became aware of the significance of the Ministry of Health documents:

> *I think the sad part about it is that I didn't have that sense when I was on the ground floor or even in middle management. There wasn't the same connection between the Ministry [of Health's] direction and what you were doing on the coal face.* (Carole, 3).

She said that unless staff were involved in setting and working with strategy the documents lacked relevance:

> *I think there is still that risk of a disconnect between the people*
> *with their head down bum up doing the same job that they have*
> *always done in the same way that they have always done it,*
> *because they are busy and haven't quite had time to put their*
> *heads up and really think about if there is a different way.*
> (Carole, 3).

Workload pressures for frontline clinicians created a barrier to understanding and keeping current with the numerous numbers of government frameworks and strategies. The time devoted to responding to clinical needs meant that clinicians lost touch with developments in the wider policy framework or failed to appreciate the significance of developments with potential flow on consequences for their work. Tom described this as clinicians being: "*caught in a transaction of daily activity*" (Tom, 3).

Participants held contested views about policy. They wanted to have these as a value and guiding framework but were too busy to read in detail and think through the issues. They spoke about the need to provide a 'grassroots' summary whereby these documents were interpreted for clinicians as Evelyn noted: "*Clinicians see them … as 'motherhood and apple pie'. So it is actually you need people that can synthesise that information and turn it into real action points for clinical areas*" (Evelyn, 3). Evelyn felt that this would demonstrate the relevance of policy to clinicians in terms of day-to-day service delivery. Geoff also felt that it was important to create space for clinicians to enable them to understand the relevance to their practice saying:

> *People feel like they're at 100% so there's not a lot of capacity.*
> *They are operating at 100% at all the time, so there is not a lot*
> *of capacity to take the time to reflect and so somehow having*
> *that capacity in-built right through to clinicians.* (Geoff, 3).

As noted in Chapter Four, the policy framework that informs mental health service delivery across the globe is complex, involving not just strategic framework documents,

but also clinical frameworks, international conventions as well as different philosophies and political viewpoints (Minas, 2005; Thornicroft & Tansella, 2004). The Aotearoa New Zealand policy context is a similar array of framework documents, strategies, reviews and best practice approaches broken down further into different specialist areas each with their own recommendations and concerns about service delivery. A consequence of the complexity is that clinicians find it difficult to devote the time to navigate and engage with these wider policy frameworks and to identify priorities for service development.

In summary, clinicians at Living Well struggled to find time to devote to the consideration of national policy documents. The daily demands of their job occupied their time and they consequently did not have time to see the relevance of the documents to their everyday practice. Compounding the complexity of the policy environment, alongside clinicians' busy and demanding workload was their need to participate and engage with local planning processes at Living Well.[128] The findings of this research consistently show the difficulties that mental health service providers face in juggling service planning with the demands of providing responsive services. Clinicians believed that local processes had more relevance and impact on their day-to-day work. However, it was still difficult for them to devote time to any sort of service planning given the priority of their clinical roles let alone engage with national documents.

Strategic Planning and Direction at a Local Service Level

This chapter highlights the complex nature of the service development environment at Living Well including the tensions embedded in the role that formal mechanisms such as policy and strategy play in the service development process. Thus far, discussion has considered national policy and frameworks and the role of the Ministry of Health in informing service development and delivery. This section extends this discussion by

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[128] Clinicians role in local strategy and planning is discuss in greater detail later in this chapter under the subheadings Strategic Planning and Direction at a Local Level as well as in Chapter Seven.

exploring the nature and role of formal planning mechanisms at a local level. It contextualises the local planning processes of Living Well within the wider District Health Board and national framework and then provides a discussion of the value and relevance of local strategy to service development.

The government's political priorities drive the strategic framework of the Ministry of Health and all District Health Boards are required to have a strategic plan that identifies the clinical priorities for their region. The plans are there to provide guidance in terms of funding priorities and to outline the overall strategic priorities and direction of the District Health Board. District Health Boards were established under the New Zealand Public Health and Disability Act 2000. This legislation provides clear systems of accountabilities including checks and balances in the form of reporting and audit requirements, a prescribed process for service planning, and the requirement that the District Health Board is identifying priorities for service delivery based on evidence.

The New Zealand Public Health and Disability Act (2000) requires each District Health Board to have a District Strategic Plan with a five to 10 year focus and a District Annual Plan that includes their Crown Funding Agreement[129] relating to the national policy framework and priorities within the local region. As discussed earlier in this chapter, the government, public, staff and clients all expect the District Health Board to deliver on these targets and to follow the planning processes prescribed in legislation.

Living Well is subject to the strategic plans, reporting structures and audit requirements implemented from the District Health Board level. The priorities identified by the wider District Health Board impact on Living Well. Yet, while Living Well reports to the District Health Board, it has its own formal business and management structure outlined in Chapter Five. As such it undertakes business planning, meets accountability and audit requirements; oversees recruitment and other human resource issues; and monitors its

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[129] The Crown Funding Agreement is a legislative requirement outlined as part of the Public Health and Disability Act 2000, which outlines the amount of money and the associated services that the government agree to provide to each District Health Board.

own financial performance that is then reported to the District Health Board's Board on a regular basis.[130]

Living Well's strategic goals were developed at a formal planning day held in 2005 involving senior management, clinicians and representatives from other key stakeholder groups such as clients, family/whanau, primary health care and community providers. The inclusive planning process identified strategic goals that aligned with the raison d'être of the organisation of providing responsive mental health services and the main values contained within its interpretive scheme. For example, the goals targeted bringing greater alignment between national strategy and service delivery at Living Well. The discussion at the planning day identified three strategic priorities. These included collaboration and relationships between services, workforce development and primary health care project priorities. They reflected the philosophies and principles from the national policy framework. All except one of the participants in this research participated in the development of these priorities and were able to quote the three strategic priorities decided at the day. These new strategic areas replaced five previous areas for project development identified 12 months earlier, which were access and responsiveness, inpatient bed management, clinical pathways of care, the patient journey, review of models of care and clinical case-management strategies/models.

The General Manager, Tom, described the latest strategic goals as *"a loose collection of thoughts"* which existed as a common understanding between those in leadership positions guiding the service. However, the reality as he saw it was that despite the time and effort that went into formal planning mechanisms, priorities shifted and consequently the original goals of any strategic plan were often superceded and became less relevant:

> *I mean we had a strategic plan which is alive until the end of*
> *next year, but like a lot of things it was really a loose collection*
> *of thoughts around areas that were under-developed in the*

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[130] These formal systems inform Living Well's archetype.

service and needed to be developed to achieve the vision of a
fully integrated system, but like many of those things in a five
year horizon the game plan changes quite often as we get to
know more information, other problems come up, so yes loosely
we have got a strategic direction and a vision. But it is still very
much a loose collection of things what we haven't done is
actually operationalise that vision. (Tom, 1).

Tom's views capture a consistent theme in the way mental health services respond to all policy and strategy, whether this is at a local or national level. The everyday clinical and operational demands of providing mental health services change the nature of the service delivery and demand immediate responses on an ongoing basis. This also means that the interpretive scheme for the organisation remains in a state of flux while the core raison d'être stays the same, the priorities and methods embedded in the organisation's interpretive scheme change. Hinings and Greenwood (1989) describe this process as "competitive commitment", which they assert destabilises the structure and systems of the organisation and creates opportunities for the development of a new interpretive scheme resulting in the creation of a new hybrid archetype rather than remaining in a state of flux. However, the findings at Living Well including the participants' responses over time, project goals and discussion items in meetings suggest that priorities embedded within its interpretive scheme were continually re-evaluated based on environmental demands such as risk management, staffing and client acuity. The results at Living Well are therefore broadly consistent with Kirkpatrick and Ackroyd's (2003a, 2003b) critique of archetype theory which found that social service organisations could operate in a permanent state of flux responding to priorities as they occurred.

An example illustrating the changing priorities embedded in Living Well's interpretive scheme was the organisation's inability to maintain a focus on the five strategic priorities from 2004 known as the "Priorities for Action". At the time of their development, these priorities had significant project resources attached to them and were, at the start of this research in 2005, regular agenda items at the Senior

Management Team Meeting. However, only 10 months later the three new priorities replaced the original Priorities for Action, which had disappeared from discussion at meetings at all levels as well as from the agenda and minutes of the Senior Management Team Meeting. Over the intervening period teams at all levels had shifted their attention away from the Priorities for Action to operational requirements such as meeting accreditation assessment standards, pandemic planning, addressing staffing requirements, as well as focusing on performance targets within individual units as opposed to the strategic focus of the organisation. The Priorities for Action while originally championed by senior managers, lacked relevance over time for clinicians and unit managers when measured alongside the daily clinical and operational demands of units.

Mental health services, such as Living Well, are complex systems that involve the management of a myriad of subsystems including physical resources such as buildings, finances and staffing; as well as less tangible aspects such as demand for services, referral systems and clinical decision-making processes (Callaly & Minas, 2005; Minas, 2005). Business planning including formal strategic plans at a local level is an important part of the accountability mechanism for all mental health providers (Callaly & Minas, 2005). The aim is to create transparency and predictability to service development and delivery by following formal processes thereby minimising risks and ensuring quality service planning. In this research, those working at senior management levels considered local strategic and business planning processes as crucial to a coordinated and planned approach to service development. However, as with national policy and frameworks, strategic policy and planning at a local level, despite being regarded as important, was rarely given dedicated time and sufficient resources to ensure implementation in the long-term. An example of this was the Community Review. The purpose of the Review was to engage in a planning process and identify strategic goals for the Adult Community Mental Health Service for the next 10 years. The Review involved extensive staff, client and community participation. The final strategic plan and goals contained within it reflected the vision of all stakeholders. Following the publication of the plan a Project Manager was appointed to coordinate its

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implementation. However, just six months into this process the project person was seconded to work on another project related to developing better relationships with primary care, reflecting the changing priorities of the organisation. No further resource was dedicated to the Community Review or the implementation of its strategic plan. Just two years later, internal documents reveal a lack of awareness of the Review, little knowledge of the Strategic Plan and very few of the goals were achieved.

In summary, the development of strategic plans and priorities was an important part of the formal processes of the organisation with legislative controls monitoring the implementation at a District Health Board level. At Living Well, Senior Management saw the process of setting strategic priorities as representing the values and priorities of the organisation. However, the changing nature of the service delivery environment meant Living Well was unable to maintain a consistent strategic focus as priorities shifted. Therefore while the organisation's raison d'être remained the same aspects of the interpretive scheme were continually being altered in response to the changing nature of the delivery environment as seen in the changing strategic and project priorities of the organisation. Although at other times the lack of alignment between strategic priorities and the interpretive scheme created barriers to service development and the implementation of strategic priorities.

Implementing Local Strategy

As already noted, Living Well is a large, regional mental health provider with a number of different service components including Adult Mental Health, Rehabilitation, Child, Adolescent and Family Services, Intellectually Disabled Persons Health, Forensic Services and other Speciality Services.[131] As discussed in the previous section, Living Well had some general strategic priorities governing the direction and development of services. However, in practice the existence of strategic or business plans at a service or

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[131] Including Anxiety Disorders, Eating Disorders among others.

unit level were rare. This section examines the relevance of business planning to services involved in direct service delivery.

As discussed earlier in this chapter the national policy framework lacked direct, practical relevance to clinicians at Living Well. Cliff commented that strategic direction at any level generally lacked credibility with clinicians:

> *I think we plan with the best of intentions, but the reality of what we do doesn't quite meet what our planning does. Like for example when they moved from the old building to the new building the idea of having less beds and having better services was really good. You know the idea and the concept, you know everyone knew that we needed to provide a different kind of service in a different way which was fine, but the reality of actually doing that didn't happen so since then we have kind of been reactive as opposed to, you know the idea was good but it just didn't work, because the things that needed to be in place I guess for it to work weren't all there… The overall plan is good, it is the nitty gritty of how it works doesn't seem to.* (Cliff, 1).*

Cliff's point was that ultimately, strategic directions were unrealistic given the nature of the service delivery environment and consequently staff prioritised the delivery of services directly to clients rather than the development and implementation of strategy.

Planning days did occasionally occur at the unit level, and priorities were identified but the ability to maintain a focus on these was difficult and the priority around planning became the "*on top issues*" which were approached as a "*pile of projects*" or "*a group of ideas*" (Paul, 1) rather than a coordinated strategic plan reflecting the focus on the operational factors related to service development. Paul described the strategic vision within his area of responsibility as: "*Not so much a strategic plan just a pile of projects*

that we are basically working towards." (Paul, 1). Eliza also noted a similar lack of a coordinated response stating that she believed service development was generated in response to problems and lacked considered forethought stating: "*I think that is the way the District Health Board runs, it gets a problem and then it thinks we'll have to fix it. I don't think there is a lot of forward planning*" (Eliza, 1).

Carole said that she had no idea what was included within Living Well's Strategic Plan or even if the organisation had a strategic plan:

> *I mean here in this role I hear things about well they are thinking about this service or that service, or developing this or developing that. But I don't have a very clear idea from the very top about exactly where we are going and I don't know whether that is just because I haven't read something that I should or (laughs) what that's about…and so I have a sense that it is more that we just drift along and then a few things change.* (Carole, 1).

It was her feeling that service development and change was responsive rather than being planned or coordinated under any form of strategic vision.

Carole noted that the aims and goals of a strategic plan were typically conveyed in high level language and could consequently be ignored, discarded or interpreted in various ways and used to justify any new and/or existing initiatives as well as the termination of programmes which could loosely be framed within the intent of the plan:

> *I think that from the strategic plan there are ethereal statements like access and responsiveness (laughs) and so each of the [services] picks this up and says well what does this mean for us and then someone says well single point of entry would be a good idea and then someone says we'll only do it this way and*

so (laughs) so I'm thinking that there is a link somewhere, but I am suspecting that also that individuals pick up something and fit their hobby horse into that. (Carole, 1).

Carole's statement supported the idea that policy and strategy were used to justify service development decisions made as a result of operational and clinical factors, rather than driving this process from the outset. She felt that this was not always a bad thing as often the service development decisions had improved the responsiveness of services and the outcomes for clients aligning with Living Well's raison d'être.

Staff engaged in clinical service delivery found it difficult to remain current with all the service development activity across the organisation. Jacob commented on the complexity of the system at Living Well that had a multitude of different policies, approaches and treatment strategies:

I think that also probably there are systems issues; we are a large bureaucratic organisation with millions of policies which many of the staff don't understand or don't follow so I think there are lots of inbuilt structural impediments to things flowing more smoothly. (Jacob, 1).

In order to remain up-to-date staff had to balance the time required to stay current with policy and proposed service changes across Living Well with the priority of meeting the needs of clients within their direct work area. Cliff was a senior nurse in the Acute Inpatient Service with many years of experience and noted the challenge of providing services in this environment. The consideration of strategic priorities did not occur to him in his clinical duties, rather he was focused on delivering quality care to clients who were very unwell in an environment which was over capacity, under staffed and under immense pressure on a daily basis:

I don't think it is relevant. I don't think it really impacts on what we do day-to-day. It might impact slightly on where we do it, but it won't impact on what we do and our core business for nurses working in there is assessment and treatment. (Cliff, 1).

The conflict articulated by Cliff between strategy embedded in management values and operational or clinical demand that aligned with clinical values, meant that strategic planning was seen as being irrelevant and unnecessary to clinicians as it actually had no real immediate benefits or outcomes for them in direct clinical service delivery. This point was also made by Geoff who stated:

Persuading people of the value of these things [strategy and policy] when all they see is another task that they have to perform when they are busy and when you know they are worried about somebody maybe who is a risk around the corner and they are sitting in front of a computer screen, it's hard to tie those two up. So everything has got to come with the resource and ability to do it. (Geoff, 2).

The views of both Geoff and Cliff reinforced that at Living Well the immediacy of both clinical and service delivery problems consistently took priority over formal long-term service and strategic planning and these issues shaped service direction and clinical focus on an ongoing basis. The example of the Community Review discussed in the previous section also reflects this pattern as once resources were no longer dedicated to implementing strategic goals staff attention shifted back to the priority of delivering clinical care.

Living Well's interpretive scheme was thus involved in ongoing tension between management priorities which valued the role of strategic plans, policy and frameworks and clinical imperatives of delivering responsive services to clients. The clinicians who provided the services gave priority to the immediate needs of their clients and

essentially saw the formal, bureaucratic structures including strategic plans and priorities as fulfilling formal organisational and political requirements rather than having a close connection to service development or delivery. This tension supports the complexity of providing services within this environment and means that Living Well's interpretive scheme had to balance the demands of national, local and clinical priorities in considering its approach to service development.

The Senior Management Team

The purpose of this chapter is to discuss the role of government policy, politics and strategic planning in service development. The Senior Management Team sat at the top of the hierarchical management structure at Living Well and had the ultimate responsibility for overseeing the implementation of government policy, as well as the planning, development and implementation of strategy at a local level. Staff regarded these team meetings as the primary decision-making forum for Living Well and the location of all service development decision-making. Participants identified formal pathways that confirmed the progress of ideas up to this level and the allocation of tasks out from this level. As with most other formal planning activities discussion related to operational and clinical priorities dominated the senior management team meeting leaving little time to discuss planning, strategy and service development. The Senior Management Team played an important role in the development of strategy at Living Well, certainly all the members of the team participated in the planning days that developed the strategic priorities for the organisation.

The Senior Management Team meeting occurred weekly, with a monthly strategic or planning meeting scheduled as part of this.[132] Strategic planning was not a frequent agenda item in either the operational or the strategic meetings with little discernible difference in the agenda items between the two meetings. Participants who had been

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[132] Nineteen meetings occurred in the period of this research. Minutes could only be located for eleven of these meetings. Mid-way through this period the minute template changed to include an action template which was attached to the minutes to track activity on the items discussed.

members of the Senior Management Team felt that the Operational Manager and General Manager typically discussed and decided on issues related to strategy outside of this forum. Despite seeing the Senior Management Team meeting as the location for all service development decision-making upon reflection Matt, Carole, Paul and Tom all felt that in actuality the Senior Management Team meeting was more of a reference group for the General Manager and Operations Manager and that strategy and service development planning occurred elsewhere. This was a theme reflected in the minute analysis, which found that the Senior Management Team meeting was often used as a place where the Senior Management Team could test ideas for proposed service development and strategy rather than using the established processes to progress proposed priorities into service development initiatives.

The activities undertaken by the Senior Management Team reflected the values embedded in the organisation's interpretive scheme as well as the organisation's raison d'être through the priority allocated to discussion items at meetings. Paul, himself a member of the Senior Management Team, noted that in his experience the Senior Management Team meeting had two formal functions. These were, to consider change coming up from below and to generate strategic priorities for action. He also commented that the operational demands of the service meant that strategic decision-making took a back seat meaning that the acuity of pressures currently facing each unit determined the significance of initiatives. Responding to everyday clinical delivery was therefore the primary concern of Living Well's Senior Management Team reflecting the organisation's raison d'être, giving strategic planning and policy implementation less significance. The analysis of minutes and observation of the Senior Management Team meeting confirm this as agenda items including staffing, medication errors, documentation, and the nature of clinical responsibility as well as management activities for the week dominated discussion.

Tom said that the Senior Management Team meeting had been set up with the intent of it fulfilling the role of developing strategy to shape decision making:

> *What we have tried to do in the last three or four years is create the Executive Group of [Living Well] which is primarily General Managers with Operations Managers and their equivalent Clinical Leaders who meet on a weekly basis and we are, or we have attempted to try and create that group as the decision, as the ultimate strategic decision making body for [Living Well]. So that people get to expect and they know decisions are made.* (Tom, 1).

He did acknowledge that this goal had only been partly successful and that due to the lack of cohesion between group members often key decisions related to service planning and development were actually made elsewhere:

> *It's been marginally successful, yes we have managed to deal with things particularly well in terms of removing some of the confusion and conflict that was in the organisation before, but again due to some of the nature of the personnel of that group and the behaviour that we had going on decisions weren't being made and it became very operational and very detailed, so you became lost in the detail of it rather than in the strategy.* (Tom, 1).[133]

In summary, the Senior Management Team played an important structural role in the consideration of strategic policy. Formal processes were in existence to facilitate the discussion of strategy. However, these processes were swamped by the demands related to everyday clinical delivery meaning that strategic planning rarely gained prominence.

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[133] The role of personalities in the service development process is discussed in greater depth in Chapter Eight.

Conclusion

The purpose of this chapter has been to explain the role of policy and strategy, both national and local, as formal service development pathways at Living Well. Living Well had formal mechanisms for engaging in service development as well as strategic goals to shape its direction. Policies and strategies at both a national and local level established the formal pathways for service development, laying out clear priorities for service development. Audit and accountability mechanisms attached to funding driven by national policy frameworks, Ministry of Health Directives and the electoral cycle, all brought pressures that shaped service development decision-making as managers at Living Well needed to give these matters consideration to ensure the organisation's ongoing viability. While those working within Living Well acknowledged the significance of these factors, they believed that these failed to recognise the complexity of service delivery.

Living Well's raison d'être was delivering responsive mental health services. Despite having systems and processes to address strategic planning and policy implementation these systems failed to account for the dynamic nature of the service delivery environment. The findings of this study revealed that while the Living Well's raison d'être remained consistent throughout this research, the changing demands and complexity of providing mental health services meant that the values that contributed to the organisation's interpretive scheme were in a perpetual state of flux and there were a range of contrasting views about service development across participants' responses. An example of this was apparent in the tension between the different value systems of clinicians from those in management roles, a theme evident across this research. Managers acknowledged the importance of strategy and policy in terms of highlighting political priorities and defining the overarching frameworks required of a mental health service. However, clinicians felt that the need to have autonomy and discretion in how they responded to people who were unwell on a daily basis meant that despite the best of intentions, there was little time left to devote to planning beyond the immediate short-term needs of those in front of them.

Another important finding of the research was that formal service development pathways created through the implementation of policy, strategy and planned processes came into conflict with the interpretive scheme of the organisation. These initiatives often bore little relationship to the reality of service provision and failed to take into account what it actually meant to respond to the acuity of mental illness, staff shortages and resource constraints. The need for mental health services such as Living Well to be responsive to clients, the primary concern or raison d'être underpinning the interpretive scheme, meant that strategy and policy regularly took a backseat to service delivery.

Ultimately, it seems that the problem of putting a strategic plan into operation was similar to the dilemma faced by the Ministry of Health in terms of their vision for mental health services nationally. Aotearoa New Zealand's history of failing to provide strategic and policy leadership across the sector appears mirrored in the priority given to this at a local service delivery level. The question becomes: at what point/level do strategic plans and national frameworks need to be put into operation and where does this responsibility sit? As without resonance with the organisation's interpretive scheme including demonstrated relevance to clinicians, the vision of the service gets lost.

At Living Well, projects and reviews were often set up in order to implement the strategic vision of the organisation and were a mechanism intended to ensure that local service development aligned with national policy frameworks. The next chapter provides a discussion of the role planned service development in the form of projects and reviews played in service development at Living Well.

Chapter Seven: Formal Pathways for Service Development - Projects, Reviews and Evaluations

Introduction

This chapter continues the discussion of formal service development at Living Well outlining the role of projects, reviews and evaluations in the service development process. The main triggers for formal service development are presented as well as the outcomes and barriers to achieving significant results. This chapter also extends the discussion on the relationship between formal service development and Living Well's interpretive scheme.

Archetype theorists consider that service development and change occurs as a result of the interplay between the formal structures and systems of an organisation and the values, beliefs and ideologies that represent the organisation's interpretive scheme (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999). The previous chapter outlined the role of government policy and strategy as part of the broader context for service development at Living Well. Other planned or formal approaches to service development at Living Well were projects, reviews and evaluations.[134] These mechanisms form another part of the formal structure and systems of the organisation. In order to achieve successful archetype change the processes and outcomes of these activities also need to align with the organisation's interpretive scheme (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999).

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[134] The terms formal and planned are used interchangeably throughout this chapter.

As noted in the previous chapter, Living Well's interpretive scheme was dynamic and appeared in a perpetual state of flux responding to the changing nature of its environment. The primary concern of the interpretive scheme is its raison d'être which for Living Well was delivering responsive mental health services. The service development process at Living Well was complex and sometimes systems appeared contradictory. While formal pathways existed and were used across the service, the need to respond to the clinical needs of people with mental illness on a daily basis took precedence over planned service development. This shifted the organisation's focus and created new priorities for service delivery.

The Function of Projects and Reviews in Service Development

Projects and reviews occurred frequently at Living Well. These activities provided formal processes for identifying problems, exploring alternatives and recommending conclusions to inform service planning and development. This section analyses the purposes of formal service development activities such as projects and reviews at Living Well, it details the frequency with which these events occurred and highlights the differences between project and review types. Further, the justification for undertaking this type of activity is discussed.

This research found that there were two pathways for service development at Living Well: planned or formal service development such as policy, strategy, projects and reviews; and unplanned or informal service development created through the need to respond to clinical and operational demands. In a similar vein to policy and strategy, formal projects and reviews had a varied impact on service development at Living Well. Participants regarded projects and reviews as a valid mechanism for addressing service development as Evelyn noted: "*They're an attempt to improve things. They are an opportunity for those who are particularly interested to get involved if they want to*" (Evelyn, 2). However, participants expressed frustration at the time and resources

involved in the process and were exasperated at what they believed was a lack of tangible outcomes.

Formal service development in the form of projects and reviews fulfilled many of the characteristics of Weber's criteria for rational legal administration (Beetham, 1987; Blau & Meyer, 1971; Blau & Scott, 1962; Mouzelis, 1967; Weber, 1947; Weber, 1948). This type of service development included clearly articulated processes; rules around activity in the form of terms of reference; a hierarchy outlined in the project's structure that identified roles and responsibilities; accountability mechanisms including reporting lines; plans for consultation and engagement with stakeholder groups; clear aims and objectives as well as steps for risk minimisation. Staff at Living Well considered projects and reviews the most legitimate and appropriate pathways for service improvement due to their formality. Evelyn used the project process in place to address the accreditation process for Living Well as an example of the formality ascribed to projects and reviews:

> *It has a very structured project formula, we have project phases,*
> *stage gates and all that sort of stuff and that's kind of quite an*
> *easy way you can just basically follow from one to two to three.*
> (Evelyn, 2).

In agreement with international research, staff at Living Well felt that these processes would mean correct processes would be followed thereby ensuring accountability and preventing the abuse of power within the organisation (Beetham, 1987; Blau & Meyer, 1971; Blau & Scott, 1962; Casey, 2004; Kallinikos, 2004; Matheson, 2000; Mouzelis, 1967; Olsen, 2005; Olsen, 2008). Consequently, reviews and projects were frequently utilised as a response to concerns about the nature and scope of service delivery as well as to implement strategic vision as Matt commented: "*within [Living Well] it is the way you get things done.*" (Matt, 2). Unfortunately, in practice strict adherence to these formal processes meant that planned service development was often slow, cumbersome,

and resource intensive, frequently failing to deliver on the promises of improved services for clients.

Organisational documents provide context, illuminate assumptions within an organisation and provide insights into organisational life (Chreim, 2005; Hartley, 1994; Tsoukas & Hatch, 2001). [135] Documents can also provide an analytical or historical reference point against which other accounts can be tested (Hartley, 1994). At Living Well, there were a large number of documents, which supported both service development and delivery including clinical guidelines, internal policy documents, meeting minutes, discussion documents, plans, reviews and project documents among others. In order to support and triangulate the data collected as part of interviews, meetings and minutes, formal service development documents including reviews, projects, business cases and strategic plans produced at Living Well between July 2002 and April 2006 were located and analysed. In total twenty-eight formal service development documents with relevance to adult mental health, were included within the analysis.[136] These documents captured a written record of formal service development activity at Living Well and provided links between the interview accounts of participants in this research and these planned activities.

Across Living Well, formal service development initiatives in the form of projects and reviews involved the assessment of some elements of a service's characteristics and outcomes based on predetermined criteria or goals acting as a form of evaluation (Alkin, 1990; Patton, 1982; Weiss, 1998a).[137] The aim of most formal service development activity at Living Well was to provide information or recommendations to inform choices about service development or delivery as evidenced in the analysis of project and review aims, objectives and recommendations.[138] More generally, the reasons for undertaking project, reviews or evaluations of programmes or services varied, usually

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[135] This was discussed in Chapter Four.

[136] It is important to note that only those documents that were located were included as part of this analysis. The researcher is aware of other project activity that took place during this time period, but the documents related to these could not be found.

[137] This was evident in the terms of reference of the project and review documents analysed as part of this research included in Appendix A.

[138] Appendix A provides a summary of project and review goals.

related to the intended uses of the project or review (Cox, 1990; Patton, 1982; Patton, 1984; Patton, 1990a; Rutman, 1984a; Weiss, 1990a; Weiss, 1998a; Weiss, Murphy-Graham, Petrosino, & Gandhi, 2008). Projects and reviews can also occur for other less explicit reasons such as responding to a situation, to support a particular viewpoint or provide justification for an intended course of action (Rutman, 1984a; Weiss, 1990a; Weiss, 1998a; Weiss et al., 2008). Jacob summarised his view of the broad range of formal service development activities undertaken at Living Well: "*all the reviews and projects are driven by what seems to be new problems, old problems worsened. A lot of them based around increased demand, new services, new treatments being possible, money being cut etc.*" (Jacob, 2).[139] The analysis of documents at Living Well revealed that projects, reviews and evaluations at Living Well were undertaken: to provide direction about aspects of a service that were working well; to indicate areas requiring improvement; to offer different interpretations of events; to ensure meaningful accountability around service provision and resource allocation; to facilitate critical thought with regard to service performance as well as to justify decision making.

The terms review, project and evaluations were used interchangeably to refer to formal service development activity at Living Well, as there was very little distinction between each of these service development activities. However, following analysis of the documents retrieved from Living Well slight differences were evident in their terms of reference, project activity, findings and nature of their recommendations. The formal service development activities at Living Well could be divided into the following categories:[140]

➤ Reviews: These activities were designed to describe and analyse current practice and service provision based on a predetermined set of criteria defined in the review's terms of reference or initial plan. Information was collected with regard to current activity in the area under focus, conclusions drawn about the quality of activity and recommendations made for changes to clinical practice or service development.

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[139] The main factors for planned service development are discussed further later in this chapter.
[140] A list of the project and review documents is provided in Appendix A.

Typically, reviews were focused on addressing problems or investigating concerns about the nature or efficiency of service delivery. They highlighted activity in the unit at the time of review and did not generally include an historical analysis or client needs analysis.

➢ Projects: While reviews were aimed at explaining the nature of a problem or issue, projects were more focused at finding and implementing solutions to problems. They could be delivery focused for instance changing aspects of a service or piloting an initiative such as the Watch House Project, which involved piloting a Ministry of Health initiative; or focused on exploring an issue or process such as the Best Use of Beds Project, which investigated ways to address barriers to clients moving between services. [141]

➢ Evaluations: Evaluations were rarely undertaken, however when an evaluation was undertaken this was in order to ascertain the efficacy of a pilot initiative and focused on assessing whether or not the pilot had achieved its original goals without creating risks or disruption to clinical service delivery.

➢ Strategic plans: Also among the formal change documents at Living Well were strategic plans. In contrast to projects, reviews and evaluations strategic plans provided a road map or framework that outlined future developments and directions for a service or area of clinical service delivery. [142]

As already noted, the main purpose of formal service development in the form of projects and reviews was to provide information upon which decisions about service delivery could be based. Projects and reviews occurred frequently at Living Well and while differing in their goals each project or review had clearly articulated processes and timelines for achieving their objectives outlined at the commencement of the process.

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[141] The Watch House project was discussed in Chapter Five. The Best Use of Beds project is discussed in greater detail later in this chapter, under the subheading of Outcomes from Planned Change.
[142] Strategic Plans were discussed as part of Chapter Six.

The next section provides an analysis of the processes involved in generating and undertaking projects and reviews as part of formal service development.

Generating Project Proposals and Ideas for Service Development

Projects and reviews involved planned processes with logical steps based on objective reasoning. Staff from across Living Well could generate ideas for service development and in order for an idea to be progressed beyond just a proposal to a project or review it required the support and sign off from the Senior Management Team. The mechanisms for generating ideas and gaining support for proposals did not always follow the prescribed processes and often involved the strategic use of relationships to engender support. This section explores the different ways that proposals for formal service development in the form of projects and reviews were generated at Living Well. In addition, the role of the Senior Management Team in supporting project or review proposals is discussed.

Across all formal service development initiatives there were typical components that provided formality to the processes and included: the existence of a project leader/sponsor; terms of reference for the project/review that outlined its goals; feedback mechanisms such as a communication strategy for clients, family/whanau and other stakeholder involvement; and the production of recommendations at the conclusion of the project. The analysis of service development documents found that despite these formal processes there was not one consistent template or process for undertaking a project or review. Carole's view illustrates the lack of consistency across project and review processes:

> *My impression is that there doesn't appear to be a uniform*
> *format or a uniform kind of set of expectations for any particular*
> *project. I think the two most important things are common sense*

and a sense of humour ... But in terms of actual templates and
expectations, I don't think that they are uniform, although I think
you could line them up aside each other and be able to tick key
milestones as being the same. (Carole, 2).

This meant that projects and reviews all differed in the nature of the processes undertaken. The lack of consistency allowed for flexibility in terms of how projects and reviews were undertaken. Project and review teams often developed intuitive processes based on the nature of the service development, their membership, service delivery pressures and the allocated timeframe.

At Living Well, service development initiatives could be generated at any level, but more typically, the ideas emerged from within the Senior Management Team or more specifically from the General Manager. They were generally discussed at the Senior Management Team meeting and then progressed from there. The General Manager expressed regret at the lack of project or review proposals that emerged from outside of the Senior Management Team stating: "*I'd like to think that ideas can come from anywhere. I don't believe they are encouraged significantly enough from the people who are working directly with service users.*" (Tom, 1). He saw this responsibility ultimately sitting with himself and the other members of the Senior Management Team facilitating and encouraging ideas and project proposals from other levels of the organisation. Cliff, a front-line nurse summarised his observations of the service development process including proposals which emerged at the top of the hierarchy as well as those that came from the level of clinical delivery:

I think some things they decide at a management level and it is
fed back down and people can make some comments and put
some ideas together and then feed it back and that is a process
that I have seen work. I have also seen ideas come from the
bottom, [clinicians] who say look we need to do this for
example in the Acute Inpatient Service and this would work

really well and push it up a way and so you know it goes up to the Executive Group in the Acute Inpatient Service who have a look at it and do their thing with it and feed it back. I have seen change work both ways I guess. (Cliff, 1).

As Cliff noted on the occasion when an idea was generated at the level of clinical delivery the process was for it to be presented by the clinician to the area's Unit Manager, their Clinical Executive Group, and then progressed up through the Service Manager to the Senior Management Team.

The Senior Management Team was crucial to the formal service development process at Living Well. All project and review proposals, as well as project plans and terms of reference, irrespective of where they came from, required the approval of this group. The Senior Management Team also had a role in monitoring and overseeing all service development initiatives with all the activity from planned projects and reviews reported to this group on a regular basis. Team members were also project sponsors and served on steering groups of projects. Consequently, participants felt that without approval from this group of professionals there could be little service development. Evelyn provided an example of the Project to Counter Discrimination. This project had proposed changing direction and required approval from the Senior Management Team to do so:

> *[We] put in a new project plan for the Countering Discrimination Group and it was then at that point it was kind of like well hang on [until the Senior Management Team sign it off]. But it is still kind of waiting, and in the meantime what happens is a bit, well, almost destructive, which is not probably the right word, but you get my drift. As you've got the teams there and you have people sitting in business meetings [reading the agenda] and they say okay quality improvement – yes, etc etc. Countering Discrimination and you know everybody sits*

and looks at each other and it is kind of like well no. And then,
they just sort of move on and that kind of undermines
countering discrimination. (Evelyn, 1).

Evelyn's view was that a lack of decision-making from the Senior Management Team had stalled the Countering Discrimination project. Staff did not want to act on the initiative without sign off from the Senior Management Team and the delay had undermined the project's validity across Living Well.

Eliza as one of the Consumer Advisors, was also frustrated by the slow process of obtaining approval for formal service development from the Senior Management Team and expressed exasperation about the delays involved in this process:

You know we have to put everything to [the Senior Management
Team] before we do anything. An example of this is advanced
directives[143] which we are working on at the moment and we
have to go to [the Senior Management Team] before we can do
anything and it takes time and [they] only have a specific
amount of time for each meeting and I don't know how they
prioritise what they deal with. (Eliza, 1).

As noted earlier Tom, as General Manager, had expressed regret at the frequency with which project proposals came from clinicians outside of the Senior Management Team. As Eliza's quote illustrates part of the reason for this was due to the slowness of approval for project and review proposals for new service development initiatives. These factors added to the reluctance of clinicians to submit ideas for service development within their area, instead they used informal processes to develop and

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[143] Advanced directives are defined under Right 7, Right to make an informed choice and give informed consent, in the Code of Health and Disability Services Consumers' Rights 1996. An advance directive enables a person to give an indication about the type of care they wish to receive in future treatment (Health & Disability Commissioner, 1996).

implement incremental service development within their smaller units removing the need to gain support from management hierarchy.

The process of obtaining the Senior Management Team's support for a service development initiative required the proposed change to align with the dominant value systems of this group of people. The Senior Management Team had its own ways of operating. At each meeting, the Operational Manager and General Manager allocated priority to the agenda items for discussion. For a project or review proposal to reach the top of the agenda, it consequently required support from these people. Participants felt that the likelihood of a formal service development initiative gaining support increased when relationships were strategically used (change agents) to get an initiative heard.

The complexity of elevating an idea for service development up the hierarchy meant that motivation and the original impetus for a proposal was often lost, as Geoff commented:

> *One of the issues I have as a Unit Manager, I am dealing directly with the people who are coming up with the issue and the solution, but then I deal with a Service Manager who then deals with another group so there are two or three stages ...the concern though is that some of those things that I should be following up I then hand up ... I'm presenting it to a Service Manager who has already got other issues and maybe doesn't share my concerns and is further removed from it.* (Geoff, 1).

Consequently, the ability of staff to navigate the organisation's hierarchy influenced the likelihood of change adoption within a certain area.

Chapter Two on archetype theory discussed that bureaucratic organisations including the professional bureaucracy are often criticised for depersonalising and limiting the opportunities for those working within these institutions to demonstrate innovation and creativity in their work (Beetham, 1987; Blau & Meyer, 1971; Blau & Scott, 1962;

Jaques, 1976, Kallinikos, 2004; Kohn, 1971; Mouzelis, 1967). Contrary to this, personal relationships were an integral part of the service development process at Living Well and staff had to show creativity and innovation in terms of getting their ideas heard and accepted by the Senior Management Team. Cliff commented that the main barrier to service development was: *"Getting enough support. Getting enough people to think that it was a good idea. So if you don't you can have the best intentions and unless you have some support to change it is never going to work."* (Cliff, 1). If a proposed project or review had the support of key people and was seen to be a priority amongst other competing agendas then it was more likely to gain approval. Professional relationships with members of the Senior Management Team also influenced topics for the agenda and the priority given to discussion and decision making at the Senior Management Team meetings. Jacob, also a member of the Senior Management Team, explained that alliances influenced the priority given to issues:

> *I think the key dyad is the Service Manager, Clinical Director responding to discussions around the [Senior Management] table, responding to pressures from their own service and these get batted around... So I think that the group I work with [the Senior Management Team] do generate these [project proposals] ideas and push them on.* (Jacob, 1).

Jacob's view was that generally individuals at a senior management level generated ideas for service development with projects then developed to justify and support the implementation of these ideas.

Concurring with the findings of Hinings, Brown and Greenwood (1991) the credibility of the person proposing a new service development initiative was very important. The ability of this person to engender support from those in leadership positions influenced the likelihood of success (Hinings, Brown, & Greenwood, 1991). While these people were not necessarily the decision-makers within the organisation, what they shared was an ability to translate the proposal into language that would engender support from those

at the top (Powell, Brock, & Hinings, 1999). Change agents were those individuals who were able to navigate the organisational hierarchy. This included having direct paths to people in positions of influence with the most ability to shape service development such as the General Manager and Operations Manager. Evelyn commented on her strategic use of change agents stating: "*doing [proposals] through the official channels there is a sense that they would be ignored anyway. There's more chance of getting something heard through informal channels*." (Evelyn, 2). Consumer Advisors were people who had direct links to the General Manager despite having very little actual decision making ability themselves; Cliff had used this mechanism on occasion and found it to be very effective:

> *In my opinion one of the things that in our service gets things done … is get the Consumer Advisor on our side, you know go and talk to them about it, because they seem to have much more … they have easy access to Management … they seem to be listened to quicker than any of us do*. (Cliff, 1).

In Cliff's experience, using strategic relationships had resulted in changes within his work area such as getting clearly displayed name badges for all staff. While seemingly trivial, trying to implement this initiative at a unit level had failed due to resource constraints and implications for other inpatient units across Living Well. The Acute Inpatient Executive Group had recommended drafting a formal project proposal and forwarding this to senior management for approval. Using the Consumer Advisor had short-circuited the process, as they had raised the issue directly with the General Manager, meaning it was addressed much sooner. Cliff explained that if this idea had followed the prescribed service development process it would have required a written project proposal, which would have needed to be escalated through the management hierarchy and then be considered alongside other priorities before gaining approval.

The longevity of service of those involved in the service development process also influenced which ideas were adopted due to the nature of long-standing relationships, a

point made by Evelyn: "*Because I think that [the General Manager] and [Operations Manager] have worked here for a long, long, long, long time and they know who they want to listen to and who they don't want to listen to*" (Evelyn, 1). Careful relationship management was therefore an important component influencing the likelihood of senior management's support for a service development initiative across Living Well.

A key feature in determining the archetype of an organisation is the relationship between the formal structures and systems of the organisation and its informal processes and value system (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999). The relationship between personalities and service development factors at a senior management level demonstrated that most formal service development initiatives reflected a top down approach to service development. Service development responded to triggers generated at the higher levels of the organisation rather than emerging out of clinical service delivery at the ground floor.[144] The importance of change agents and strategic relationships created a system within Living Well that was reliant on the personalities or relationships involved in the service development process. The slowness of the official processes meant that clinicians found alternate ways to secure project approval or at least to short cut this process.

This section has identified that Living Well had a formalised set of processes that governed formal service development. These processes reflected the formal bureaucratic model and emphasised a hierarchical approach to formal service development. Ideas for service development required approval from the Senior Management Team prior to the commencement of projects or reviews. The relationships of the individual proposing the initiative was crucial to its successful adoption and implementation. People with influence (change agents) were able to champion and secure support for proposed service development initiatives, but they could also co-opt processes to ensure that service development reflected their own agendas. The importance of strategic relationships created a system within Living Well that was reliant on the personalities or

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[144] The triggers for formal service development are discussed further later in this chapter.

relationships involved in the service development process. The slowness of the official processes meant that clinicians found alternate ways to secure project approval or at least to short cut this process including the use of change agents with strategic relationships and the ability to influence others.

The Need for Ongoing Service Development

Service development across all mental health services is perpetual with services constantly looking for ways to improve service delivery (Callaly & Minas, 2005). The purpose of this section is to explore the motivating factors that drove the need for ongoing formal service development at Living Well. This includes a discussion of the organisational factors and culture at Living Well that contributed to the belief that formal processes for planned service development would lead to improved service outcomes. Further, this section explores the relationship between Living Well's raison d'être, delivering responsive mental health services, and the need to provide a considered approach to service development.

The interpretive scheme of an organisation emerges from the values, beliefs and ideologies of its members (Bennett, 1997; Hall, 2002; Hinings & Greenwood, 1989). The culture of an organisation develops through the patterns of interaction across the organisation, the nature and location of power, as well as the ways in which day-to-day work is actually undertaken (Boje, 1991 Hinings & Greenwood, 1989; Pentland, 1999; Tsoukas & Hatch, 2001; Weick & Browning, 1986). The language of service development at Living Well included the terms service improvement, quality improvement and development. Across the interviews, participants conveyed the assumption that all change was positively motivated and that service development would result in better services. What resulted was a desire for service improvement and service development. Consequently, change in the form of service development was always on the organisation's agenda. As noted by Paul: "*it is a very complicated system [Living Well] and we undervalue the amount of change we are constantly are in.*" (Paul,

1). Paul's quote emphasises that service development was a normal part of life at Living Well with staff seemingly oblivious to the amount of service development that was occurring around them.

Continually striving to improve services through formal service development activities meant that there was always service development occurring and as a consequence a reluctance to pause for periods of consolidation. The need to be seen to be responsive to both internal and external pressures also meant that at times Living Well would rush into projects based on feelings that they should respond to a particular issue and ideas about what they could be doing differently; elements that were supported by Carole's experience of projects and reviews: "*My impression is that change happens here more because someone has an idea about something, rather than directly as a result of evaluation.*" (Carole, 2). The need to continually develop and refine service delivery often meant a lack of formal consideration of the quality and effectiveness of current services' abilities to meet clients' needs. This was evident in the project and review documents analysed as part of this research, where formal evaluation of current service delivery or an assessment of clients' need rarely occurred as part the project's processes.

Participants commented that at Living Well services were constantly working on projects to address issues that were perceived to be priorities, "on top" issues or in-vogue ideas meaning that other projects were sometimes abandoned midway through the process as new needs were identified and their service development proposals escalated. In the case of the initial interviews, participants identified the priorities for service development as including projects around Home Based Treatment and Single Point of Entry. By the third round of interviews, participants' focus had shifted to new projects including the establishment of a clozapine clinic[145], the Watch House Project[146] and developing partnerships with primary health care. The analysis of the review and

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[145] The Clozapine Clinic project was a clinician driven initiative, which saw the establishment of clinics to monitor clients using clozapine. This project is discussed further in Chapter Eight.

[146] The Watch House project was a Ministry of Health Driven project involving locating psychiatric nurses alongside police at their Watch House.

project documents demonstrated this shift in focus as project timeframes overlapped and essentially one project process superceded another.

Jacob explained that the changing nature of the delivery environment required the organisation to continually plan projects and adjust:

> *There is a wider process going on of [organisational] development and it is something that will never stop, I mean it is a continuous process and every area, every division has to keep looking at it all the time in response to what is changing around them.* (Jacob, 1).

Jacob's belief was that ongoing service development was necessary to remain current in terms of policy and funding frameworks as well as to be responsive to the changing needs of the community.

The Home Based Treatment Project was an example of a project proposal adopted as a response to pressure from clinicians who were struggling under the pressure of growing client acuity and demand for inpatient care. Geoff spoke about the genesis of this idea:

> *As I see it, the prime motivation was that our acute inpatient service is chronically over numbers. But as well as that there is the push to treat people in the least restrictive environment which is clearly a good thing and some other peripheral things that we are basically still connected around those. So that is where the idea came from is that we had pressure on our inpatient beds, the culture continues to change in the direction of looking after people in the most suitable environment for them as opposed to the institution. So there is the main genesis of the idea of need.* (Geoff, 2).

Cliff spoke similarly about the Home Based Treatment initiative saying that this idea had: "*been floating around for a long time … I think as the service has become more stressed and under more pressure then the need for that has kind of highlighted*" (Cliff, 2).[147] The Understanding Acute Demand Project was a project undertaken annually between 2003 and 2007 looking into the characteristics of a random sample of clients admitted to the inpatient unit. As both Geoff and Cliff stated, support for the idea for Home Based Treatment was due to an alignment with current values and popularity of the approach rather than an examination of the nature of acute care presented in reports like the Understand Acute Demand Project.

Another consequence of Living Well's need to remain responsive was that at times areas that were working well were subject to service development under the guise of service improvement and quality. Paul stated: "*It is almost like you have got to come up with a new project to do this year and what are you going to do in your area, and so you think there is an issue*" (Paul, 2). Paul felt this approach to problem solving questioned the efficacy of some projects as service goals changed each year. Carole also expressed concern about the validity of ongoing service development when she spoke about setting up a new triage and referral system for the Community Mental Health Teams:

> *I'm not sure how much benefit that is going to be for referrers, for clients because I think [the new process] was actually mainly set up to make it easier for referrers, and for the life of me I struggle with what the hell we are trying to do there. At the moment we flick a referral between [teams] when it comes to the wrong place, so the referrer doesn't have an issue with it. We just say oops that person lives in north, I'll give it to the north team. And I just give it to north. I don't go back to the doctor and say you have sent it to the wrong place we don't care.* (Carole, 1).

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[147] The Home Based Treatment Project will be discussed in greater detail in the section entitled Project Examples at the end of this chapter.

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Carole saw this service development initiative as simply formalising the processes that occurred anyway and consequently regarded the project as unnecessary.

Justifying decisions was another reason for service development at Living Well and meant that on occasion projects occurred for what appeared to be their own sake. Evelyn commented that often the rationale for formal service development processes was to justify already-made decisions: "*I think that they have arrived at an informed decision at the outset*" (Evelyn, 1) meaning that service development processes existed to reinforce decisions that had been made already.

In summary, Living Well's raison d'être was about the delivery of responsive mental health services. This key determinant of the organisation's archetype underpinned all aspects of Living Well's interpretive scheme including its approach to service development. Staff at Living Well accepted service development as a normal part of the culture of the organisation and were almost unaware of the extent of service development that was occurring around them. Projects and reviews were regarded as valid mechanisms for addressing service priorities across Living Well and consequently were rationalised as part of improving service delivery. The service development processes focused on resolving priority issues in line with the organisation's key values.

The Pace of Formal Change

As noted in previous chapters, mental health organisations are highly complex entities, involving multiple system factors both external and internal to the organisation including political agendas, policy demands, staffing and operational factors (Callaly & Minas, 2005; Karp & Helgø, 2008; Minas, 2005). Described as traditionally conservative organisations, they are generally slow to adapt, yet as described in the previous section are characterised by a culture of ongoing and abrupt change (O'Connor & Kotse, 2008). The following discussion addresses the pace of formal service

development at Living Well. It explores the slow pace of formal service development and the perceived lack of tangible outcomes that influenced the willingness of staff at Living Well to participate in these activities on an ongoing basis.

Irrespective of the amount of resource and effort expended in the process of developing any new practice within mental health services, its adoption and ongoing implementation can take many years, sometimes in excess of a decade (Panzono & Roth, 2006). It is consequently not surprising that staff became frustrated with the sometimes very slow pace of service development evident across all mental health services, and Living Well was no exception.

At Living Well, members of the organisation greeted a new project or review with enthusiasm. The initial engagement phase of the project typically involved consultation with various internal and external stakeholder groups including staff, unions, clients, family/whanau and other community providers. Despite this initial enthusiasm, participants felt that formal projects took an inordinate amount of time achieving very little of their original objectives. The reasons for slow progress of formal service development activities varied but included the importance of operational issues; changing priorities of organisational members; a lack of commitment to the original goals of the project; changes in staffing and leadership positions; lack of resourcing; the complexity of projects and resistance to the change itself. In addition, unanticipated events such as Ministry of Health directives; changes in policy; sentinel events and operational issues sometimes occurred during the course of reviews or projects making the original aims or goals no longer relevant, or of such importance.

At Living Well, project steering group members carefully developed the goals of projects and reviews, their terms of reference and timelines, outlining key tasks for completion as part of each project. Often, despite the best initial intentions, the motivations of those involved in a project or review waned as time progressed, and priorities shifted elsewhere in response to operational pressures and risk factors, displacing the original goals of the project. Jacob noted: "*it seems at times like progress*

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is glacial" (Jacob, 2). These factors contributed to a lack of momentum for formal service development at Living Well.

Successful service development is heavily dependent on the commitment and involvement of organisational members (Jaskyte & Dressler, 2005; Powell, Brock, & Hinings, 1999). Consequently, maintaining momentum is important to ongoing staff commitment. At Living Well, staff were very frustrated at the lack of pace of the existing service development processes and saw this as a barrier to improving and developing services across the organisation. Eliza and Geoff summarised their feelings with regard to this: "*[the] cogs work very, very slowly. I think they work really, really slowly.*" (Eliza, 2). "*There is an inherent frustration in there that often these things can take a long time. Quite a few of them peter out without getting anywhere.*" (Geoff, 2). The slow pace of service development also meant that by the time any solution or outcomes were identified the original problem had often changed into something entirely different, a view conveyed by Cliff:

> *I think we are good at the idea, how do we, what we need. We are good at that assessment part of it and coming out with what should be and that's where it kind of stalls… it can take a long, long time and I think that's part of the problem that quite often by the time that happens there is almost a need for another change.* (Cliff, 2).

Research indicates that interceding events can occur during project timeframes consequently displacing the original goals or intent of a review or project (Alkin, 1990; Weiss, 1984; Weiss, 1990a; Weiss, 1990b). This was a pattern observed at Living Well. Matt discussed the myriad of intervening factors that could occur during a project or review's timeframe, which either altered the goals of the project or essentially made it redundant including:

an interim review which suggests that maybe this isn't the way we need to look at going, there may be breakthrough research or a new kind of idea that comes from overseas which says no, no, we don't need to do it like... or no, here's another way that is better at doing what we were looking at, or what we were investing in. There are all sorts of potential reasons, you know change of government, change of emphasis in terms of where you want to focus on. (Matt, 2).

Paul also found that priorities as well as the professionals involved in projects changed:

I think there [are] changes we take little bits off you know and that well, that takes our mind off what we changed last time... Projects take a year or 18 months, and some two years. Usually the people have changed, people have moved on, the issues are different. (Paul, 2).

The lack of consistency in terms of personnel as well as changing priorities made maintaining project momentum very difficult.

A key problem with the role personalities played in service development at Living Well was that responsibility for action rested with these key individuals and when they left or had their attention directed elsewhere the service development initiative lost momentum. Eliza had recently been part of projects where key professionals had left stating that:

I think one thing that is really bad in the service is that there is limited feed over if someone leaves and then it is three to six months before someone gets appointed to take that role on or the role gets consumed by other things it sort of just gets left there on the shelf and no one knows really what to do with it. (Eliza, 1).

Carole also noted that even if one person in a service development pathway was away on leave this could undermine and delay the whole initiative:

> *It seems as though only one of those people in that food chain has to be on leave and the thing gets stopped so if the Unit Manager and an Acting Unit Manager isn't prepared to make a decision then nothing happens. Or if the Service Manager is on leave there seems to be no time for anybody else to cover off so nothing happens.* (Carole, 3)

Service development was therefore very much reliant on individuals, these individuals were deeply invested in the project and when absent the enthusiasm or passion for the initiative came second to other priorities such as clinical delivery.

As noted earlier in this chapter all projects required sign off and oversight from the Senior Management Team. Following the development of a project or review plan including their terms of reference, the Senior Management Team shifted the responsibility for monitoring the project or review to its steering group and they moved their focus to other priorities. The analysis of the minutes for the Senior Management Team detected this shift in responsibility to steering groups. While projects were typically on the Senior Management Team meeting's agenda at the start of the project period over time they dropped off the agenda. Project outcomes and discussion related to project recommendations also rarely occurred as part of this group's business. Both Paul and Evelyn believed that Living Well's priority-driven approach to service development meant that once new issues were transformed into projects the presenting issue was viewed as being dealt with, as Paul explained:

> *We deliver the project back to [the Senior Management Team] and say this is the outcome. Then monitoring them [the project] almost stops about how is that being implemented as normally*

the next projects have taken over ... So by the time the project is finished, it might have been superceded by another issue. Another project has started or something like that. (Paul, 2).

Paul's point was that as projects or reviews progressed they became less significant and therefore commitment from the Senior Management Team seemed to wane. This was a point also noted by Matt as he considered the number of pilot projects that halted without any explicit explanation:

Sometimes it appears as though there are certain projects which are instituted which seem to work quite well, but then they are just finished. And maybe [there are] lots of reasons for that which at my level I might not be privy to, but on the surface it often looks like "wow someone's doing something that's quite different", but people are getting you know their needs met and that, then all of a sudden it's like that project finished at the end of last year, so we are not doing it anymore. But we are not offering any alternatives for this group of people either. (Matt, 2).

Matt also highlighted the lack of direct involvement of clinicians in the activities and decision-making processes of the Senior Management Team reflecting the top down approach to service development, outlined earlier in this chapter.

A key component of successful archetype transformation is the alignment between proposed changes and the dominant values embedded in the interpretive scheme of the organisation (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999). Living Well was staffed by people from a variety of different clinical and management backgrounds. The different values and perspectives of all the players in the service development process resulted in a number of different ideological, clinical

and epidemiological perspectives, meaning that Living Well's interpretive scheme was similarly a plethora of different values and perspectives. Consequently ensuring that projects, evaluations and reviews had processes to consult and have input from a variety of viewpoints required significant time and resources delaying the service development decision-making process.

Clinical engagement and support for service development is critical (Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999; Denis et al., 1999). Staff resistance to service development is more likely to occur when they feel that change is imposed on them, especially in situations where there have been varying levels of commitment (Hinings, Brown, & Greenwood, 1991; Hinings & Greenwood, 1989). At Living Well, staff's disconnection from the decision-making processes at the Senior Management Team level meant at times they made up their own rationalisation for decision-making getting frustrated at a lack of information and results emerging from their participation in the formal service development processes.

The slow processes of formal service development also created anxiety for staff. The wait for the outcomes from projects, not knowing how the final results of the service development process would impact on them, placed additional stress on already stretched services and people as noted by Carole: "*from the ground it does seem that things take a huge amount of time and the period of time that people are in limbo is actually a really stressful time for those people*" (Carole, 1). Evelyn also commented on the sense of limbo created in the space between commencement of a planned service development process and the recommendations being announced or implemented: "*Everything kind of goes into abeyance because it is difficult for people who are being disestablished to maintain motivation; teams don't know who they're reporting to and all this sort of stuff and so things go in a standstill.*"(Evelyn, 1). As Evelyn noted at Living Well essentially all service development halted as areas waited for the outcomes from a project or review. This pattern was also evident in the analysis of agenda items and minutes from areas including the Acute Inpatient Service, Rehabilitation Service and the Community Mental Health Team's meeting. At times when formal projects or

reviews were occurring items related to quality initiatives such as streamlining documentation, reviewing triage processes or addressing staffing concerns disappeared from the agenda and minutes of these meetings as staff waited to see what would emerge from the conclusion of the project.

The slowness of projects and reviews at Living Well provides another example of the complex nature of the service development process within mental health services. Participants regarded projects and reviews as a way to remain responsive to changing priorities and trends in service delivery. Consequently, projects and reviews were frequently commenced and project structures put in place to address priority issues. However, the dynamic nature of the service delivery environment meant that needs changed quickly, new priorities were identified and projects and reviews developed which superceded existing project and review arrangements. The consequence of continually responding to these immediate operational, political and clinical needs meant that the Senior Management Team struggled to maintain oversight of projects and reviews occurring across Living Well. This resulted in frustration at the time taken to complete projects or reviews as well as at the lack of tangible outcomes, a topic that is discussed in greater depth in the following section.

Outcomes from Formal Change

Staff regarded formal service development such as projects or reviews as legitimate activities for service improvement and all those involved expected these to point the way towards constructive change. A defining characteristic of projects and reviews are that they are intended for use (Alkin, 1990; Cox, 1990; Patton, 1984; Patton, 1990c; Rossi, Lipsey, & Freeman, 2004; Weiss, 1998a; Worthen, 2001). This section explores the outcomes of projects and reviews that occurred at Living Well and provides a discussion of the barriers to successful project implementation within this context. Again the primacy of daily clinical and operational tasks was the central feature of the service development environment that limited the usefulness and priority given to

implementing project and review findings. This presented a tension in the organisation's interpretive scheme as it struggled to balance the need to plan services with responding to the primacy of clinical demands.

Professional bureaucracies like Living Well have composite interpretive schemes that attempt to balance the multiple and sometimes contradictory value systems embedded within the organisation (De La Luz Fernandez-Alles & Llamas-Sanche, 2008; Olsen, 2008). As already discussed, the environmental and political context within which a project or review is undertaken can constrain and limit the activities of those involved and ultimately the usefulness of the process (Alkin, 1990, Alkin & Taut, 2003; Christie, 2003; Patton, 1984). The utility of formal service development is linked to both the explicit and implicit reasons for undertaking the project or review in the first place. In addition, the characteristics of the personalities involved in the project or review process including the project manager and the sponsor/s or Service Manager, as well as the programme's context and the project or review activity itself all impact on its potential usefulness (Alkin, 1990; Alkin & Taut, 2003; Rossi, Lipsey, & Freeman, 2004). This leads to a system with multiple and sometimes contradictory processes which struggle to balance the different agendas, priorities and concerns of all those involved (Olsen, 2008; Powell, Brock, & Hinings, 1999).

At Living Well, organisational members measured the success of change initiatives by what they saw as the result; a service that was developed, a practice that was changed, a new process, or the disestablishment of a position or service. Participants regarded projects and reviews as rational processes, designed to achieve their stated purpose. They explained that the service development process needed to achieve something, there was meant to be a visible outcome. In the initial round of interviews, many participants reflected on the fact that they enjoyed participating in service development and change as Jacob noted concerning his involvement in service development: "*It is the part I most enjoy … the service development part is where I should be able to have some lasting influence, so therefore it is enjoyable*". (Jacob, 1). However, a sense of frustration quickly replaced the original enthusiasm directed at the slow pace of service

development and the perceived lack of outcomes that occurred as a result. These fluctuating positions demonstrate the complexity not just of the service development processes but also the relationships staff had with these.

As previously discussed, participants regarded the overall goals of any project or review at Living Well as having the best interests of clients at their centre and were about generating information that would improve processes or outcomes for clients. In this way, the goals of these activities aligned with the organisation's raison d'être. Archetype theorists stress that for successful archetype transformation the proposed change needs to echo the core values of the organisation (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989, 2003; Powell, Brock, & Hinings, 1999). Consequently, the alignment between the overall goals of projects and reviews at Living Well with its' raison d'être and interpretive scheme should have increased the likelihood of successful implementation of the service development initiative. In reality though, participants felt projects and reviews often achieved very little of their original objectives rather delaying positive service development and contributing to a general level of reticence and resentment towards any project and review activity:

> *They tend to just slow up processes. They tend to make the status quo just sort of carry on, just go on and nothing seems to get any better so you are all waiting for the project, and then nothing happens. So you have spent all that time in a holding pattern for the project to come and say something wonderful, and then it doesn't, or it does say something wonderful but nobody actually likes what it has said, so you are still in a holding pattern.* (Evelyn, 2).

As this quote from Evelyn captures, alongside the slowness of change people expressed frustration at the lack of results from projects and reviews and consequently their enthusiasm and willingness to participate in any type of service development initiative

diminished. Eliza expressed a similar level of frustration at the service development process: "*In all honesty I feel a lot of the time it is a waste of bloody time*" (Eliza, 2). Participants' disappointment at the lack of outcomes from formal service development meant that despite initial enthusiasm they had few expectations of these processes.

The lack of visible outcomes from formal service development was the normal experience of those involved in this research. The participants were able to list a number of projects which they had been part of that in their eyes had achieved very few of their recommendations. These included: Home Based Treatment, The Best Use of Beds Project, The Community Review, the Integration project, The Access and Responsiveness Project, the project to address Clients with High and Complex Needs, the Mental Health Standards Project. Evelyn spoke with reticence about these past projects that in her view had achieved very little:

> *I mean I suppose really my sense is that they are all big plans and big reviews and then nothing actually sort of happens or something different happens; because other constraints come in, like financial or personalities or something or the other.* (Evelyn, 2).

Evelyn's sentiments reflect the changing nature of the service delivery environment and the inability of projects and reviews to keep up with changing needs and priorities.

Participants' experiences of projects and reviews became part of Living Well's interpretive scheme. While participants wished to achieve the raison d'être by engaging in projects and reviews the subsequent lack of outcomes undermined the validity of these approaches as successful mechanisms for service development. Eliza further outlined her frustration with the project and review process:

> *Thinking about it I think one of the biggest disasters of this organisation …is that nothing happens and I get really pissed*

off and I think of the amount of time that is spent and the
amount of money that it costs to spend that time it is just a
waste of time and I have to admit that I am getting to the point
where I am starting to get very cynical and think well is it worth
putting all this effort into it because what is going to happen,
what is its flow on effect going to be 'cause it's not. (Eliza,1).

Eliza's frustration was typical of many and reflected a general uneasiness about the value of participating in any formal review or project as part of the service development and planning process because outcomes were not achieved.

As noted earlier in this chapter, those involved in projects were often distracted from their original objectives as emerging internal and external practice as well as policy issues changed the need for a project or the direction it should take. Carole saw this as being one of the major factors that influenced a project's momentum; that other issues took priority and consequently the original goal or impetus for the project became irrelevant:

I suspect that quite a few projects do run out of steam and fail
or, maybe fail is not the right word, but become so modified that
they may not adhere to the original vision that was being held
and I think that is quite a danger. (Carole, 2).

Carole said that in her experience it took a lot of courage to follow a project process and stay true to its original intention and purpose while still remaining responsive to the nature of Living Well's environment and the complexity of delivering mental health care. Paul noted when projects and reviews remained true to their original objectives they were more likely to achieve their original purpose, which did not necessarily equate with the findings of the project being implemented. He felt that staying true to their original goals may have reflected the projects lack of flexibility and ability to respond to the changing nature and priorities of the service delivery environment. This created real

challenges as staff balanced the twin imperatives of remaining true to project goals while adapting to the changing demands of the service delivery environment.

Successful service development requires the support and cooperation of organisational members, with power an important component within this (Hinings, Brown, & Greenwood, 1991). Powerful groups can undermine service development and maintain the status quo by intentionally resisting attempts to change (Denis et al., 1999; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). The slow pace of change and lack of outcomes of service development processes at Living Well sometimes resulted from intentional stalling or delaying tactics by project members or the Senior Management Team, who did not believe in the goals or direction of the project. Tom, the General Manager at Living Well, commented that at times he intentionally held up projects:

> *I think we end up procrastinating and sitting on things and not doing stuff, possibly because it is too hard, possibly because and I know from my position I've held up a few projects because I do not believe that they have the right evidence and I've become quite strong on evidence and information. And I'm not interested any longer in seeing things happen because someone thinks it is a good idea.* (Tom, 1).

Tom's view was that this process of procrastination essentially worked by allowing attention to be drawn to other projects enabling them to take priority. Other participants saw the Senior Management Team as intentionally stalling the service development process to filter decisions, in some cases slow down processes or to halt the momentum of a project meaning outcomes were not identified or implemented. Evelyn stated that she thought the primary role of the Senior Management Team was sometimes: "*to sort of sit in there and argue the toss and things*" (Evelyn, 2). She used an analogy of a woodchopper to explain her view of the prioritisation of formal service development by the Senior Management Team:

I kind of have this view that stuff goes into [the Senior Management Team], [which] is just this great big machine that comes out and it's just splattered everywhere. (laughter) you know like a wood chopper's machine, you know how they put the branch in....and the bits are sprayed and it's just somehow is just a machine that slows everything up. (Evelyn, 2).

The personalities of steering or working group members could also monopolise the project process. Tom had direct experience of this and discussed the difficulties he had faced when working with a very senior psychiatrist on the Community Review project:

If you remember [Adam Scott[148]], who was pretty detailed, anal and controlling, and tried to have quite a bit of control over the findings. So that was a wrestle...if I look at my personal experience of that, I just got so utterly pissed off with the Clinical Director of the day's controlling nature of the world. His inability to actually accept and that in fact he wanted to move in this direction and staff didn't. (Tom, 3).

Tom's view was that the involvement of this person had compromised the quality of the recommendations for the project. Evelyn also discussed that the reliability and validity of service development was affected by the priority given to personal opinion:

So that if we have got a project and it looks like this and it is done here in mental health and you've got say we have got ten staff from mental health do it and they come up with these recommendations, and you put exactly the same project in another District Health Board's mental health services, they might come up with different things because of the sort of

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[148] Pseudonym allocated to provide for confidentiality.

*personalities involved, how dominant somebody is, that sort of
stuff. It is very localised.* (Evelyn, 2).

Paul gave a couple of other project examples, including the Home Based Treatment
project and the introduction of a single point of entry for Child, Adolescent and Family
Services, where he believed personalities had overtaken the process stating:

*Areas are at risk of having a very driven person... [they]
believe it is going to fix the problems in [their] area by giving it
to another area who should be responsible. And so you have
very strong people dictating where things are going to go.
Dictating projects.* (Paul, 2).

He believed that the introduction of a single point of entry for the Child, Adolescent and
Family service was an example of how an individual's preference (the Clinical Director)
shaped the service development process:

*It was an idea of [Jerry's][149], you know. He said: "I want a
single base, and I want a single campus. Plus I want people to
come through the front door." So the whole project was driven
by him. Now, you would have a lot of people who would say all
the way along, well I don't agree with this from day one, but,
it's been [Jerry's] idea.   So the reality is that the
recommendations are going to be what [Jerry] wanted at the
start.* (Paul, 2).

The introduction of a single point of entry for the Child, Adolescent and Family Service
progressed irrespective of opposition from clinicians due to the authority and influence
of the Clinical Director who was in charge of the project. Paul's view was that at Living

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[149] Jerry is a pseudonym allocated to protect confidentiality.

Well personal viewpoints were often given more priority than clinical data and international research.

Another factor cited for the failure of projects or reviews to achieve any significant outcomes was their complexity. A number of participants noted that the majority of projects had broad stated goals such as improving access to services and in this respect were too complex to ever be achieved. Jacob reflected on an example of this: the Best Use of Beds Project which was a project to look at continuity of care across the entire mental health spectrum.[150] This project had robust processes; clear terms of reference; involved extensive consultation and engagement with stakeholder groups; the establishment of many working groups in an attempt to maximise clinical and client participation; as well as ensuring that the recommendations reflected evidence based solutions which could practically be applied across Living Well. Jacob explained:

> *[That] was a project that won't be repeated because of the way we went about it I think. But we involved all the possible stakeholders at an early stage... So we started out as a bottom up exercise which proved to be somewhat overwhelming really. Instead of starting out with small, key people who brainstormed the purpose of the whole project... it was simply an aspect of a whole wider issue and in fact it was actually a huge project that didn't have satisfactory outcomes because the scale of it was too big.* (Jacob, 2).

Despite the huge amount of time, planning and resources involved in the project, none of the recommendations were implemented and the problems related to services working together remained. Hinings, Brown and Greenwood (1991) would locate the failure of projects like the Best Use of Beds in the complexity of the tasks involved. They argue that following project commencement those invested in the project lose interest as they

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[150] Appendix A includes detail related to this project.

fail to see the connection between the tasks and the goals of the project (Hinings, Brown, & Greenwood, 1991).

The goals of the Best Use of Beds Project were very broad including: "*to investigate opportunities to provide a better service to patients with complex needs and to identify mechanisms to manage [Living Well]'s bed-state*" (Best Use of Beds Project Plan, 2003). The project involved giving consideration to promoting core values, implementing strategy and researching new programme opportunities. The scope of the project was across the entire breadth of Living Well, the recommendations of the project required services to work together, alter their intake processes and consider resource sharing. The scope of the project meant that no one service was ultimately responsible or invested in the implementation of its findings and the nature of the recommendations required levels of commitment that threatened to undermine service alignment and the autonomy of professionals working in these areas.[151] Hinings, Brown and Greenwood (1991) believe that another result of this type of project's complexity is the lack of explicit connection between the project or review and the organisation's interpretive scheme. This lack of connection results in a lack of commitment from those involved in the project or review's process, which was also the experience of those involved in the Best Use of Beds Project.

In summary, projects and reviews at Living Well occurred for all sorts of reasons and staff were enthusiastic about the potential outcomes for service delivery and client care. Projects and reviews at Living Well had robust processes with clear terms of reference, structures and timelines creating expectations amongst staff that outcomes would occur. However, as with many other aspects of planned service delivery despite the robustness of processes this did not ensure that these would be followed or guarantee successful outcomes. The lack of project outcomes is a symptom of the complexity of service development at Living Well. While project goals may have aligned with the raison d'être of the organisation, they failed to account for the multiple, competing pressures of

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[151] The role of organisational belonging, service alignment and professional autonomy was discussed in Chapter Five.

the service delivery environment. Across Living Well, staff had become frustrated at the lack of tangible outcomes from planned service development. There was not a single determinant for project success. Service development stalled because of the pressures of clinical service delivery, changing priorities, intentional procrastination, as well as project complexity. This prior experience had become a part of the value system of Living Well and an embedded part of its interpretive scheme influencing staff's willingness to participate in service development processes.

Function of Meetings in the Formal Service Development Process

Meetings form a part of the systems of an organisation and provide a mechanism for staff to come together and share understandings of service development initiatives (Hinings & Greenwood, 1989). They further provide a place where shared understandings of problems and solutions can be generated and contribute to the interpretive scheme of the organisation (Denis et al., 1999; Hinings, Brown, & Greenwood, 1991). At Living Well, participants placed considerable importance on the role of meetings in planned service development and more precisely in the project and review process. Meetings occurred on a regular basis for a variety of different reasons. Participants described routine meetings that happened on a weekly, fortnightly or monthly basis with the purpose to address operational issues; meetings that occurred as part of planned service development initiatives; as well as meetings higher up in the organisation's structure with oversight of strategy and decision-making. The purpose of this section is to highlight the importance of meetings in the planned project and review process and the role they play in creating resonance between service development and the organisation's interpretive scheme.

Meetings as part of planned service development fulfil an important role in terms of sense making for organisational members (Stensaker, Falkenberg, & Crønhaug, 2008). Stensaker, Falkenberg and Crønhaug (2008) studied service development at a large

Norwegian oil company. They found that meetings enabled participants in their study to process the proposed service development change through formulating and discussing their interpretations of the proposed action (Stensaker, Falkenberg, & Crønhaug, 2008). Through the process of discussing the proposed service development, participants were able to gain a better understanding of the changes and the reasons for implementation, resulting in greater commitment and motivation for the project (Stensaker, Falkenberg, & Crønhaug, 2008). The observation and analysis of planned service development at Living Well supports Stensaker, Falkenberg and Crønhaug's (2008) findings as all meetings irrespective of function, involved discussion and the sharing of ideas about how to develop services and improve clinical service delivery facilitating new understandings of proposed service development. An example of this was evident in the Rehabilitation Executive meetings that occurred on a fortnightly basis. These meetings provided an opportunity for the representative units, teams and professional groupings to share information about events and activity in their areas and in response, the Service Manager and/or Clinical Director provided an update on issues that they believed might influence service delivery from an organisation wide perspective.

Analysis of data collected from the Community Executive meetings, revealed the large quantity of side conversations both related and not related to the agenda. The members of the meeting rarely met and only ever came together at both this and the Community Quality meeting.[152] Many of them had similar levels of experience and had worked alongside each other in past roles and used the less structured component of the meeting to catch up on each other's news, share views about service delivery and discuss planned service development initiatives. Some of the side conversations involved discussion between three members about how a recent audit went within one of the teams, discussion around how individual units were managing client acuity, waiting lists, organising staff cover and swaps between units, implications of changes to service delivery and recording processes around managing clients who had been trespassed from services.

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[152] See Appendix B for the schedule of meetings attended as part of this research.

The process of dialogue at both meetings discussed above, generated new ideas for practice in some areas and helped to make sense of planned service development; in the Rehabilitation Service, this included the proposed change to service configuration and in the Community Executive meeting discussion centred on the Clinical Governance Strategy.[153] These meetings also enabled the professional groups represented to discuss how service development initiatives aligned with their values and those of the organisation. This process either generated support or firmed up opposition to the proposed initiative. An example of this occurred at the Community Executive meeting held on 21 February 2007, where discussion centred on the process of moving psychiatric registrars around units to cover gaps created by the resignation of a number of psychiatrists. Concern was expressed by some staff members about what this would mean in terms of continuity of care and potential gaps in service provision. The Clinical Director responded to these concerns and acknowledged that the process was not going to be easy. However, as the discussion progressed teams indicated their willingness to work with each other to support the proposal. This process enabled staff to articulate their concerns, discuss the potential implications of the change and then come to a position supporting the proposed initiative.

Participants in this research were initially emphatic that meetings were the source of service development decision-making. However, as participants reflected on their project and review experience and their attendance at meetings it was felt that meetings did not actually serve as a location for this type of decision-making. Often meetings involved discussion of new service development ideas, but these typically had their origins elsewhere. Participants noted that decisions related to projects and reviews actually occurred in less formal settings other than a project meeting. These included conversations in corridors, discussions by phone or emails. Cliff commented on the significance of the work that occurred outside of meetings:

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[153] The Clinical Governance Strategy was released by the General Manager and aimed to refocus the management structure around clinical governance and involved the removal of the Unit Manager role. The proposal for change is the central discussion feature of Chapter Nine.

> *Lots of these things are done informally, you know they gather*
> *support on an informal level, it's like any idea for change*
> *doesn't start off as, you know it starts off on an informal level,*
> *[it] doesn't very often start at a meeting, at a formal meeting.*
> *You know a lot of work is done before it even gets to that kind of*
> *stage.* (Cliff, 2).

Cliff's comments point to the importance of preparation prior to meetings and the development of strategic relationships in order to secure support and commitment for service development, activities that occurred outside of the set structure and systems of the organisation. Consequently, the informal processes that formed part of Living Well's interpretive scheme informed service development decision-making rather than the formal prescribed systems of the organisation.

Executive and Quality Groups met regularly across the organisation with established processes to address planned service development.[154] Working groups were established alongside each of the Executive Groups to focus on tasks generated from discussion at these meetings. Their purpose was to explore an issue and come up with potential solutions, essentially operating like mini-project groups. The Executive Groups then acted as steering groups who provided oversight and feedback to the working groups. The working groups generally included a mix of clinicians and other representatives involved in the front line delivery of client care. An example of this was a working group that was established out of discussion at the Rehabilitation Executive meeting focused on the reconfiguration of the Inpatient Rehabilitation Ward including the responsibility for clinical care. The working group included: psychiatric, nursing, allied health, consumer, family/whanau and Maori representation. The group undertook tasks delegated by the Rehabilitation Executive Group and reported back to them on a monthly basis.

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[154] See Appendix B for the schedule of meetings attended as part of this research.

Working groups and Executive Groups were not effective ways for progressing planned service development because they could only generate recommendations for service development. Consequently, service development initiatives did not frequently progress beyond the proposal stage. The example of the Inpatient Rehabilitation Ward's reconfiguration outlined above provides evidence of the lack of effective decision-making power within both the working group and Executive Group. Any decisions relating to changing the service structure, focus or the nature of service delivery needed approval from the Senior Management Team. Therefore, both groups were only able to generate ideas and project progress was delayed awaiting senior management approval. The experience of the Inpatient Rehabilitation Ward's reconfiguration demonstrates how the formal systems and structures of the organisation created barriers to service development. Despite alignment and support from members of the Rehabilitation Service, the hierarchical processes of the organisation hampered service development by slowing the process.

In summary, meetings were part of a sense making process for staff, as they gained an understanding of key issues and shared knowledge about proposed service development. Meetings also facilitated discussion around how service development aligned with the different value systems of professional groups, creating support or generating opposition to a proposed initiative. Meetings are therefore a core part of planned service development pathways. Terms of reference, meeting agendas and minutes created expectations for staff about what should and should not occur, as well as the frequency, membership and purpose of each group. Despite these clear processes, the main function of planned service development meetings at Living Well was around the sharing and discussion of ideas rather than the generation and allocation of tasks, project monitoring or implementation. Project or review tasks occurred outside of the meeting process and were reliant on people in positions of influence in terms of progressing key items. The next section discusses the impact of the availability of resources on formal service development.

Resource Implications for Formal Service Development

As already detailed staff at Living Well experienced high levels of frustration with regard to the lack of implemented outcomes from formal service development. Archetype theory purports that successful archetype transformation including service development involves weighing the constraints of the external environment alongside the organisation's interpretive scheme as well as the institution's capability to fully embrace and implement the result (Hinings & Greenwood, 1989). Resourcing is an environmental factor that can influence the success of service development. This section aims to explore the relationship between resourcing and the outcomes of formal service development initiatives at Living Well. Staff's view of the role of the funder as part of the planned service development process is examined as well as whether the consideration of resource implications was included as a routine part of the project and review process.

As already noted, formal service development including projects and reviews are resource intensive; they take time, cost money and occur within the context of ongoing service delivery. The inputs involved in projects and reviews include staff time, administration costs including the preparation of project documents, and other sundry resources, not to mention the costs of implementing recommendations. Project managers and sponsors face continual pressure to undertake projects and reviews quickly, cheaply, with minimal interference to service delivery, while still producing outcomes of a high quality (Alkin, 1990; King, 2003). It is not the intent of this thesis to explore the adequacy of resourcing and funding levels at Living Well, rather to show that resourcing was an important factor when developing and implementing new service development initiatives. Interestingly, participants did not feel that funding was a significant issue for current service delivery within Living Well, rather it was seen as a barrier to the successful development and implementation of new service initiatives. The lack of resources to implement project and review recommendations influenced service planning and had implications for the robustness of service development, with very few resources dedicated to problem solving.

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Weiss (1984) found that funders were so engaged with planning and developing new projects or reviews that they had little time to consider how to develop and implement existing service and project recommendations. Participants in this study linked the lack of resources dedicated to project and review implementation with the perception that the funding arm of the District Health Board was not open to proposals from Living Well due to potential funding and resource implications.

When Living Well was considering a new service development initiative, it often required bridging funding in order to enable the new service to establish itself prior to the old service closing. Paul explained that bridging funding enabled a more seamless process to service delivery as a new service could be established and services transitioned without significant implications for the continuity of care for clients:

> *So there's gaps in our system that we need to actually get some funding for. The problem is that you almost need bridging funding to start those while you are doing what you're doing because you can't just stop and close down beds in order to start the others unless you've got both systems running for a period of time and I don't feel that Funding and Planning or the Ministry [of Health] are happy with the bridging finance so you can run two systems and then you know you have one up and running so you can stop the other.* (Paul, 1).

Paul's view was that bridging finance was actually not a realistic option and hence service development proposals that required this type of funding did not progress past the development stage.

Funding allocation processes and the contracting methods meant that managers at Living Well were unable to shift costs and resources from one area to another, as this did not fulfil the details of funding requirements. Consequently, all projects and reviews

that recommended new services or significantly altering existing services required approval from the funder in order for successful implementation.

The consideration of the resource implications of formal change, including the financial and staffing costs of implementing recommendations, generally occurred at the end of a project. As the previous chapters have discussed at Living Well there was ongoing tension between management roles and priorities, including funding, accountability and policy with the primacy clinician's allocated to their professional values of clinical expertise, autonomy and peer review. This tension played out in the project and review process as each party assumed that they both shared the same priorities and values. The Senior Management Team assumed that project members would scope out the feasibility of proposed solutions as part of the project plan. However, the primary concern for those involved in projects was that the goals supported their professional values; for example nurses were concerned with improving the quality and nature of the clinical engagement from a nursing perspective. This meant that, in general, project participants saw implementing best practice solutions that aligned with their professional values as being their key concern and that resource demands were the responsibility of those in senior management roles at meetings like the Senior Management Team meeting. These results are consistent with those of other studies and suggest that professional values dictate the nature and quality of professionals' work rather than administrative and managerial controls including resource allocation (Powell, Brock, & Hinings, 1999; Mueller, Harvey, & Howorth, 2003; Olsen, 2008). This was also evident in the goals and recommendations of projects and reviews that were analysed as part of this study. These frequently reflected best practice ideals based on professional values rather than consideration of what was actually achievable in the current resource environment. An example of this is the Improving the Patient Journey Project (2004) with the goal to "*To identify the individualised care needs of 12 patients with chronic and severe mental illness who are in [Rehabilitation] clinic in order to facilitate their reintegration into the community*". The tasks and recommendations of the project were based on professional values of providing the best possible support and outcomes for these clients

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and those involved in the project had assumed that funding would be forthcoming to implement the recommendations.

The contradictory views of management and project participants represented a lack of role clarity around who was responsible for placing resource parameters around projects and reviews and meant that despite formal processes it was difficult to control all elements of the project. Consequently, as part of the haste and subsequent enthusiasm of starting a new project or review at Living Well the implications of planned service development initiatives were frequently overlooked.

Service development research stresses that consultation should occur with decision-makers and funders as part of the initial engagement phase of a project or review (Rutman, 1984a; Weiss, 1984; Weiss, 1998a, Worthen, 2001). Consultation should include discussion about what outcomes are actually feasible to ensure that these are possible given the organisational and political context (Rutman, 1984a; Weiss, 1984; Weiss, 1998a, Worthen, 2001). While Living Well had meetings with the funders on a regular basis and engaged with them about potential resource issues, this process was fraught with politics and risk including those mentioned earlier in relation to the stage of the electoral cycle as well as the need for the funder to ensure value for money. These meetings rarely resulted in additional funding as evident in the lack of funding to support the outcomes from the Improving the Patient Journey Project.[155]

Failing to consider the resource implications for service development meant that sometimes project or review goals were unrealistic and unachievable. Both Eliza and Geoff felt that adequate resources were a critical factor in ensuring projects succeed. Eliza believed that engaging the funder early in this process was essential:

> *I think there needs to be more talking amongst people before*
> *you get to that point of having a big meeting and then having*

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[155] The Improving the Patient Journey Project is discussed in more detail later in this section. Information about the project is also contained within Appendix A.

> *funding and planning saying we don't agree with it... Because to me if funding and planning is not on board, why do we bother? You know because if funding and planning is not there, well we are not going to achieve anything.* (Eliza, 2).

Even when the funders were involved in all aspects of project development, this did not guarantee the availability of resources as was the case with the Home Based Treatment Initiative,[156] which involved a member of the funding team as part of the Steering Group. Cliff spoke about the lack of consideration of resource demands with regard to this project:

> *We work in reality, I mean we are stretched now, not only funding wise, staffing wise, facility wise and to make something like that work which is a really good idea you are going to take experienced staff away ... as you can't put brand new people in a job like that. So it is kind of yeah good, sounds fantastic, but in reality we work in here, we know you know you take 20 staff out of this service who are all really experienced people, it is not going to work.* (Cliff, 1).

Cliff felt that the Steering Group had not fully considered the resourcing implications of Home Based Treatment, stating that if this proceeded it would place further staffing demands on the already stretched Acute Inpatient Service.

A further example of the lack of funding available to meet clinical service development initiatives was a project entitled Improving the Patient's Journey.[157] This project was developed to look into the care and treatment of people with severe and enduring mental illness in response to the number of clients who were currently in inpatient beds, who, it was believed, would be better cared for within the community. As noted earlier,

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[156] Appendix A contains details related to the Home Based Treatment project including project goals and summary recommendations.

[157] Appendix A provides information about this project's project goals and summary recommendations.

clinicians felt that if resources were made available in the community to care for this group then they could be discharged, freeing up much needed acute inpatient beds and improving client quality of life.

Two research participants, Paul and Cliff, noted that statutory mental health services such as Living Well were the only providers who had no choice but to accept clients. While admitting all clients who required treatment was seen as a strength of District Health Board services, a lack of treatment options further along the care continuum meant clients became stuck at certain points within this. Participants commented that NGOs were not prepared to accept clients with severe and enduring mental illness due to their inability to appropriately respond to the complexity of their needs. Yet, the funding arm of the District Health Board was unprepared to allocate packages of funding around these clients despite clinicians at Living Well collating significant evidence outlining the sort of care that was required. The packages of care appeared to align with the strategic priorities of the Ministry of Health such as the recovery framework, but did not align with funding criteria administered by District Health Boards. Paul explained what happened following their assessment of client need:

> *We had these assessments done at the front line, so that when somebody came in the rehab service, we knew what their journey was going to be and where they were heading at the other end, like discharge planning at the start and all these things that we are told we have to do. We then took it to [the funder]. We said... this is what these people need to get out of hospital and they [the funder] didn't know what to do with it... They said well we can't provide half of this and we are not providing full packages of care any longer or individual funding agreements so we can't meet all these needs. But we're [staff at Living Well] saying this person is in an inpatient bed and this doesn't meet a recovery vision and all these other things that you [the funder] are telling us that we have to meet,*

> *and yet we can't move a person on because we can't meet these*
> *needs. However a) Funding and Planning didn't have anywhere*
> *for them to go at the other end when we did, even with all the*
> *assessment that we have done and b) they then said well even if*
> *they did, even though they had given us some sort of, I believe,*
> *a commitment at the start to help us out in reducing the beds,*
> *they said you can't change bed prices into [staffing] prices.*
> (Paul, 2).

The project looking into the needs of clients with high and complex needs had been resource intensive and involved what the Service Manager believed was a robust project and assessment process. In the end it was not adopted because the funder had not considered the resource implications despite their early engagement in the process. The formal process for service development had not improved the likelihood of ensuring positive outcomes and processes outside of the project's span of control influenced the outcome.

In summary, the availability of resources to implement project or review findings is an important factor to consider at the outset of the service development process. At Living Well, this was a task frequently overlooked meaning that at times the original goals and objectives of planned service development were never actually achievable. It was important that clarity was sought around resource availability and that where necessary the funder engaged early. However, even when 'correct' or 'proper' processes were followed, where the funder was involved in the project from the outset and/or the initiative had the support of the General Manager, this did not mean that the project or review findings would be implemented. There was also a lack of role clarity between management and project participants over whose responsibility it was to consider the resource implications with each assuming that the other would address this.

Project Examples

As discussed throughout this chapter resonating with the key tenets of archetype change, projects within Living Well needed to align with the interpretive scheme, meaning that any proposed change required clear goals, committed leadership as well as support from the main professional groups affected by the change (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). This needed to be balanced alongside the systems and structures of the organisation including the competing resources, operational and risk management demands (Brock, 2006; Brock, Powel,l & Hinings, 2007; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). All of these factors created a complex environment where project success was unpredictable and formal processes did not ensure successful outcomes.

As part of document analysis for this research projects and reviews undertaken at Living Well between July 2002 and April 2006 were located. These included internal reviews, projects, businesses cases and strategic plans that had relevance to adult mental health. This information was tabulated and then thematically analysed to provide insight into the role these activities played in service development. Twenty-eight documents were located. The information related to these projects is included in Appendix A. The following three project examples: Single Point of Entry; Home Based Treatment; and Improving the Patient's Journey; serve to illustrate the different experiences of planned service development at Living Well. They highlight the difficulties of planned service development and identify factors that contributed to successful outcomes as part of this. Each of the projects examines elements of Living Well's interpretive scheme, as well as its relationship with the formal structures and systems.

In the first round of interviews in early 2006, participants had spoken very enthusiastically about three new projects Single Point of Entry (SPOE); Home Based Treatment and Improving the Patient Journey, which were developed out of the Priorities for Action strategic goals developed at a strategic planning day in 2005 and

were expected to be implemented by the end of 2006.[158] The third round of interviews occurred in April 2007 approximately one year after the first. Over the intervening period only one of these projects, SPOE had proceeded as planned and a number of the participants identified the project as being a key success over the previous 12 months. Home Based Treatment had simply fallen off the agenda and was not discussed unless raised by the researcher. Improving the Patient Journey had involved a comprehensive process of analysing client need through adapting the Camberwell Assessment of Need[159] to the Aotearoa New Zealand context. Packages of care were identified for each of these clients and then presented to the funder for consideration. Unfortunately, as discussed earlier in this chapter, the funder had declined these packages of care and at the time of the third round of interviews all 12 clients included as part of this project remained inpatients at Living Well.

Single Point of Entry (SPOE) Project

The SPOE project emerged in May 2005 from the Access and Responsiveness project, which was part of the Priorities for Action. The project aimed at streamlining referral and triage processes for Community Mental Health Services to reduce duplication of tasks and speed up the process of clinical assessment. Jacob succinctly described the SPOE project as a system where:

> *All the referrals that go to Adult Community Teams come into an office … that has got a fax and a computer and about three staff and all the referrals are examined and triaged and more information is sought by phone if necessary and sent to the right team and that's reduced the waiting times from about six weeks to about three weeks in those teams.* (Jacob, 3).

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[158] The Priorities for Action were strategic goals that the Senior Management Team had identified at a planning day in 2004. These were discussed in Chapter Six.
[159] The Camberwell Assessment of Need is a comprehensive needs assessment tool designed to assist with the care and treatment of clients with severe and enduring mental illness (Phelan, Slade, Thornicroft, Dunn, Holloway, Wykes, Strathdee, Loftus, McCrone, Hayward, 1995). It has proven validity and reliability (Phelan et al).

The aim of the initial project was to "*to ensure consistent access and provision of service to all new and existing clients of [Living Well] and immediate access to information/triage 24 hours per day*" (SPOE Project Plan, 2005). The project presented two options that would meet the requirements of the project aims which are included as part of Appendix A. The Senior Management Team approved the first of these options, which included making front of offices changes to the process of triage and delivery. A Project Manager was appointed to implement the project, resourcing was made available and the project implemented.

Participants felt that having one person responsible for the implementation of the project and the commitment from senior management to resource this was critical to SPOE's success:

> *It just was given increased emphasis and that last bit that it needed which was the focus of somebody to come in there and say "right-e-o this is what we are going to do and that was fairly well defined for single point of entry, we added that last bit of human endeavour actually even of just employing somebody to get in there and do it, and hire people, find computers and find a room and you know when a problem came up solve it and actually we went from a committee to a couple of individuals basically, to say "right-e-o, you know we have done the consultation so now let's do it" as the doing part is hard to do by committee. I mean you need to finally get down and say let's get on with it.* (Geoff, 3).

While Evelyn thought the SPOE was successful in the main she felt that with any change in service delivery not all people, in this case the Crisis Team, were happy about the implications of this for their workload and saw it as duplicating services: "*People are singing its praises, but some people aren't like [the Crisis Team] staff aren't,*

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because they think that they are getting just pulled into single point of entry to all the jobs anyway." (Evelyn, 3). Evelyn's quote suggests that the Crisis Team were reluctant to embrace SPOE due to the threat to their current ways of working as well as potential workload ramifications. This view is supported by the work of archetype theorists who suggest that professionals working in organisations like Living Well may greet any new projects with suspicion and as a threat to their professional autonomy (Denis et al., 1999; Hinings, Brown, & Greenwood, 1991; Olsen, 2008).

Despite Evelyn's concerns regarding the Crisis Team's acceptance of SPOE, in terms of analysing archetype transformation, the SPOE project fulfilled many of the criteria required to ensure successful adoption of the project. It was relatively simple, it had clear processes outlined to achieve its objectives and had the support and commitment of senior management. While it had a steering group, the Project Manager undertook most of the work and the steering group was just required to provide oversight to the process reducing the factors involved in implementation. The project also aligned with the dominant views of the interpretive scheme as it aimed to improve the responsiveness of the organisation by streamlining intake processes.

Home Based Treatment

The Home Based Treatment project was set up to consider alternatives to inpatient admission in order to reduce the demand placed on the Acute Inpatient Service (Home Based Treatment project proposal, 2005).[160] Home based treatment was greeted with much enthusiasm by staff, clients and family/whanau when the idea was first raised. This support was in response to the operational issues of unsustainable levels of demand for Acute Inpatient Services. However, participants did not regard the project as a success and no changes to service development had occurred as a result.

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[160] Details related to the project are provided in Appendix A.

When the project first commenced it had general support from everyone across the organisation (it aligned with the interpretive scheme) as well the commitment and resourcing required from the systems and structure of the organisation. The Senior Management Team mandated the project, it was allocated resources to establish project groups, a Project Manager was given responsibility for the project and senior Acute Inpatient Unit staff were sent overseas to look at programmes. As time progressed the project stalled, the issues related to acute demand continued and other more pressing issues took priority. The explanations for the lack of progress were related to the cost and resource demands of the proposal, which were seen to be unjustifiable. The resource implications, plus a lack of clear project goals and insufficient evidence to support the initial expectations that this type of initiative would lead to reduced demand for inpatient beds combined to ultimately lead to the project's demise a view conveyed by Jacob:

> *Some people were keen to import a model from the UK and other places but as time went on it became clear this was very expensive, required a lot more workforce, and we could probably do it a lot, in a way that was more cognisant of local needs*. (Jacob, 3).

Participants were asked to reflect on why they felt that one project had succeeded where this one had not and what they felt were the main factors that influenced this. One of the key factors cited with regard to the Home Based Treatment project was that the person leading it did not have the ability to maintain general support and enthusiasm for the project. The credibility of the person leading service development and their ability to engender support from affected staff as well as their connection with the interpretive scheme influences the success of service development (Hinings, Brown, & Greenwood, 1991). Without this connection staff fail to see the benefits of a project and become distracted by other more pressing concerns involved in service delivery (Hinings, Brown, & Greenwood, 1991). Evelyn felt that this had been a factor with Home Based Treatment commenting: "*I can't help thinking that the face didn't fit that was promoting*

it, and that person, yeah I think that the person that promoted it, was sort of a problem because the style sort of just turns people off." (Evelyn, 3). Paul was cynical about Home Based Treatment as he noted that those involved had a pre-existing agenda about implementing this type of initiative commenting that:

> *The two people went [to look at UK examples] were committed to it before they went, so they were only going to see the rosy side to it before they went. They've came back and said this is going to cure all our acute demand, this home based treatment… we are hanging our hats on this is going to stop acute demand. And no one has actually evaluated the people that are getting those admissions, and where they live, what they are like, and do they have family support, and those sorts of things, before we even start the project. Yet we are into phase two of the project and we are asking for the FTE [positions] to fund it and no one has shown me an environmental scan. So I mean it's doomed before it starts.* (Paul, 2).

The complexity of the project was also cited as a reason for its failure. The proposed service was resource intensive requiring the establishment of an entirely new service, a site to provide this from, and 24 hour staffing. It was also unclear to many people how home based treatment would actually reduce the demand for acute services. This is another example of what Hinings, Brown and Greenwood term the "*operational gap between the concept and the actuality*" with the absence of a clear project plan enabling general support for the project at the start (Hinings, Brown, & Greenwood, 1991, p.387). In the case of the Home Based Treatment project, while many participants supported the idea initially they lost interest as they became aware of all that would be required to implement it, as Carole explained:

> *One of the problems with Home Based Treatment, for sure, was for me and I think a number of others, there wasn't a clear identification of the problem and a clear marrying up of the solution to the problem. So it was an absolutely fine idea but in order to solve the problem which they said was overcrowding in [the Acute Inpatient Service] that actually was a mismatch so I think that was a barrier, resourcing is clearly another one and ... a lack of clarity about what they were on about.* (Carole, 3).

Tom had expressed reservations about the idea from its inception, but understood the need to consider all alternatives to address the concerns presented by acute care. However, for Tom the resource demand and lack of evidence to support the success of this type of initiative meant that the project was unsustainable when considered alongside other priorities:

> *We began to look at priorities and you know the case that was being put forward was for an investment of another 1.5 – 2 million dollars of staffing for something that hadn't persuaded the planner and funder and myself was actually going to deliver the outcomes that it was intended to which was to reduce acute inpatient beds. And we began to get evidence from Britain which started to say well look this thing called home based treatment is a little over cooked.* (Tom, 3).

Often projects in mental health are revisited cyclically in response to need, fashion and ideology (Aarons et al., 2011; Braden Johnson, 1990; Butler, 1993; Callaly & Minas, 2005; Falloon & Fadden, 1993a; Hoge & Howenstine, 1997; Keating, 1998; Norcross, Garofalo, & Koocher, 2006; Panzono & Roth, 2006; Reay, 2010). This was evident with regard to participants' views of the Home Based Treatment Project as many of the participants felt this project had not halted entirely. The problems presented by the acuity of clients and the lack of available beds in the Acute Inpatient Service meant that

this was still an area requiring further exploration. Many participants felt that it was being revisited under a new guise of alternatives to inpatient admission, which interestingly enough, was the stated initial goal of the Home Based Treatment Project. As Geoff commented:

> *We had one crack at it, probably bit of more than we could chew I think would be a fair summary and so we are now coming back to having another look at it and this time it is community teams based or more community services based. And we are looking at a more manageable model to start and grow from rather than go into it from the deep end straight away.* (Geoff, 3).

Jacob spoke about developing a model of addressing alternatives to inpatient admission that resulted from improving aspects of the existing system stating: *"I suspect that the answers are going to lie in improving many different areas rather than putting a new model in"* (Jacob, 3). Tom described this as shifting focus from a programme solution to looking at defining the nature of the actual problem:

> *We prefer to talk about alternatives to acute inpatient admission and we've got a number of those elements and have had them in place for a number of years; the Community Intensive Care Team, crisis respite. We haven't got them well integrated and we haven't got a central point of control for those things.* (Tom, 3).

Despite addressing a number of the factors influencing archetype transformation, the Home Based Treatment Project did not proceed reflecting the complex nature of service development at Living Well as unpredictable elements influenced the project's success. The project was complex and resource intensive. The person leading the project was unable to demonstrate the ongoing relevance to clinicians meaning the project did not

sustain the ongoing support of staff. Yet the idea of providing alternatives to inpatient care aligned with the raison d'être of the organisation meaning the topic never fully disappeared from Living Well's service development agenda.

Improving the Patient's Journey

Another project that participants spoke about at length about was the Improving the Patient's Journey Project, which emerged from the Inpatient Bed Management Priority for Action.[161] This project explored packages of care for clients with particularly high and complex mental health needs. These clients remained long-term inpatients at Living Well due to a lack of community services willing and able to meet their complex needs.

A discussion of the main reasons for project failure was provided earlier in this chapter. This was linked with the lack of alignment between clinical and funding ideologies as well as resource availability. Paul felt that this had flow on consequences when asking staff to participate in service development. As Paul explained there was a lot of staff, client and family/whanau involvement in the project process, but in the end despite providing comprehensive information about what clients required the funding arm of the District Health Board refused to accept the findings:

> *We did a whole lot of family interviews we interviewed the consumer, the family. Spent a lot of time putting huge packages of care around these people about what their needs were. Sent them to Funding and Planning saying this is what this person needs to live out in the community, and they were saying we are not funding individual packages of care you have to use existing NGO providers. Well the existing NGO providers couldn't take these people that's why they are in here for one or two years or more, so that is frustrating.* (Paul, 1).

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[161] The priorities for action were discussed in Chapter Six.

This experience had left staff cynical about undertaking clinical evaluations as part of projects and jaded about the ability to bring about change within a system that seemed unwilling to facilitate this process.

In summary, archetype theory provides a heuristic framework for understanding service development. It stresses that for successful archetype transformation there needs to be alignment between the proposed change, the organisation's interpretive scheme as well as its systems and structures (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). The organisation's relationship with the environment is another factor in the service development process (Bhargava & Sinha, 2001; Robbins & Barnwell, 2002). These projects provide examples of the different ways Living Well undertook formal service development. Each project had different priorities and expectations attached to them. Their processes differed, as did the factors influencing their success or failure. They highlight the unpredictability and complexity of the formal service development process and the subsequent difficulty of undertaking service development in this environment.

Conclusion

The purpose of this chapter has been to explain the process of formal service development at Living Well. This has been undertaken through a discussion of the process, pace and outcomes of reviews and projects that were commenced at Living Well between July 2002 and April 2006. The discussion centred on the relationship between the systems and structures of the organisation, its interpretive scheme and raison d'être. This involved exploration of the role of resource demands, the lack of pace, outcomes and barriers to service development. The findings in this chapter served to highlight that while formal service development in the form of reviews and projects frequently occurred at Living Well, they did not always result in successful service development.

The process of formal service development through planned projects and reviews at Living Well was typical of the characteristics of bureaucratic organisations. This type of change was characterised by adherence to set processes outlined in project plans, aims and objectives, as well as reporting frameworks and structures. At Living Well, formal service development in the form of projects and reviews were regarded by staff as the most legitimate and appropriate mechanisms to address concerns about service delivery and to investigate options for future service development.

The nature of service delivery within Living Well was driven by the raison d'être of the organisation, meaning that informal processes embedded within Living Well's interpretive scheme dominated any attempt to plan service development. These factors included the ability to provide responsive mental health services including operational concerns and clinical issues such as the acuity of mental illness, over-crowding, lack of staffing and risk minimisation. When clinicians at Living Well saw the practical benefits of a proposed initiative they were more than willing to participate. This was evident in the successful implementation of the Clozapine Clinic and Watch House Project. Managers also struggled with facilitating staff involvement in the service development process, not wanting to take clinicians away from service delivery yet still wishing to ensure meaningful input.

The process of exploring service development opportunities was ongoing at Living Well under the rubic of continually improving and streamlining services as well as ensuring efficiency and accountability. While robust frameworks existed for formal service development pathways, there was a lack of clear, written criteria to assess which initiatives were adopted and which were discarded. Alongside this, the absence of a strong administrative or managerial framework to allocate tasks or take responsibility for overseeing service development increased the likelihood of strong personalities as well as professional groupings dominating service development. These results corroborate the findings of Denis et al., (1999) and Hinings, Brown and Greenwood (1991) as personal preference became the criterion for assessment.

The findings explored in this chapter confirm that the interpretive scheme of Living Well was in a continual state of flux allocating different priority to different values and concerns at any point in time. Environmental concerns including funding constraints also played a role in service development. Consequently, the complexity and unpredictability involved in service development created further uncertainty for those wishing to plan the nature and scope of mental health services.

The following chapter provides another perspective on service development at Living Well, focusing on the role of informal factors such as clinical participation, clinical reflection, resistance and leadership as part of this process.

Chapter Eight: Informal Processes Shaping Service Development

Introduction

The previous two chapters have addressed formal service development pathways at Living Well including the roles played by national policies, internal strategy as well as projects and reviews. The result of these formal service development pathways at Living Well was often frustration at the slow pace of change and a lack of tangible outcomes. This chapter further explores the informal processes that contributed to developing and implementing service development at Living Well.

Informal service development pathways involve unplanned responses to: day-to-day operational concerns; immediate requests for services; responding to clinical demand or clinical reflection. Clinician involvement in service development is a central concern of this chapter, the chapter begins by providing some examples of clinically driven service development. This is followed by a discussion of the difficulties of engaging clinical participation in service development. The adjustments to clinical practice and service delivery that occur spontaneously in response to clinical demand and reflection are then analysed. The chapter also considers some of the barriers to service development including the origins and functions of resistance as well as the ability of certain professional groups to co-opt service development in their own interests. The chapter concludes by considering the role of leadership in service development.

Clinically Driven Projects

Clinical support for service development was crucial to any form of service development at Living Well. As a key stakeholder group, ideas for service development rarely proceeded beyond the discussion stage if they did not align with the values of

clinicians. The most celebrated service development initiatives at Living Well were those that had high levels of clinical support and involvement across the development and implementation processes.[162] The purpose of this section is to discuss clinically driven service development initiatives at Living Well.

Archetype theorists believe the key to organisational change lies consistently in the alignment between an organisation's interpretive scheme underpinned by the raison d'être, and its formal structure. In contrast, Panzono and Roth (2006) reviewed 85 projects across mental health services in the United States and found that it was impossible to predict the likelihood of a clinical or service development initiative's adoption. The service development process at Living Well was certainly not straightforward needing to take into account the plurality of viewpoints within mental health services; different societal values; government policy; accountability demands; resource constraints and a lack of consensus around what constituted effective evidence based practice.

Participants in the third round of interviews identified what had been the most successful service development initiatives at Living Well over the preceding 12 months. Projects highlighted as being successful included:

- The Watch House project;[163]
- Methadone Establishment Clinics;
- Aftercare services;
- A nursing recruitment position;
- Clozapine Clinic.

These projects had emerged in response to operational issues, clinical demand and Ministry of Health requirements and had not been mentioned in earlier interviews. The projects presented pragmatic solutions to issues that affected clinical care and improved service delivery without creating additional burdens for clinicians. They were either clinically initiated or had high levels of clinical involvement throughout. Clinicians saw

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[162] These were the projects that interview and meeting participants reported on positively.
[163] The Watchhouse Project was discussed in Chapter Six and was implemented initially as a Ministry of Health pilot project and then adapted by clinicians to meet the needs of clients.

value in the projects and understood the benefits for their clients and themselves. Clinicians came up with the projects that supported and improved the current delivery of services directly to clients. The projects aligned with clinical values and were consequently driven and supported by clinicians.

All of the participants identified the introduction of a Clozapine Clinic as one of the most successful achievements at Living Well over the past 12 months. The development of the Clinic had provided a simple resource solution to case management for clients prescribed the drug Clozapine to manage their mental illness.[164] The idea for a Clozapine Clinic had emerged as an operational issue created by the pressures placed on the Community Mental Health Teams and Case Managers who continued to manage clients prescribed clozapine. Paul said the impetus for the initiative came from clinicians as:

> *We started off with only two or three people on Clozapine we now have 480 on Clozapine. We can't discharge those people because of the risk of leucopoenia and it's a specialist only charted drug so they have got to stay in our system. It has been quite a successful drug in that they are actually very well, but they have to stay in the system.* (Paul, 3).

Jacob explained that due to the nature of Clozapine and the risk of leucopoenia[165] psychiatrists needed to review these clients on a regular basis. He further outlined that this group of clients did not need the intense level of case management that was provided by the Community Mental Health Teams: "*They don't need to be under our services anymore and we suspect there could be 150 [clients] we could get off the traditional case management model. So that frees up five Case Managers*" (Jacob, 3). Jacob said that the creation of the Clinic meant reallocating a number of clients previously managed as part of the Community Mental Health Team to the Clozapine

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[164] Clozapine is an anti-psychotic drug used in the treatment of psychosis such as schizophrenia and schizoaffective disorder.

[165] Leucopoenia is a decrease in white blood cells, which placed clients at increased risk of infection.

Clinic, freeing up case management slots for other clients. These clients were then followed up: "*on a plan every six months and have a review, so they are not case managed on a daily basis just on a clinic review and we check their drugs regularly.*" (Paul, 3). The establishment of the Clinic had reduced some of the demand on clinical workloads while still meeting client needs. Clinicians saw value for both clients and their teams in establishing the clinic and consequently they supported project implementation.

In summary, gaining support from clinicians as the dominant group at Living Well was crucial to successfully implementing any service development initiative. The projects which participants identified as having been the most successful had been generated or adapted in response to clinical concerns about service delivery. In order to ensure successful outcomes in terms of service development the nature of the initiative needed to align with clinical values and not pose a threat to the expertise of clinicians. As discussed earlier management and other non-clinical staff managed formal service development as gaining meaningful clinical input into service development was very difficult. Yet when ideas emerged from within clinical practice and were seen to be of practical value to clinicians and their clients, then, clinicians were willing to embrace being part of the process even if this placed additional workload pressures on them as they could see the initiative's long-term value. Unfortunately, as discussed in Chapter Seven, ideas for service development that resulted in projects or reviews rarely emerged from the level of clinical staff and often lacked alignment with clinical values.

Clinical Involvement in Service Development

As noted in the previous section clinical engagement in any type of service development activity increased the likelihood of successful implementation and meant that proposed changes to service delivery reflect the reality of clinical service provision. Chapter Five discussed that at Living Well the professional value system of clinicians encompassed an ethic of care, as well as autonomy, ethical practice and peer review. These values underpinned service delivery and consequently any proposed service development

initiative needed to build on the expertise of clinicians and take into account the consequent flow on impact of making changes to the delivery of mental health services. The purpose of this section is to explore the difficulties of engaging clinicians in the process of service development alongside the demands of service delivery.

Chapter Two introduced Greenwood and Hinings' (1989, 1996) idea that levels of commitment influenced service development outcomes. These levels relate the degree of staff acceptance of a proposed service development with the likelihood that it will be successfully implemented (Greenwood & Hinings, 1996; Hinings & Greenwood 1989). In the first level of commitment, staff are viewed as being satisfied with the way services are currently delivered and see no need to change preferring instead to maintain the status quo (Greenwood & Hinings, 1996; Hinings & Greenwood 1989). The second level of commitment occurs when staff do not express an opinion about either the current situation or a proposed change, often resulting in the service development initiative being implemented anyway (Greenwood & Hinings, 1996; Hinings & Greenwood 1989). The third level, competitive commitment, involves some members of the organisation supporting the change and others opposing it (Greenwood & Hinings, 1996; Hinings & Greenwood 1989). In this situation, a stalemate often occurs and the change does not proceed. The final level relates to staff being against the proposed change and preferring an alternative solution known as reformative commitment (Greenwood & Hinings, 1996; Hinings & Greenwood 1989). While useful in explaining the interaction between staff's value systems and the implementation of new service development initiatives, Living Well's diffuse power structure[166] meant that information was filtered and reinterpreted many times over-complicating the process of gaining staff commitment to service development. Additionally, Greenwood and Hinings' discussion about levels of commitment fails to acknowledge the difficulty related to engaging with clinicians in order to enable meaningful contribution as part of the service development process. It further does not address how to manage the complexities of the different

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[166] Living Well's functional structure was hierarchical whereas the diffuse power structure was embedded within the organisation's symbolic structure as discussed in Chapter Five.

power relationships embodied within this system, which is explored throughout this chapter.

As discussed earlier in this thesis at Living Well while different professional value systems informed each professional grouping, working as multidisciplinary teams enabled the sharing of values, including the organisation's raison d'être of delivering responsive mental health services and an ethic of care, across professions. Living Well's interpretive scheme was very important to the process of service development as Cliff noted: "*[an idea for service development] has got to be supported, because if people support it, it is more likely to happen*" (Cliff, 1). Through a process of negotiation, the dominant values of each of the groups within the organisation came together to inform which service development initiatives were adopted and which simply fell by the wayside. Staff recounted stories about how things should work and what had worked well in the past as part of the service development process. Paul spoke about the value of historical knowledge saying:

> *We have a box full of projects we have done in the last 20 years that is as high as the hills … and I suppose like me if you are here long enough you say I've seen that one done before that one doesn't work, we've tried that, we did that way back then and this was the problem. It basically relies on people's knowledge within the system … rather than any outcome.* (Paul, 1).

The priority assigned to clinical delivery drove service development, however only proposals that aligned with the interpretive scheme would get clinical support and proceed past the ideas stage.

Implementation research talks about the benefits of clinician involvement in service development and links this with the increased likelihood of an initiative being successfully implemented (Aarons et al., 2011; Callaly & Minas, 2005; Gkeredakis et

al., 2011). Clinician involvement in the service development process enables changes to services delivery to be negotiated so that they are practically achievable, acceptable and sustainable; meaning they are realistic and do not disrupt clinical expertise and the ability to make decisions with and for clients (Callaly & Minas, 2005; Aarons et al., 2011). Pathways through treatment are ultimately the responsibility of clinicians and it was the perception of staff working at Living Well that clients trusted staff to place their best interest at the forefront of decision-making in order to achieve positive outcomes as Evelyn commented: "*we are here for the consumers. We are here for their benefit! That is what we are here for.*" (Evelyn, 1). Consequently, clinical involvement was an important part of service development.

In agreement with the findings of Powell, Brock and Hinings (1999) service development processes at Living Well attempted to ensure democratic and collegial mechanisms were in place to prioritise the views of staff. The reliance on professional expertise to deliver services also created the expectation amongst staff that any service development initiative would involve consultation and engagement with them in order to ensure that services were responsive and reflected professional and ethical values. However, the process of ensuring meaningful engagement was not straightforward as noted in Matt's discussion of stakeholder, including clinical, input into service development:

> *We tend to look at a large group of what seems to be key stakeholders, and so populations or persons that are regarded as having some kind of interest in a particular project or whatever the case may be, are normally invited or asked if they could find some representative to be part of the specific project. And I think it is kind of trying to cover all the bases really, trying to make sure that all perspectives are considered and no significant perspective is left out or there isn't room for someone to speak on that perspective's behalf... It's quite complex isn't it? The whole idea of getting a group of people*

together to work on a particular thing, because everyone has their own way of seeing it and often it is at odds with other people who have an equally big interest in what's going on. And I guess you are trying to carve out some kind of consensus amongst the group and sometimes that can happen naturally, other times it's a lot more difficult. (Matt, 2).

Matt's past experience had shown that any service development decision-making process which relied on representative input had the potential to become a long, protracted process often with little agreement on future service development directions.

A key finding of this research is that service development at Living Well had few clearly articulated parameters determining when a service development initiative would be adopted or rejected. Written processes were in existence and professionals could describe the pathways to gain approval for service development, although participants could not identify any specific framework for analysis to determine which ideas were adopted and implemented and which were not. Staff had the expectation that service development at Living Well would follow the formal processes laid out in policies. Consequently, when the formal processes for service development were not followed staff were puzzled and could not understand what actually informed this process. Eliza commented: *"I think something happens, but I don't know how it happens someone comes up with what seems like a good idea"* (Eliza, 1). Eliza's view was that the process of service development decision-making was confusing and did not reflect a considered process of needs analysis or forward planning. Instead of following formal pathways Living Well's service development processes often reflected the patterns of other professional bureaucracies caught in a trap between following rational bureaucratic processes, facilitating professional autonomy and responding to the needs of both internal and external environmental factors (Olsen, 2008; Powell, Brock, & Hinings, 1999). Consequently, no single theory was able to explain the intricacies and complexities of managing an organisation like Living Well (Gkeredakis et al., 2011; Olsen, 2005). It is therefore not surprising that clinicians struggled to understand the process of service development and

found it difficult to justify devoting their time and commitment towards participation in an uncertain process that may or not be successful.

The priority given to clinical delivery and the competing demands already placed on clinical time meant that at Living Well clinical input into the service development process was difficult to achieve. Clinicians struggled to place priority on attending service development planning meetings and undertaking the tasks required of being a member of a project group alongside dealing with the complexity of delivering services to clients with mental illness, Cliff commented: *"we don't talk about it [service development] much at a ward level because we are busy doing our job."* (Cliff, 1). Evelyn elaborated on this point capturing the frustration that clinicians experienced as they tried to balance managing clinical delivery alongside service development:

> *Most people's core job is just hard out, isn't it nowadays, they are just absolutely hard out. So any project stuff is just half-hearted. It's like shit, I've got that meeting at 2pm, You kind of go along, you're not prepared, haven't had a minute to think about it since you last went to it.* (Evelyn, 2).

As outlined by Evelyn, many clinicians saw involvement in service development as an additional 'burden' on top of their already overstretched workload and rarely had the time to devote to it.

All participants understood the importance of having clinical input as part of the service development process at Living Well. As noted above, staff regarded participation in service development an additional imposition on clinical time and consequently left managers and other non-clinical staff who had previously held clinical roles to represent their views and advocate on behalf of clients. Service development processes often occurred behind the scenes to minimise the impact on clinical practice. This meant that managers, project managers, and others who had a service development component to their job description undertook the investigation, planning and approval for service

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development projects in a manner that had the least impact on clinical practice. Further, it left the important issues of clinical buy-in until the implementation stage, when it is too late. Using non-clinical staff to undertake service development activities lessened the workload burden on clinicians. Yet, the lack of direct clinical involvement across all stages of the service development process failed to acknowledge the sometimes conflicting priorities of managers with a focus on accountability and efficiency outcomes with those of clinicians who prioritised responsiveness, an ethic of care, clinical expertise, autonomy and peer review.

Tempering clinical participation in service development is concern that changes to service delivery could have hidden motives and result in harmful consequences for clients (Callaly & Dinesh, 2005). For example in 2002 a project entitled the Consideration of Issues at Family Mental Health Service at Living Well was set up in response to staff concerns about clinical role clarity and improving client access to the service. The outcomes from this project actually laid the foundations for the disestablishment of the service just two years later.[167] The eventual closure of the service was not the goal of clinicians in asking for the initial review and the outcome was consequently unexpected.

Clinicians did not always feel that management held clients' interests at the forefront of their decision-making. Staff wished to ensure that services were delivered that improved outcomes for clients and saw themselves as the experts in this regard as discussed by Matt:

> *From a nursing perspective that's really the basis of what we do, it's all around justifying it in terms of your practice is improved and therefore people are getting a better deal, they are getting better care, those are the sorts of things.* (Matt, 1).

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[167] Appendix A contains details related to both projects undertaken in relation to the Family Mental Health Service.

As a result of the perceived tension between clinical and management priorities, clinicians engaged in service development processes with reluctance in order to preserve the values embedded in their value system and improve the outcomes for their clients.[168]

Managers and clinicians across Living Well struggled with how best to ensure meaningful clinical input. The General Manager believed that one way to gain staff support for a new service development initiative was to keep everyone fully informed of what was occurring and to ensure that no information was a surprise. Tom provided an example that involved meeting with union and professional groupings prior to adopting a change in terms of the role and functions of Clinical Directors noting: *"If you get to them on the front foot, like we did last week with the review, it can stymie any real negative approach which is when they think "you're hiding something from us"* (Tom, 3).[169] Matt also referred to the need for open communication as part of any service development process:

> *I think it is very important that what we do and the way that we do things can be seen without it looking like we are just covering things up or hiding things. The bottom line is that the [service development] process is going to influence the way that [clients] receive care in some shape or form so we have to be mindful not to commit the errors that we have in the past.* (Matt, 3).

Matt's view was that there was a need for transparency in service development and delivery to ensure responsiveness and accountability. While value systems can be deeply entrenched, the consultation and communication processes described above are mechanisms for gaining alignment between the vision of those undertaking service development and other key stakeholders (Brock, Powell, & Hinings, 2007). Through a process of communication and consultation, shared understandings of the problems and

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[168] The reluctance of clinicians to participate in formal service development processes is discussed in greater depth in Chapter Seven.
[169] Despite this approach, clinicians were still strongly opposed to the proposal.

priorities of the organisation can be created; thus, helping to provide justification for the need to alter services delivery creating opportunities for change (Brock, 2006; Brock, Powell, & Hinings, 2007; Denis et al., 1999; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999).

Evelyn also spoke about the need to contextualise decision-making for staff, stating that if staff became aware of all the factors influencing a decision there may be a greater appreciation for the end result:

> *I often wonder if sometimes there is not enough information about things, people that know the information, people that make all the decisions they kind of know all the information and stuff like that? But it is other people that could well have input that don't actually understand the full information and implications.* (Evelyn, 1).

She discussed this as being difficult to achieve as clinicians received so much information on a daily basis that being able to prioritise information processing was difficult. Jacob suggested that in order to gain greater clinical input and commitment to service development that a proportion of clinical time needed to be set aside to focus on these wider issues: *"If we can allow people to have more of their professional time devoted to it [service development] you would probably have a better outcome."* (Jacob, 1). Jacob's suggestion was deemed unrealistic and unachievable by management, as it required additional staffing resources in a system already struggling to maintain a full complement of staff. Jacob's and Evelyn's views emphasise one of the many contradictions within service development at Living Well, that while clinical buy-in to service development was a key barrier to effective service planning and development; resource, time and workload constraints made clinical participation and implementing sustained service development even more difficult.

The reality of ongoing service provision at Living Well, the acuity of clients and the clinical demands across the service meant that clinical engagement was difficult to achieve and sustain. A clinical workload was therefore a barrier to effectively participating in service development and change. Paul reflected that ideally there should be clinical engagement and consultation with a number of groups in the community but the reality was that pressure and priority was instead given to operational and clinical issues, he stated: "*the barrier to that is we never get the time to do that, never ever get the time to do all that*" (Paul,1). Paul's view was that the formal project processes were actually unrealistic ideals in the context of delivering mental health services.

Participatory or collaborative processes are one method for gaining greater commitment and receptiveness within a formal change process. This enables those directly involved with a programme to have direct input into the project's or review's processes and provides a mechanism for those coordinating the project/review to feed back interim findings as the process progresses (Aarons et al., 2011; Conner, 1984; Gkeredakis et al., 2011; Karp & Helgø, 2008; Patton, 1990a; Patton, 1982; Weiss, 1998b). Clinical staff involvement is said to facilitate greater commitment to the process and consequently to the implementation of the project's findings (Aarons, et al., 2011; Gkeredakis et al., 2011; Karp & Helgø, 2008; Patton, 1982; Patton, 1990a; Weiss, 1998b). Participants in this research believed that much more time and effort was required to engage staff from Living Well in the service development process so that they could see the value of their participation and the achievement of meaningful outcomes as a result. Carole's quote sums up her thoughts on resourcing clinicians to participate in service development:

> *Staff are incredibly busy on ground floor, however if we resource them somehow to be able to have a bit of space to reflect on so how can we work better .... I'm sure they would come up with some fabulous ideas so it is about giving the time and the leadership and the ability to kind of nut those sort of things through and that is certainly something I would like to see some investment in. (Carole, 3).*

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Carole mentions the need to give clinicians time away from their clinical activities to enable their participation in service development. Project and review processes at Living Well made some allowances for the pressures of balancing a clinical caseload alongside participating in service development initiatives by having a project manager to coordinate project activities. Having a dedicated project manager meant that this person had the time and ability to undertake the project tasks as Geoff stated: "*you've got to have someone whose main energy is directed at that project, rather than somebody else who is trying to do another job and do that*" (Geoff, 2). However, the organisation still struggled to find balance between clinician participation in projects and reviews and the daily demands of delivering a mental health service.

Jacob saw the role of a project manager as being critical to enabling clinicians to participate in projects stating that the appointment of a project manager: "*acknowledges the fact that everybody else who should contribute is busy enough without having to arrange meetings, find venues, get things typed and it's got to reside with one person.*" (Jacob, 2). This was generally only done at the start of a project process and it was rare that following the conclusion of a project that a person would be appointed to oversee the implementation of recommendations. Paul noted from a senior management perspective: "*we read it and then no-one gets the job of implementing the changes or the evaluation or do something about the evaluation, so it just basically sits there in the end*" (Paul, 2). Paul believed that this was another factor contributing to a lack of outcomes from projects and reviews as without someone to drive the process other issues took priority.

Despite the appointment of project managers at the start of projects, there was still the expectation that there would be input from the various stakeholder groups including staff throughout the entire project or review process. In addition to attending project meetings, project/review committees or working group members were expected to complete project tasks, and be a representative for their clinical area or professional grouping acting as a link for their stakeholder reference groups and keeping them up to

date with the change process, consulting and gaining feedback as required. Participants felt that clinical representation was just tokenism and decisions were made at the senior management level irrespective of their participation in the project or review process and their ability to get feedback from others, Carole commented that:

> *They kind of say that [gaining input from others] is a load of rubbish or whatever will be will be, what's the point in us saying anything because someone's already decided. So I think it is an incredibly difficult management task to give people enough information that doesn't overwhelm them but does give them a clear kind of picture of why we've got to where we've got.* (Carole, 1).

This belief contributed to staff's reluctance to participate in the project process as not only did they fail to see tangible outcomes because of planned service development, but also they believed decisions related to the scope and nature of service delivery actually occurred elsewhere.

There were examples of projects at Living Well that had involved intensive staff, client, family/whanau and other stakeholder involvement including the Best Use of Beds Project, the Community Review and the Priorities for Action projects. Despite receiving initial support from all levels of the organisation these projects were resource intensive and had taken significant periods of time (a year to three years in some cases) to produce recommendations which either had not been adopted by the Senior Management Team or failed to be implemented as a result of resourcing and other operational constraints such as staffing or clinical demand.

This section reinforces the complex and often contradictory relationship between formal approaches to service development and the reality of service delivery within mental health services. A critical tension embedded in Living Well's interpretive scheme is whether to prioritise planned service development or if being responsive to daily clinical

and operational demands represents the ideal approach to service delivery. Clinicians and managers both struggled to reconcile this tension, with responses to service development caught in the conflict between the two. Balancing the need to have clinical input in planned projects and reviews was difficult to achieve yet was crucial to successful project and review processes. Additionally clinical participation in formal service development activities increased the likelihood that the findings from these processes would align with clinical values and therefore be practically implemented to improve outcomes for clients with mental illness.

Clinical Reflection and Quality Initiatives

In contrast to the difficulty of gaining clinical input into planned service development activities, service development generated by informal pathways including clinical reflection, clinical audit and quality initiatives occurred frequently across Living Well resulting in both minor and major adjustments to clinical service delivery. Examples of these changes were evident in the minute analysis, meeting observation and participant interviews. They happened as part of everyday clinical practice without the need to engage in the formal mechanisms required to secure approval for a new service development or programme proposals. They addressed matters such as streamlining clinical practices including duty systems or medication review processes; administrative issues such as filing systems; or dealing with aspects of the physical environment for example the installation of slip mats in showers. The purpose of this section is to highlight the ease with which such changes occurred across Living Well, with new processes and initiatives put in place quickly and easily in order to improve clinicians' ability to provide responsive services to clients.

Changes to service delivery in response to informal processes occurred regularly across Living Well as barriers to effective service delivery were identified by staff as part of their everyday practice. In addition, clinicians continually evaluated and altered their practice based on their clinical background, frameworks, individual client outcomes and clinical audit requirements. As Matt said: "*I think that people reflect on what they are*

doing in terms of are they doing a good job. Are they able to meet the needs of the people that they are working with?" (Matt, 2). Practice was then adjusted and new systems put in place to meet these clinical needs. Other changes, related to the everyday operation of each clinical unit, were implemented quickly and easily without the need to escalate issues up through the organisation's hierarchy. Examples of these practices were evident in the minute analysis of the Acute Inpatient Service and the Community Mental Health Team Meeting and included altering the location and content of resuscitation trolleys, medication-dispensing practices, the nature of daily activities for clients and triage processes. Cliff observed:

> *At the bottom level we act on them, we do things, we change things frequently, we change forms, we change how we document things and how we do specific tasks, we do that and we can change that easily within the service and that is a day to day thing that is easy to change. Generally, people can see a need for improvement or they can see the benefit in that, they can do it and come on board and change happens frequently.* (Cliff, 2).

These changes to service delivery occurred outside of the prescribed formal service development processes instead emerging out of discussions at team or Quality meetings, through supervision sessions and even informal discussions amongst clinicians. The side conversations evident at the Community Executive meeting revealed an example of how clinicians had altered their recording of client information following audit feedback without the need to implement a formal service development process.

As noted in the above example, collegial support and the sharing of ideas at 'business' meetings across the organisation also served as informal pathways for service development. Team meetings essentially represented service delivery at the coalface.[170]

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[170] Team meetings were held in every clinical unit across Living Well and involved all members of the direct clinical team including administration staff, nursing staff, allied health professionals, the Clinical

The discussion and items raised by clinicians in these meetings reflected the pressures and frustrations that influenced their ability to provide services to clients on a daily basis including providing duty cover, assessment processes and computer problems. The analysis of the Community Mental Health Team's meeting minutes highlighted how staff focused on improving their ability to deliver services to clients and regarded team meetings as a way to gain information and seek clarity around infrastructure that could support service delivery. Executive meetings were another forum where staff came together to share ideas and processes which altered the nature of service delivery. Each service area held Executive meetings that involved Unit Managers, Clinical Coordinators and other representatives such as Consumer Advisor(s), Family Advisor(s), Nurse Practitioner(s) and Allied Health Representative(s). Amongst other purposes, these meetings had a peer supervision or collegial function where staff openly discussed issues and vented frustration at the slow pace of service development and the lack of resolution to issues within their area. These items included the ongoing delay in resolving computer access at the Community Mental Health Team and the progress related to receiving feedback on the Clinical Governance Strategy[171].

Across Living Well, staff attending Executive Meetings were also able to develop strategies with their colleagues around problem solving mechanisms, they learnt from others' experiences of similar issues and adapted practice accordingly. An example of the sharing of ideas was at the Community Executive meeting on 7 March 2007 where staff spent time discussing how they dealt with clients who had been trespassed from their services as well as how frequently they reviewed their 'trespass list' with two Clinical Coordinators stating they would alter their practices following the discussion.[172]

Often the only managerial approval sought prior to implementing changes to clinical delivery that emerged from informal pathways, including discussion at meetings, was from the level of Clinical Coordinator or Unit Manager. Geoff outlined that service

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Coordinator and the Unit Manager. Clinical Directors generally do not attend and it is up to other psychiatrists to decide whether or not to attend.

[171] The Clinical Governance Strategy is the focus of Chapter Nine.

[172] See Appendix B for a copy of the meeting schedule for meetings attended as part of this research.

development of this nature was generally a straightforward adjustment to service provision and consequently did not require the approval of senior management: "*If it is a relatively simple process then it is just about putting it into a quality innovation model and doing it or at least piloting it.*" (Geoff, 1). The quality innovation model was a way of introducing an idea to the quality meetings and then having it followed up through this forum once a change had been implemented within the team setting. This type of idea did not require robust project processes and enabled teams to have flexibility in terms of the way they made changes to service delivery within their work areas, while still providing accountability by reporting progress back to the Quality meeting. In a later interview, Geoff mentioned this again saying: "*I think there are a lot of little things that have happened that probably don't get the title of project, but that still come in and move on*". (Geoff, 3). Tom agreed with Geoff's assessment stating that often spontaneous service development occurred in response to immediate clinical issues that required a solution to be implemented quickly:

> *There is change because there is an immediate problem that needs to be dealt with now; an immediate clinical problem; or you need to change a door; through to this system is actually not working as our length of stay is too long and something is going wrong.* (Tom, 1).

It was difficult to determine the difference in definition between minor and major change, Tom linked major change with resource, risk and funding allocation. It was consequently up to individual Unit and Service Managers to determine the appropriate service development process, that is whether clinicians could go ahead and implement a change or if formal service development processes needed to be followed. Both Paul and Geoff based their determination on whether an idea needed to follow formal processes or could be implemented directly on resource requirements and potential impacts across Living Well. Paul discussed how he differentiated between these two approaches to service development:

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Well financially, whether or not you can do it within your current resource or if the extra resource you require is available within [Living Well], that is, how you are going to meet that resource? Are you going to drop beds to meet that resource? ... You can't just set up something and go and do it unless there is no extra costs in it. If there are no extra personnel you could probably go and do it, but if there is cost and personnel then there is a bureaucratic process to follow. (Paul, 1).

Paul's comments reflect that if a proposed change to service delivery required resources beyond the allocated budget for that area, staffing, or potential impacts such as bed reductions with a potential flow on affect for other service areas, then a formal project or review process needed to be initiated.

In summary, at Living Well changes to both the nature and scope of services as well as clinical practice did not always follow formal pathways for service development with change also occurring spontaneously in response to clinical reflection, clinical audit and quality initiatives. These changes occurred frequently resulting from frustrations experienced by clinicians who quickly identified pragmatic solutions to problems and then altered their practice accordingly. These ideas emerged from within the value systems of clinicians, who consequently understood the worth of altering their practice. Clinicians did not feel threatened by this type of service development, saw benefit in its implementation and consequently were happy to incorporate the service development initiative into their everyday practice. There was only a loose framework for identifying which ideas were implemented at a service delivery level and which required elevation through the organisation's hierarchy following formal planned project and review processes.

Resistance to Service Development

As discussed throughout this thesis, staff commitment is vital to successfully implementing a new service development initiative. In situations where staff do not support a proposed change they can actively or passively undermine service development and implementation processes resulting in either the status quo in terms of service provision or the implementation of an alternate way of working that is more palatable to the staff majority. This section focuses on a discussion of clinical resistance as it relates to service development at Living Well. An analysis is also provided of how certain staff groups such as psychiatrists can dominate the service development process and therefore subvert service development. When viewed through the lens of archetype theory these staff responses reflect Greenwood and Hinings's (1996) level one (status quo) and level four (reformative commitment) with regard to staff commitment to change. In level one staff resist any change as they are satisfied with the current ways of operating and see no need for change. In level four, staff are opposed to the proposed change and actively resist it, preferring instead to implement an alternative option.

The slow pace of formal service development was a key concern of staff at Living Well.[173] Minas (2005) discusses that often the slow pace of change within health systems is attributed to staff resistance. Oreg (2006) notes that staff do not generally resist change rather they resist negative consequences that could occur as a result of the change. The outcomes of a service development initiative may result in role changes either within a particular unit or across the entire organisation altering existing power dynamics and creating uncertainty for those affected by the changes (Oreg, 2006). At Living Well, the potential negative consequences of service development for clinicians included workload repercussions, threats to clinical autonomy and expertise, resource cuts, changes in the nature of service delivery and the potential for client outcomes to come secondary to the accountability and efficiency requirements of the organisation. Geoff commented on his perception of staff resistance to service development:

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[173] As discussed in Chapter Seven.

I think there are two parts to it: one is that people have a natural resistance to change. And two, those who are promoting the change often don't listen to that resistance as some of that resistance is based on good ground common sense of things that won't work. (Geoff, 1).

All of the participants believed that staff resistance to change was a feature of service development. As discussed in earlier chapters, the introduction of management priorities of risk management, accreditation and efficiency since the 1980s have constrained clinical autonomy, resulting in a level of distrust between management and clinicians (Woods, 2011). Clinical suspicion of service development has meant that many service development initiatives in health care are only begrudgingly implemented contributing to a growing culture of professional resistance towards management and management driven service development (Denis et al., 1999; Kirkpatrick & Ackroyd, 2003; Mueller, Harvey, & Howorth, 2003). Resistance and scepticism towards management at Living Well contributed to clinicians' tendency to prioritise issues related to the immediacy of clinical delivery over and above other more planned approaches to service development. Any service development which was regarded as having little or no direct benefit to clients such as the development or review of policies, financial audit mechanisms and accreditation frameworks were viewed as being: "*insignificant management tinkering*" (Evelyn, 3) to clinicians, which they accommodated as a technical necessity, but in their view did not justify clinical input as noted by Cliff:

I don't think it [management driven service development] really impacts on what we do day to day. It might impact slightly on where we do it, but it doesn't impact on what we do and our core business for nurses working in there is assessment and treatment. (Cliff, 1).

Staff response to this type of change fulfils the criteria of Greenwood and Hinings's (1996) second level of staff commitment towards change (indifference), which often

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results in the initiative being implemented as staff do not actively resist it. Matt commented on the perceived imposition of management driven change on clinical practice: "*as you'd expect there is an incredible amount of resistance at times [especially] whenever you bring something in that means nurses will have to write more stuff out.*" (Matt, 2). The dilemmas presented by attempting to secure clinical involvement in service development have been discussed earlier in this chapter. The findings of this study concur with research undertaken by Callaly and Dinesh (2005) who found that clinicians working in the area of mental health in Australia often saw service development as an unnecessary intrusion on their practice and failed to see the purpose or logic behind it. Consequently, in order to reduce the likelihood of staff resistance to service development, the processes that informed this needed to be realistically achievable with minimal interruption to service delivery (Barnes & Brannelly, 2008; Karp & Helgø, 2008).

Clinicians working in mental health settings are typically very highly trained and have developed expert knowledge and experience within their specialist area. As discussed throughout this thesis, an ethic of care was a core component of clinician's value system, underpinned by professional expertise, autonomy and peer review processes. Consequently, proposed service development that changed or limited this was greeted suspiciously and at times resisted.[174] Each person involved in service development at Living Well had an impact on the process as they attempted to shape it and achieve what they believed to be the 'right' outcome. Clinical autonomy created space for individual personalities to use their position of authority or influence to exert their preference on a proposed initiative. Carole commented that strong personalities had influence across Living Well stating: "*you get people with far too bigger ego (laughs), I'm sure they are in every team and in every workplace and it is always a wee bit tricky to manage.*" (Carole, 2). Matt linked the ability to influence the service development process to an individual's power and perceived authority stating:

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[174] An example of clinical resistance was the response to the project to change the role of Clinical Directors discussed in Chapter Five.

Certain people feel very strongly about taking a certain stand, or a certain perspective within a project and so therefore the recommendations reflect the way that they see things... as with all groups there is a power dynamic going on and there are certain individuals within the group that have a lot more power, and so therefore they will make sure things are going to turn out the way that they feel they should. (Matt, 2).

Consequently, service development processes required careful selection of working group participants and relationship management to ensure that barriers were not placed in the way of developing and implementing a new initiative.

The different perceptions of both staff and management with regard to resistance to service development served to highlight the ongoing tension between clinical and management values. Evelyn provided an example from within one of the Community Mental Health Teams she managed where they were asked to provide clinical cover for another team over weekends:

There was a big sort of outpouring of anxiety is the best way of describing what it ... In lots of ways I think what happened there was that people were hugely challenged because they may be in a position where they have to do an assessment by themselves with a consumer who is not really likely to be kind of acutely psychotic or anything like that but, and that they had been heavily reliant on the team to support them and their clinical decision making and now all of a sudden they may be having to do a cold assessment and so there was resistance, big time resistance from that. (Evelyn, 1).

Evelyn discussed that any change to existing practice was greeted with resistance, sometimes she felt this was understandable and at other times it reflected staff's lack of

confidence in their own abilities. Matt also regarded nursing resistance to service development as justifiable in some situations, providing an example of the introduction of additional paperwork for nurses to illustrate his point. He stated that nurses believed in the quality of care they provided (an ethic of care) and had little time for new initiatives that did not have demonstrated value in terms of clinical outcomes:

> *You go through in terms of looking at decision making are really aligned and that people are aware of: "why it is important?" and it is not just conceived as something that is meant to result in the clinician having to write more…it's all around justifying it in terms of your practice is improved and therefore people are getting a better deal, they are getting better care, those are the sorts of things. There is an incredible amount of resistance at times whenever you bring something in that means that nurses will have to write more stuff out.* (Matt, 1).

Geoff, as a Unit Manager, had a different perspective and attributed staff resistance to belligerence stating: "*a lot of the resistance I meet as a manager is because people go I don't want to do that it's bullshit*" (Geoff, 1). For Geoff staff resistance to service development was an unnecessary distraction and presented a significant barrier to improving services.

Despite these different viewpoints, participants reported that the origins of staff resistance to service development at Living Well rested with both clinicians and managers. As discussed earlier clinicians were naturally suspicious of any service development initiative directed from management and believed that management failed to listen to their concerns. Carole stated that clinicians at Living Well often felt disenfranchised by service development processes, holding the view that: "*whatever will be will be, what's the point in us saying anything because someone's already decided*" (Carole, 1). Eliza shared Carole's view citing a recent management decision to change

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the gender configuration of the Acute Inpatient Service's Intensive Care Ward as an example:

> *I have been involved in a group with clinicians, that is looking at gender issues in [the Acute Inpatient Service] and I think that we are behind the times in that. However, there has just been an edict passed [by senior management] that [the Intensive Care Ward] is going to be male and female, gender specific. I think that is good, however I think the decision has been made in haste and the planning hasn't gone into it. You know it was decided on in early January that it would be gender specific by the end of January and I think that sort of stuff actually needs a bit more planning around it.* (Eliza, 1).

Eliza used her example to illustrate the way management ignored the service development ideas of clinicians when making decisions. The group of clinicians she had been working with had been considering the issue of gender safety for some time and felt they were making progress, but their views were dismissed as part of senior management's decision-making. Consequently, clinicians were guarded about participating in service development and felt that management would impose changes to the nature and scope of their work with little regard for their feedback. In contrast, those in the management structure interpreted clinical reluctance to engage in service development processes as being apathy, a lack of concern for service improvement and a lack of investment in quality service delivery. Tom spoke about this from his position as General Manager:

> *I don't know if people actually want to bother trying to make change, they see something happen, they see it and they just, they'll just tuck that away and say that always happens rather than say gosh I need to change this.* (Tom, 1).

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Resistance to change is not always overt, rather than actively engaging in service development clinicians can easily justify avoiding additional tasks such as attending project meetings as this would distract from service delivery (Karp & Helgø, 2008; Oreg, 2006). Tom expressed frustration at the way in which staff passively resisted service development at Living Well, which he thought was conveyed in their more general attitudes and lack of willingness to engage with formal service development processes stating that: "*people just sit on their hands and therefore resist it because they didn't agree, but they didn't argue the point either.*" (Tom, 1). Tom's comment demonstrated that rather than always exhibiting overt resistance staff at Living Well had learnt to adapt to the ongoing nature of service planning. Consequently, they had developed ways to bypass service development in their daily routines in order to focus on elements of clinical care that they felt should take priority over other planning activities.

In summary, participants often attributed the slow pace of service development at Living Well to resistance. Managers blamed clinicians' apathy and lack of willingness to participate in formal processes and clinicians blamed managers for not listening to their concerns and failing to appreciate the reality of service provision. Resistance to service development manifested itself as part of the ongoing clashes between clinical values and management priorities. Yet, psychiatrists were able to exert more power over service development than any other group at Living Well. Having been educated to operate with autonomy and carrying clinical responsibility for clients within their units, psychiatrists were able to resist any change to service provision that they did not believe would be in their clients or their own best interests, as discussed in the following section.

The Role of Psychiatrists in Service Development

The role of strategic relationships, change agents and powerful personalities has been a consistent theme across this thesis. In organisations like Living Well, dominant groups were able to protect their beliefs through a type of custodial management, which involved giving priority to their values, ideologies and beliefs (Denis et al., 1999;

Greenwood & Hinings, 1996; Hinings & Greenwood, 1989). In situations where a proposed service development supported their view then these groups were more than happy to implement it. However, when the change did not fit with their value system they engaged in a process of discrediting or undermining the proposed service development initiative thereby enabling these groups to maintain their professional value system and ultimately the organisation's archetype (Denis et al., 1999; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989). In this situation, the power of dominant professional groups takes priority over managerial control and dilutes attempts by managers to impose service development initiatives in favour of maintaining the status quo (Denis et al., 1999). Psychiatrists were able to exert more power over service development than any other professional group at Living Well. Having been educated to operate with autonomy and carrying clinical responsibility for clients within their units, psychiatrists were able to resist any change to service provision that they did not believe would be in their clients or their own best interests. This section explores the powerful role that psychiatrists play in the service development process at Living Well. This role perpetuated a hierarchical clinical structure premised on traditional medical values where the clinical experts were doctors, with nurses in support and other professional groups having auxiliary roles.

While all of the professional groups within mental health services have power in terms of their ability to influence and shape the nature of service delivery and the scope of service provision, they vary in the extent to which they can influence this process. Some groups and individuals have more ability to effectively resist or enable change within an organisation (Greenwood & Hinings, 1996). Despite clinical services being delivered by multidisciplinary teams, all participants described Living Well as being medically driven, Paul reflected on the reasons for this stating: "*we are still pretty much a medical model here and that is probably because we have a lot more psychiatrists [here] than anyone else and so we are more medically driven.*" (Paul, 1). Psychiatrists had enormous power within the organisation and were able to have a significant influence over service development. All participants agreed that if the 'Docs' or Clinical Directors were not supportive of a service development initiative they could undermine the service

development process in both overt and covert ways Carole summarised this: "*It's mainly doctors … who can kill things and they kill it mainly by apathy, if not by deliberately stomping on it.*" (Carole, 3). Geoff agreed and stated that without support from the psychiatrists there was no point progressing with a service development initiative: "*[a lack of support from psychiatrists] is going to undermine [service development], it is going to undermine whatever direction or value you are trying to introduce.*" (Geoff, 3). The psychiatrists were also able through their positions of influence, to recruit other practitioners to either support or oppose a proposed service development initiative. The Community Integration Project, discussed in Chapter Five, was an example of how the practice of psychiatrists eventually undermined the outcomes of the project. Consequently, without support from this group service development was unlikely to proceed as noted by Tom: "*There'll be no buy in and there will be absolute destruction ... medical staff hold a huge amount of sway.*" (Tom, 3). This finding supports the view of Ackroyd (1996), who in his study of professional organisations within the United Kingdom, found that managers in health acknowledged that they needed to have support from senior doctors in order to implement any management idea.

Across mental health services, psychiatrists enjoy a high degree of autonomy, instilled in them from very early in their training (Callaly & Minas, 2005). The power of psychiatrists at Living Well lay with the notion of clinical responsibility that meant that doctors were ultimately responsible for all clinical processes. Paul spoke about his view of the power wielded by Clinical Directors: "*It's like "I'm the Clinical Director and this is my responsibility and if I am responsible, I'll make the changes and you will go along with them.*"" (Paul, 2). In the subsequent interview, Paul again discussed the ability of Clinical Directors to influence service development: "*Clinical Directors, Docs, get the final say because as Clinical Directors they are director of all clinical processes in their service*" (Paul, 3). It was therefore important to non-psychiatric staff and management that psychiatrists were in favour of proposed changes to service delivery. Matt commented: "*if they [psychiatrists] are not on side with something then it is very unlikely that we are going to be able to work very far with whatever that might be*" (Matt, 3). Tom, as General Manager, acknowledged the power held by psychiatrists

because of their role as senior clinicians stating: "*Until we can break down things like responsible clinicianship and have that spread across competent practitioners not just medical staff then we are going to continue to have that.*" (Tom, 3). Tom's view was that unless the boundaries and roles around clinical responsibility were changed doctors would continue to hold power across the organisation. Tom had initiated a project to address the imbalance of power he believed was held by senior psychiatrists. However, as discussed in Chapter Five, this project was unsuccessful due to a lack of support from this group. Tom noted this: "*if this dented social workers then it wouldn't get any momentum at all [due to their small numbers and lack of authority over client care], because there are the numbers of doctors around things can then actually have a major impact so it depends on the groups.*" (Tom, 3). The power and influence held by psychiatrists due to their role as senior clinicians at Living Well meant that service development remained medically focused driven by their priorities and treatment strategies such as medication.

Both non-psychiatric clinicians and management understood that for service development to be successfully implemented the support of psychiatrists was essential. Despite attempts to share clinical responsibility across other professions and an increased focus on recovery amongst other professional groupings, Living Well was still dominated by the medical value system of psychiatrists. The ability of psychiatrists to control and subvert service development served to highlight the role that power plays in the service development process.

Leadership

As an important stakeholder group staff willingness to embrace and implement a service development initiative was critical to its success at Living Well. The Implementation literature in health promotes the value of leadership to successful adoption of evidence based practice initiatives (Aarons et al., 2011; Callaly & Minas, 2005; Torrey et al., 2011). Leadership is an important theme within archetype theory. Archetype theory describes a relationship between the credibility of the person proposing a new service

development initiative and successful archetype transformation (Hinings, Brown, & Greenwood, 1991). At Living Well, it was evident that leaders were not necessarily a person in an appointed management or senior leadership role. Rather, being a leader was linked with an individual's ability to influence the organisation's hierarchy as well as other staff, client groups and key stakeholders so that all could see that the proposed service development initiative had merit and would result in improved outcomes and efficiencies. The purpose of this section is to discuss the function of leadership in gaining staff support and commitment for service development.

Consultative processes enable staff to have regular input into planning and development, encouraging ownership of the plan or service initiative and increasing staff investment in achieving the outcomes (Goding, 2005). In addition, the presence of one or more individuals in leadership positions, committed to the service development process increases the likelihood of the project or review being utilised (Aarons et al., 2011; Alkin, 1990; Callaly & Minas, 2005; Hinings, Brown, & Greenwood, 1991; Hinings & Greenwood, 1989; Torrey et al., 2011; Patton, 1984; Weiss, 1984). The involvement of clinical leaders in any change process within a mental health service is especially important as they are able to influence and negotiate with other clinicians to ensure that any proposed change to the nature or scope of service delivery will be viewed as being of value and able to be sustained in the long-term (Callaly & Minas, 2005). The ability of this person to engender support from affected staff as well as their connection with the interpretive scheme influences the likelihood of successful change (Hinings, Brown, & Greenwood, 1991). [175] A person who was able to influence and engage others including staff in the merits of any proposed service development initiative increased the likelihood of successful service development at Living Well. Matt discussed the importance of the characteristics of the person leading out a project stating: *"It is about the way in which something is presented and who the person is, the person who presents it and whether they are really motivated to present it or whether they are indifferent or otherwise."* (Matt, 1). Matt viewed a person's ability to lead others and influence effectively as critical to the process of implementing service development.

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[175] The role of change agents in service development was discussed in Chapter Seven.

The role of the leader was to promote the proposed service development, highlighting justifications and aligning it with the dominant values within the interpretive scheme (Hinings, Brown, & Greenwood, 1991). Eliza spoke about the importance of leadership at Living Well with regard to her work on gender issues in the Acute Inpatient Service:

> *I got a group together to look at gender issues in Acutes. At the start it was run by me, but now it has got more credibility and we've got … the Clinical Director, [Clinical Coordinators] of the [Acute Inpatient wards]. And now it is actually developing its own life cycle and it is going to have someone to take notes and it's going to be good, so I suppose you know I am quite happy to start things, but I am also quite happy to stand back from them when they have got going.* (Eliza, 1).

Eliza believed that the involvement of the Clinical Director and other senior nursing staff gave the project credibility. While Eliza spoke about the benefits of using leaders to develop and promote service development, she acknowledged that the work undertaken by the gender safety group was undermined by the decision to segregate the intensive care ward, as discussed earlier in this chapter.

Through highlighting gaps, deficiencies and presenting alternative ways of working leaders over time can alter the dominant views of staff within the organisation in both positive and negative ways (Powell, Brock, & Hinings, 1999). While strong leadership was associated with project success a lack of leadership increased staff resistance to service development, generated anxiety, anger and contributed to a lack of appreciation for the value of the proposed development. Evelyn used the example of the failure of the Home Based Treatment Project to illustrate this point saying:

> *I suppose I can't help thinking that the face [of the person leading the project] didn't fit that was promoting it, and that*

> *person ...was sort of a problem because the style sort of just turns people off ... I think probably the key thing was the style, not what it was, but how it was done was the problem.* (Evelyn, 3).

Archetype theory asserts that if the person leading a project has a set of values that do not align with the dominant interpretive scheme then the proposed initiative would most likely fail (Hinings, Brown, & Greenwood, 1991). In Evelyn's view, the Home Based Treatment Project would have achieved far more of its original objectives if a different individual had led it. As discussed in Chapter Seven, the person leading this project was unable to maintain support from staff.

Leaders use a form of strategic sense making, informed by their knowledge of organisational rules, relationships and cultural practices to inform and influence those around them (Rouleau & Balogun, 2011). They do not necessarily accept the change in its original form, rather they interpret and reframe this in terms of how it fits within an area of work or influence (Stensaker, Falkenberg, & Crønhaug, 2008). This process of translation acknowledges the reality of the everyday work environment whether this is within a business unit or in clinical practice and enables others to gain a broader understanding of the proposed service development and why it should be implemented. By focusing on particular change elements, the leader is able to generate a shared knowledge, language and understanding of the change (Stensaker, Falkenberg, & Crønhaug, 2008). Cliff saw the nurse practice consultant within the Acute Inpatient Service as demonstrating many of these skills:

> *I don't know whether that is because she has a voice with us or she's an identifiable voice that is independent, because people can go to her with kind of ideas for change you know and she'll come to us with ideas and ask "what do you think about that" and we'll sit down and have a look at it in our group?* (Cliff, 2).

Cliff felt that the Nurse Practice Consultant's credibility as a leader lay with her ability to engage with other nurses, work collegially and demonstrate the relevance of service development ideas for the Acute Inpatient Service. Tom discussed his experience of leading out service development across Living Well and shared Cliff's view that staff engagement was an important component of leading:

> *Just engaging the people to the same view. Now I have to be careful that my view is being seen to be the right one. As I say, you have got to be a bit careful about that... I am of the view that my vision is very malleable. You throw it out there and say: "come on, give us some feedback". You are only as good as your information, the decisions you make are only as good as the information you get. So if you don't get the information back, then the vision is going to stay very insular. And so, what I have had to think about is: "how do I get engaged with enough people?"* (Tom, 2).

Tom's quote once again highlights the dilemma of ensuring clinical involvement in service development at Living Well. The credibility of the person leading out service development did increase the likelihood of staff listening and participating in the process. In situations like the Home Based Treatment Project, the characteristics of the leader added to staff resistance towards the project. Therefore, for service development to be successfully implemented staff needed to see the value of the proposed change described by a leader who was someone that could align the proposal with staff's shared vision and values in terms of service delivery.

Conclusion

Clinicians at Living Well often regarded projects and reviews as impositions on their time and a distraction from the tasks of delivering services to clients. The nature of service delivery within Living Well was driven by the raison d'être of the organisation,

meaning that informal processes embedded within Living Well's interpretive scheme dominated any attempt to plan service development. These factors included the ability to provide responsive mental health services including operational concerns and clinical issues such as the acuity of mental illness, over-crowding, lack of staffing and risk minimisation.

The complexity of the service delivery and development environment at Living Well has been commented upon throughout this thesis. Traditional approaches to understanding service development in bureaucratic environments emphasise a rational approach that involves a series of predictable steps (Gkeredakis et al., 2011; Graetz & Smith, 2010). These theories assume that service development can be controlled and involve a process of "*unfreezing, moving and refreezing*" with little interruption to the delivery of services (Graetz & Smith, 2010, p.136). These rational approaches bear little relationship to the reality of everyday service delivery within organisations like Living Well that are subject to multiple viewpoints, risk factors, operational and policy demands as well as the need to deliver responsive mental health services to clients who are acutely or chronically unwell. At Living Well these different elements created an uncertain environment where service development happened spontaneously, using informal pathways, in response to operational and clinical demands rather than being informed by a planned strategic or policy focus that was sustained over time. The contradictions embedded within the various processes and value systems accounted for the inconsistent approach to service development as the organisation struggled to balance the means-end process of rational legal administration with the uncertainty of clinical delivery (Olsen, 2008; Powell, Brock, & Hinings, 1999). Two factors that increased the likelihood of adopting and implementing a service development initiative was having good leadership and the support of key professionals, including psychiatrists, who had influence at Living Well.

The contradictions embedded in the service development processes at Living Well underpin the complexity of service delivery in the area of statutory mental health service provision. Certainly, Living Well did not always follow the formal rational procedures

expected of a bureaucratic organisation. The priority of clinical service delivery dictated the nature and scope of service delivery and service development emerged from the day-to-day demands of service provision and the personal preferences of those in positions of influence across the organisation.

The next chapter provides an analysis of the Clinical Governance Strategy, an example of service development and change at Living Well. It examines the nature of the proposed change, the process of implementation as well as its outcomes

Chapter Nine: The Clinical Governance Strategy[176] - Service Development Observed

Introduction

The process of moving to a new organisational form requires altering staff perception of the delivery and structure of services to encourage them to see the value of moving to a new organisational form (Brock, Powell, & Hinings, 2007). In November 2006, the General Manager of Living Well released a discussion document entitled the "Proposal for Clinical Governance". The Proposal recommended both structural and philosophical changes to the operation of Living Well that encompassed multiple convergent service development changes. The release of the document presented the researcher with a unique opportunity to observe the process of service development as it occurred. The Proposal conforms to Greenwood and Hinings (1996) definition of convergent archetype change as it involves service development that occurs within the boundaries of an organisation such as changes to programme delivery or service configurations. This chapter examines the process of introducing and implementing the Clinical Governance Strategy at Living Well. It analyses the change process and examines staff's commitment as part of this. The discussion also considers the role of Living Well's interpretive scheme in the change process as well as whether successful archetype transformation actually occurred.

The Clinical Governance Strategy was first mooted in November 2006 and implemented from 1 July 2008. The first interviews for this research occurred not long after the release of the initial proposal in January 2007 when the discussion document was circulated to staff for consultation and feedback.[177] As part of the first and second rounds of interviews, participants were asked for their thoughts on the proposal and

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[176] The project has been renamed to protect the confidentiality of Living Well.
[177] The researcher was not aware of the proposal until the commencement of the first interviews. A request was then made to amend the ethical approval to include a third round of interviews in order to track the process of implementation of the proposal.

what they believed would be the potential impact of the change. The third round of interviews occurred seven months after the implementation of the change. At this time, participants were again asked their reflections on the original proposal, as well as their impressions of the service development process and the consequences of the altered structure.

Content of the Proposal

Tom, the General Manager of Living Well, drafted the Proposal for Clinical Governance, the initial discussion document for the Clinical Governance Strategy. It highlighted a shift from an administrative system of governance at Living Well to a new model of service delivery premised on Clinical Governance. The purpose of this section is to outline the original goals of the proposal as well as the structural and system changes required to implement it.

As already noted, Tom, the General Manager was the driving force behind the Clinical Governance Strategy, which involved both structural and philosophical changes across Living Well. A somewhat ambiguous term, clinical governance had large appeal across the health sector in the 1990s and was seen as a mechanism through which managers and clinicians could work together cooperatively, taking joint responsibility for the quality of clinical care (Callaly, Arya & Minas, 2005; O'Connor & Paton, 2008).[178] [179] Tom described his vision of Clinical Governance at Living Well as:

> *Reorganising the system to give senior clinical staff far more*
> *accountability in the running of the service and I think that*
> *brings greater engagement and alignment with our clinical*
> *staff. Because it has been too easy to say well management*

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[178] It is not the intent of this chapter to provide a detailed critique of the merits of clinical governance as it relates to mental health services rather this chapter is interested in the process of introducing and implementing service development and change. For a comprehensive New Zealand perspective on clinical governance see Wright, Malcolm, Barnett and Hendry (2001).

[179] The ambiguity related to clinical governance lies in a lack of consistency in the nature of an organisation's structural framework required to implement it (O'Connor & Paton, 2008).

don't understand so now it is about putting clinicians in the
driving seat, the same driving seat. (Tom, 1).

Through implementing the changes, Tom hoped to create a partnership between clinicians and managers premised on the values of clinical governance that would also provide a way to address the ongoing tension between these two groups.

The process of implementing the Clinical Governance Strategy involved both structural and philosophical changes across Living Well. The following sections outline the changes required to implement the goals of the Clinical Governance Strategy.

Proposed Structural Changes

The Clinical Governance Strategy outlined four structural changes including:
1. The establishment of a Clinical Governance Directorate.
2. The renaming and realignment of the functions of Quality Assurance and Business Unit.
3. The reconfiguration of specialty teams in the organisation's business structure.
4. The disestablishment of the Unit Manager role.

The establishment of a Clinical Governance Directorate, alongside new senior clinical roles including the Chief of Psychiatry and the Allied Health Leader, was to create the umbrella for Clinical Governance across Living Well. The Clinical Governance Directorate was to be a representative forum including the General Manager, Operations Manager, Chief of Psychiatry, Allied Health Leader, the senior Consumer Advisor, a representative of family/whanau, and Maori. Tom, the General Manager, described the Directorate as:

A group of people who will be responsible, truly responsible
now, for the setting of the strategic direction and the monitoring
and evaluating of that. So that group will include the Chief of

> *Psychiatry, General Manager, Operations Manager, then Allied*
> *Health Leader, family, consumer, carer, Maori, and it won't*
> *have all the other operational people [including Service*
> *Managers and Clinical Directors] on it. So that group meet on*
> *a monthly basis, but they will also co-ordinate and conduct the*
> *annual strategic review.* (Tom, 2).

The Clinical Governance Directorate's purpose was to ensure that Living Well complied with the strategy set out by government frameworks and policies including *Te Tāhuhu* (2005); *Te Kōkiri* (2006) and *Te Hononga* (2007). The Clinical Governance Directorate was positioned alongside the Senior Management Team in the organisation's structure. Service Managers and Clinical Directors were not included in the Clinical Governance Directorate's membership, but remained as the core participants in the Senior Management Team.[180] The Senior Management Team's role was to shift to a simply operational focus rather than their current focus on balancing strategy alongside the everyday demands of running a mental health services.

The Chief of Psychiatry was to be a central figure in the implementation of clinical governance and was to chair the Clinical Governance Directorate. This position was to have the same status as the General Manager in the business structure with oversight and leadership of the clinical components of strategic and operational planning.

As part of the change, the Quality Assurance and Business Development Unit, which had been responsible for administrative, audit and other business functions[181] was to be renamed the Clinical Governance Unit. Alongside the name change, researchers, project managers and other business functions previously spread across the organisation were to be relocated to the unit.[182] The core responsibility of the unit was to support the

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[180] Appendix H contains a copy of the new service structure for Living Well.
[181] The Quality Assurance and business development unit had included Human Resource Management, Financial and Risk Management Functions alongside clinical roles such as the Director of Nursing, Social Work Leader, Consumer and Family Advisors.
[182] Prior to this researchers had been located alongside the unit where they were undertaking research that is Child and Adolescent Services and early psychosis services.

implementation of clinical governance across Living Well through the development of policy, projects, research, audit and other quality initiatives.

The proposal also recommended amending the configuration of services across Living Well by moving Early Intervention Psychosis Services from Rehabilitation to Adult General Mental Health Services. In order to accommodate this, two specialty teams[183], previously located in Adult General, were moved to Specialty Services.

The most significant change in the proposal was the disestablishment of Unit Managers, a middle management role. This involved renaming the role of Clinical Coordinator to Clinical Manager. Figure 5 shows the change in direct line management from before and after the proposed change.
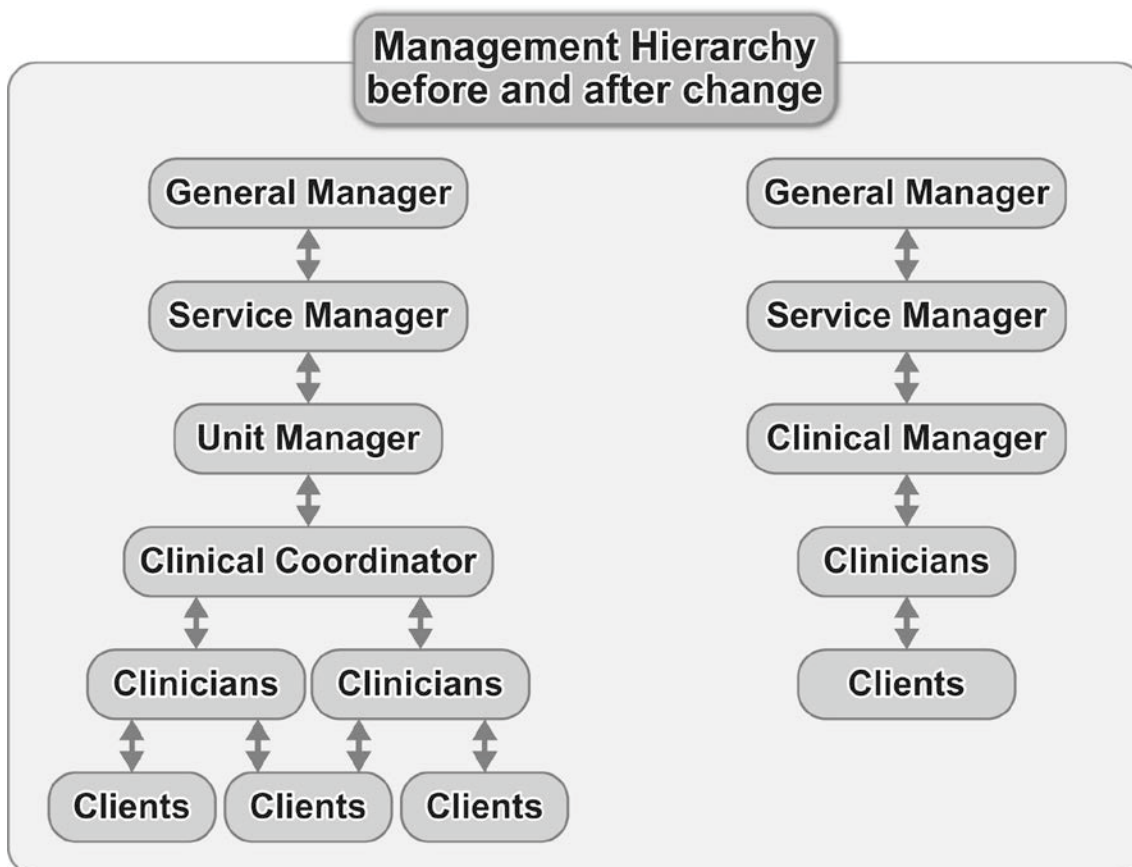

Figure 5: Management hierarchy before and after the Clinical Governance Strategy

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[183] The identity of the speciality services is not included as this identifies the research site.

Under the original structure, the Service Manager was a higher-level manager responsible for overseeing a number of units within a service area such as Adult Community or Rehabilitation Services. Their role included having overall operational responsibility for the work undertaken within these units, providing planning, strategic and accounting oversight for their service area and providing the managerial link with the rest of Living Well's structures. Unit Managers were the next tier down in the management chain and had daily operational responsibility for the teams they managed including staff cover and rosters; bed availability; maintenance requirements; risk minimisation and audit; information technology; human resource concerns; and budgetary requirements. A Unit Manager may have had responsibility for a number of different operational units. Clinical Coordinators reported to Unit Managers and were responsible for the allocation, supervision and delivery of clinical work within an individual unit. Under the proposed change, the tasks of the Unit Manager were to be redistributed between the Clinical Manager and the Service Manager for each area. In order to facilitate this process an additional two Service Manager positions were to be created. Training was also to be provided to the newly appointed Clinical Managers on human resource processes and financial management as well as other tasks previously undertaken by the Unit Manager for each unit.

Proposed Philosophical Change

In analysing the change through the lens of archetype theory, successful archetype transformation required that the structural changes outlined above occurred alongside changes to the organisation's existing interpretive scheme (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). This involves a process of challenging and questioning the existing systems and processes of the organisation, as well as encouraging staff to see benefits in the new ways of working (Brock, Powell, & Hinings, 2007). The Clinical Governance Strategy involved a shift in the interpretive scheme of Living Well from the previous hierarchical management system to one premised on a clinical and managerial partnership. Evelyn described the intent of Clinical Governance as being:

Actually, truly managers and clinicians working together for the benefit of [clients]. Actually, truly working together, not we say we are but we don't, or we say we are but we have got parallel processes, actually working together. (Evelyn, 3).

The internal systems and structures would alter from having distinct clinical structures based on Clinical Directorates and separate management roles with little interface between the two. The new system would see the two separate systems merged together as one. The intent of the structural change was to replace the current system of internal financial management to one premised more directly on client need. Figure 6 shows this process of archetype transformation.
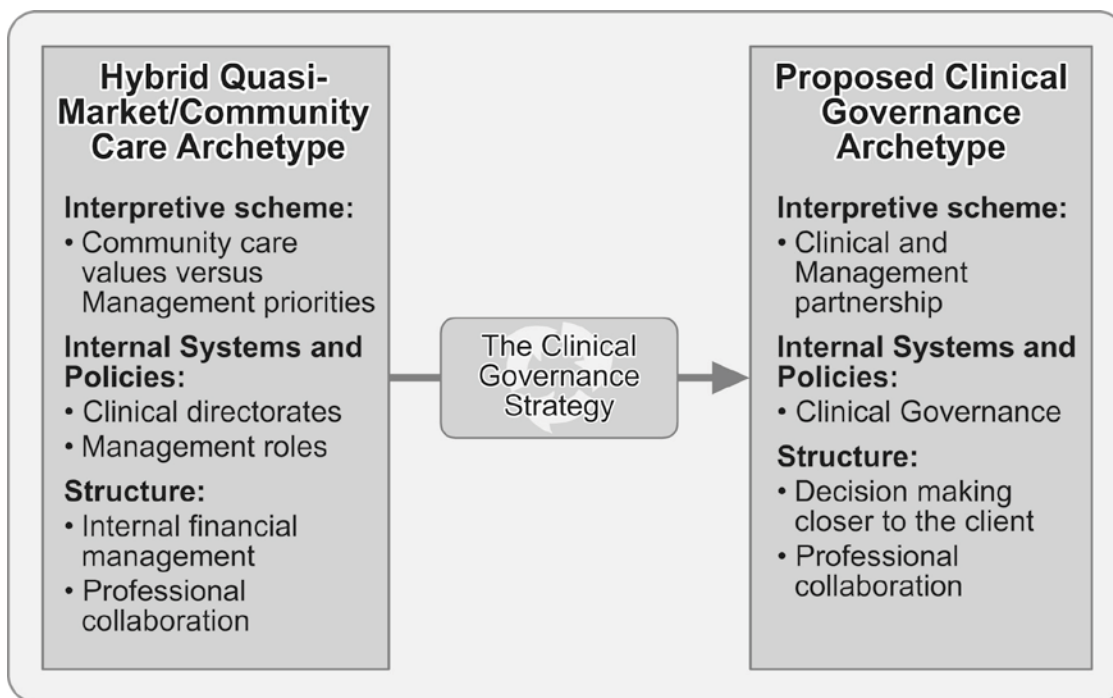

Figure 6: Transition to Clinical Governance

Implementing successful change in any organisation is difficult (Brock, 2006; Powell, Brock, & Hinings, 1999). According to archetype theory, to guarantee successful archetype transformation the values embedded within the Clinical Governance approach

needed to align with the interpretive scheme of Living Well. The complex and often contradictory processes involved in service development at Living Well made this process even more complicated and meant that multiple factors needed to align. These factors included prioritising the need to provide responsive mental health services, protecting clinical autonomy, ensuring the support of psychiatrists, and balancing power relationships across Living Well.[184] The change needed to be implemented with minimal interruption to service delivery, while still enabling clinicians to feel involved in the service development process.

In summary, the intention behind the structural and philosophical changes proposed in the Proposal for Clinical Governance was to shift from a hierarchical system with clear role differentiation between clinicians and managers to a new organisational form premised on partnership. According to archetype theory to achieve this change, the proposed structural and philosophical changes needed to align with the interpretive scheme of Living Well. As part of this process, members of the organisation needed to understand the value of the changes, and believe they would be in the best of interests of both themselves and their clients. The implementation of the changes also needed to occur in a way that was minimally intrusive to the daily delivery of mental health services and enable Living Well to continue to meets its other internal and external obligations.

Participants' Understanding of the Change

As noted in Chapter Two, assessing an organisation's readiness to change is the first step in implementing service development (Brock, 2006; Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). Stability within an organisation's system makes achieving change difficult and typically results in the organisation retaining its original archetype, whereas, tensions or uncertainty within the existing scheme creates opportunities for change (Brock, 2006; Brock, Powell, &

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[184] These are elements of Living Well's interpretive scheme that have been identified across this thesis.

Hinings, 2007; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999). At Living Well, a variety of elements had produced pressures for change including the lack of clinical participation in strategic decision-making; simplifying the management structure; addressing financial concerns; creating alignment across the District Health Board; bringing decision-making closer to the client; the more general move in health to clinical governance; and, ensuring greater connection between national policies and local strategy. This section explores participants' understandings of the intent behind the proposal as well as the underlying reasons for the change.

The Proposal for Clinical Governance did not include a statement providing the rationale for the changes although Tom's aim was to address what he perceived as a lack of clinical buy-in in service planning and strategy development across the organisation. He felt that the introduction of clinical governance as a philosophical approach would address this, stating that the Clinical Governance Strategy was instigated by his reflections of his own ability to influence the service:

> *I wasn't happy with the more egalitarian view and way of things where all the clinical services were the same and I was up here and not being able to have good governance.* (Tom, 3).

Other participants discussed the primary motivation for the Clinical Governance Strategy being to alter the management structure based on their understanding of the 'official line' presented by Tom as General Manager. Geoff described the levelling out of the management structure as improving efficiencies based on: "*a genuine feeling that a flatter management structure might keep people more involved in it*" (Geoff, 1). Both Matt, a clinician, and Jacob, a Clinical Director, concurred with this, stating that the Strategy intended to simplify the management structure:

> *Perhaps make the system work, perhaps to simplify the system, make it not so convoluted not so overcrowded in bureaucracy so it might streamline it a wee bit.* (Matt, 3).

> *I think the core intention was to be a component of continuous quality improvement… It was designed to simplify the management structure to meet some of the wishes of psychiatrists, to improve quality and to align our strategic direction probably with the Ministry [of Health]'s direction as outlined in the big three documents by the Ministry and the Mental Health Commission.* (Jacob, 3).

They felt that the Strategy improved quality and streamlined decision-making by removing some of the management tiers that service development proposals needed to progress through to receive approval.

Clinical suspicion of management within professional bureaucracies is well-documented (Denis et al., 1999; Kirkpatrick & Ackroyd, 2003; Mueller, Harvey, & Howorth, 2003). The tension between management priorities and clinical values was also a consistent theme across this research. Most of the participants, were unconvinced by the General Manager's 'official' reasons behind the Proposal for Clinical Governance and believed cost cutting was actually the primary motivation for the change. Carole acknowledged her scepticism and saw the timing as interesting given the need to make savings to address a recent pay rise for Clinical Coordinators:

> *I think that there's a part of me that is a wee bit sceptical thinking that Clinical Coordinators have just got a significant pay rise so now they are going to have to do more of the accountability work budget wise potentially to earn their increase and certainly there is some disquiet about this because you know accepting that they were underpaid before gets kind of put to one side because there is an implication that they are now overpaid to do something.* (Carole,1).

Paul concurred with Carole and explained that the financial consequences of a new employment contract with Clinical Coordinators meant either the other layers of management needed to receive similar pay rises to maintain the gaps in the pay scale or they needed to remove a tier to address this:

> *The [employment contract with Clinical Coordinators] changed most of this, the clinical coordinators as such jumped ahead of what Unit Managers [on individual agreements] had. And then the difference between the clinical coordinators and the Service Manager was so small a gap you were talking about probably about $8000 tops and you had to get another line of management of Unit Managers in there. Then the gaps reduced to only about $2000 between the jobs and people wouldn't do them because they would say why would I do that job for only $2000 more than this job. So what happened was they took out that line and the gap remained quite a big gap.* (Paul, 3).

Consequently, Paul believed that the removal of the Unit Manager role enabled the maintenance of the pay gap between management tiers, with the financial savings diverted to pay the increasing wage costs of Clinical Coordinators. Agreeing with the cost cutting argument, both Jacob and Cliff saw the proposal as just being a part of a cyclical pattern in service development in health:

> *Every few years you have these reorganisations of management and that is just what management does and I think the nurses pay rise was the initial trigger, because it made the Unit Managers unaffordable. So I think in a large part it is being driven by financial and economic things.* (Jacob, 1).

> *It kind of seems that they build up that middle management structure and then every few years they take a level out again.*

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> *You know because it is not working or not meeting the needs*
> *somewhere after that there is a gap so they have to fill that gap*
> *again and it appears like a pattern a big cycle going around.*
> (Cliff,1).

There are similarities between the attitudes expressed by Jacob and Cliff and other research that indicates that mental health services tend to follow cyclical patterns, where old ideas are rediscovered as new based on current trends (Butler, 1993; Brown, 1985; Callaly & Minas, 2005; Morrisey, Goldman, & Klerman, 1985).[185] As noted earlier in this chapter there is ambiguity in the nature of the structures required to implement Clinical Governance across the health sector. This research has not found research or literature that supports the removal of middle manager roles as part of achieving Clinical Governance, rather the removal of these roles aligns with the cost cutting and greater efficiency arguments of neo-liberalism and new public management providing justification for participants' weariness about the real intent of the Strategy.

In summary, the view held by seven of the nine participants was that the release of Proposal for Clinical Governance was to address financial concerns across Living Well. Other factors cited for the change included alignment across the District Health Board[186]; addressing dysfunction at a senior management level; to provide more clinical oversight of the organisation; to bring service development decision-making closer to the client and to ensure greater connection between local planning and national policies.

Levels of Commitment

Archetype theorists highlight staff commitment as being vital to successfully implementing service development and change across organisations. The four levels of commitment described by Greenwood and Hinings, (1996) are: status quo; indifference;

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[185] The role of cyclical trends in mental health service development was explored in Chapter Four.
[186] The areas of General and Older Persons Health had recently implemented similar systems.

competitive commitment; and reformative commitment.[187] While staff may not overtly resist the implementation of a new structural change, a lack of commitment means that over time, the adjustments made to support the new ways of working fail and service development and change does not occur (Dent et al., 2004; Denis et al., 1999; Hinings, Brown, & Greenwood, 1991; Hinings & Greenwood, 1989; Kirkpatrick & Ackroyd, 2003). In this situation, the values, ideas and culture of the organisation remain unchanged despite the implementation of new systems and structures (Kirkpatrick & Ackroyd, 2003). The following section explores participants' levels of commitment with regard to the Clinical Governance Strategy at Living Well.

As discussed in Chapter Eight and in accordance with international research, clinician involvement in service development increases the likelihood of an initiative being successfully implemented (Aarons et al., 2011; Callaly & Minas, 2005; Gkeredakis et al., 2011). Clinician engagement enables changes to service delivery to be negotiated so that they are realistic and do not pose a threat to clinical expertise and autonomy (Aarons et al., 2011; Callaly & Minas, 2005;). Communication and consultation during service development processes can create alignment between management and clinical values as shared understandings of the problems and priorities of the organisation can highlight the need for change (Brock, 2006; Brock, Powell, & Hinings, 2007; Denis et al., 1999; Hinings & Greenwood, 1989; Powell, Brock, & Hinings, 1999).

The Clinical Governance Strategy was released to all staff and widely circulated to both internal and external stakeholders. A submission process enabled staff and others to have input into the process. All participants stated they would make submissions on the Clinical Governance Strategy. However, a number expressed reservations about whether there would be any amendments resulting from the submissions and they therefore questioned the validity of the consultation process. Participants cited Tom's role in developing the project as a barrier to meaningful consultation. Participants regarded the Clinical Governance Strategy as his idea, and recognised that as General Manager, he had the power to implement the structural changes irrespective of clinical support. Paul,

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[187] See Chapter Two for an in-depth discussion of the different levels of commitment.

a member of the Senior Management Team, summarised how he believed the proposal was developed:

> *I believe that the [Clinical Governance Strategy], the new document that is out was developed by two people, wasn't developed by any more than two people, namely the Operations Manager and the General Manager. It was only minorly discussed at [Senior Management Team] and only discussed after it was put together.* (Paul, 1).

Jacob, the Chair of Psychiatry at the time the proposal was developed, was not involved in its development. While Jacob was supportive of the proposed change, his language and tenor reflected a degree of resentment about not being involved in its development:

> *And I think the proposal to elevate the position a bit is a good one. On the other hand looking at the influence, ... I was not asked to have any part in the proposal for change even though I am the senior administrative, managerial psychiatrist I had no part in it at all. And this document this just put down in front of me 10 minutes before everyone else got to see it.* (Jacob, 1).

As already noted, gaining support from staff across Living Well was important for ensuring successful service development. Jacob's wavering commitment highlights that while the General Manager was able to impose the structural change, the lack of staff commitment would make this very difficult to sustain in the long-term.

As discussed in Chapter Five, staff at Living Well were suspicious of any management driven service development due to historical threats made to clinical autonomy and the conflicting priorities of the two groups. Consequently, it is not surprising that staff displayed competitive commitment towards the Clinical Governance Strategy across the entire project period. Greenwood and Hinings (1989, 1996) describe this level of

commitment as the most contentious, where some members of the organisation support the change and others oppose it. Participants reported that the majority of Senior Management Team, led by the General Manager, Tom, gave the appearance that they were initially supporters of the change. Whereas, other staff were more cautious about the potential benefits of the proposal and took a "remains-to-be-seen" approach to the process. This ambivalence was evident in participant interviews as well as in discussion at the Community Executive meeting, the Community Mental Health Team's meeting and the Rehabilitation Executive meeting. Cliff's view was typical of others as he said: "*you never know until it happens*" (Cliff, 1).

During the first interview, participants were asked their views on the Clinical Governance Strategy including where the idea had originated and whether they thought it would be successful. Even at this early stage, eight of the nine participants expressed some reservations about the change. They thought there were potential problems with the increased workloads and skills required for those who took on the tasks of the disestablished Unit Managers. Paul believed this could have paralysing effects on the organisation:

> *I just can't see how we are going to function as an organisation, the idea is to get the Service Managers and the [Clinical Director]s closer to the ground floor to make the decision-making. That is the philosophy however a very flat system, the Service Manager will have, I think the Community's Service Manager will have something like twelve people reporting to them. Presently the Service Managers have four. You know there is just no way you can have twelve people reporting to you and continue to do the operational side and the strategic side. It is just doesn't quite work like that.* (Paul, 1).

Paul felt that the additional workload for Service Managers would leave little time to devote to strategic planning, which as discussed in Chapter Six, was already a very

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difficult task. Evelyn was also concerned about potential implications of the Clinical Governance Strategy for service development. Careful relationship management was an important component influencing service development at Living Well.[188] Evelyn felt that once implemented, the introduction of additional players in the decision-making process through the establishment of the Clinical Governance Directorate would add to the complexity of the service development process. She reflected on the current process of decision-making under the Senior Management Team:

> *Because it is six different personalities, they will all hear it different ways, they go to their services and say well this is how I want you to do it, so it is already different six times, and then we get to the services and the different services say that we are special because of this, so we can't do it that way. Ah okay well that's fine, so you do it that way, you do it that way, and you do it that way, and you don't need to do it because of that, you do it that way, and then it all just and the impact or the benefit or what have you is lost because by the time it gets out to all the services, the place is too big.* (Evelyn, 2).

Evelyn's view was that by increasing the membership of the Senior Management Team with the addition of two extra Service Managers plus the addition of the Clinical Governance Directorate, the Clinical Governance Strategy undermined existing strategic relationships and further complicated the decision-making process.

Other participants' concerns related to the proposal were linked with increased workload, the low priority given to service development and a lack of skills across Living Well to implement the changes. The priority given to clinical delivery and the competing demands already placed on clinical time meant that achieving practitioner input into the service development process was difficult. Paul felt that the removal of the

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[188] The role of personalities and relationships in the Senior Management Team was a consistent theme across the discussion chapters.

Unit Manager tier and the introduction of Clinical Governance would place even more responsibilities on clinicians and Clinical Managers meaning even less priority would be given to service development as:

> *Clinicians don't have time anyway. And so that is going to be less time for them to do projects, less time you know and if Clinical Coordinators have to, at present we have the Unit Managers assuming projects or project managers. If we have Clinical Co-ordinators trying to run them, it's a nightmare. They will never get round to doing it. They will be too worried about the roster, workforce management, getting people on the roster and getting risk assessments done, so I think that over the next two or three years, we are going to be in trouble project wise. I don't think it will actually happen. I think it's going to be worse. Whereas with that middle line of management you had certain management who could be freed up to look at strategic directional stuff.* (Paul, 2).

Jacob had similar concerns to Paul, and felt that the change in roles across the organisation would result in a skill deficit with those expected to take on additional tasks unqualified to do so:

> *The main concern I have is that I wonder if some of the Clinical Coordinators won't be up to it? They essentially are being asked to do things they weren't employed to do. And it is a significant change in their job description ...I think there are some risk issues around that.* (Jacob, 1).

Eliza agreed with both Jacob and Paul, stating that in her view the proposal was highly likely to be unsuccessful, also locating her concerns with the skill gap created by removing the Unit Managers:

I think that there is going to be a lot of difficulty with increased workload on the Clinical Coordinators and I don't know that they are going to be given the time or the information to do their job properly and I hate seeing people being set up to fail. (Eliza, 1).

In summary, research on archetype transformation suggests that a failure to engage staff in service development decreases the likelihood of its successful implementation (Aarons et al., 2011; Callaly & Minas, 2005; Gkeredakis et al., 2011; Hinings, Brown, & Greenwood, 1991; Hinings & Greenwood, 1989). Participants at Living Well displayed competitive commitment towards the Proposal for Clinical Governance. Participants in both the interviews and in meetings observed as part of this research had reservations about what the changes would mean for service development and whether it was reasonable to redistribute the additional workload created by removing the Unit Manager role. Despite these concerns, participants had not dismissed the change, and did not display any overt or covert resistance to it during the discussion stage of the proposal. Tom's enthusiasm for the proposal guaranteed that the implementation of structural elements of the Proposal for Clinical Governance due to his role as General Manager. However, over time participants' lack of commitment had the potential to undermine the proposed change meaning that the change, as first proposed, would struggle to be implemented.

The Project Implementation Process

The Clinical Governance Strategy was a significant change event at Living Well involving structural changes, the creation of new positions and the establishment of others, as well as a realignment of the philosophical values underpinning the organisation's interpretive scheme. At the third interview the General Manager, Tom, listed the implementation of the strategy as being one of Living Well's key challenges

over the preceding 12 months. This section outlines the implementation process for the Clinical Governance Strategy.

Implementation of the structural component of the change was fairly straight forward: "*People just moved into their new positions and started*" (Geoff, 3). It was undertaken using a formal management of change process. This gave notice to employees directly affected by the disestablishment of the Unit Manager positions, enabled the unions to be involved and provided clear processes and timelines for implementation.[189] Information was provided to all affected staff[190] detailing the process for disestablishing the Unit Manager role, as well as outlining the opportunity to apply for the newly created Clinical Manager and Service Management positions. Recruitment was also undertaken for the Chief of Psychiatry and Allied Health Leader positions. Once these positions were filled, the newly appointed Clinical Managers received training related to the new tasks of their role. At the same time, researchers and project workers were relocated to the renamed Clinical Governance Unit. These changes were complete prior to 1 July 2008 when the Clinical Governance Strategy officially took effect.

No one was made redundant as part of the implementation of the Clinical Governance Strategy. The roles and tasks allocated to individuals changed, but the people remained the same. There was some staff turnover at a senior management level, due to family reasons rather than because of the work environment. Five out of the seven participants interviewed at this stage in the research had changed positions due to the new service configuration. Two of these five had been through multiple role changes because of staffing changes that occurred after the change process. Table 5, p.319 details the participants' employment roles before and after the implementation of the Clinical Governance Strategy.

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[189] Five of the people interviewed as part of this research had their roles disestablished or significantly altered as part of this process.

[190] Clinical Coordinators, Unit Managers and Service Managers.

Table 5: Participants' employment roles pre and post change

Name	Employment Role pre implementation of Clinical Governance Strategy	Employment Role post implementation of Clinical Governance Strategy
Tom	General Manager	No Change
Jacob	Chair of Clinical Directors	Clinical Director for Rehabilitation and Forensic Services
Paul	Service Manager Rehabilitation	Acting Operational Manager
Geoff	Unit Manager Adult Community	Acting Service Manager for Adult Community Services
Evelyn	Unit Manager Rehabilitation Outpatient Service	Unit Manager Clinical Governance Unit
Carole	Clinical Coordinator for a Community Mental Health Team	Allied Health Leader
Matt	Nurse Practice Consultant	No change
Cliff	Nurse in Acute Inpatient Service	No change
Eliza	Consumer Advisor	No change

There was no formal process in place to implement the philosophical shift to Clinical Governance. Staff did not receive any training related to the change in approach. Rather, senior managers assumed that following the implementation of all structural aspects of the change the philosophical change would follow. However, this approach is not supported by research in the area of archetype transformation (Dent et al., 2004; Denis et al., 1999; Hinings, Brown, & Greenwood, 1991; Hinings & Greenwood, 1989; Kirkpatrick & Ackroyd, 2003). Kirkpatrick and Ackroyd, (2003a) state that in situations when management impose structural changes the values, ideas and culture of the

organisation often do not change. In order to change the dominant views of the interpretive scheme the new ways of working need to supplant the existing values by undermining the old scheme and demonstrating the benefits of the new (Denis et al., 1999; Hinings & Greenwood, 1989). The lack of a clear process for implementing the philosophical shift highlights the role of informal factors in service development at Living Well. Management assumed that the change would be adopted through a combination of the structural changes, and through informal communication pathways, strategic relationships, as well as a belief that staff would support the change as it aligned with the raison d'être of the organisation.

This section has outlined the implementation process for the Clinical Governance Strategy. The structural components including the disestablishment of the Unit Manager role and the appointment of the new Clinical Managers occurred swiftly and smoothly. The philosophical aspects of the change around adopting a Clinical Governance approach were left more to chance, relying on informal processes and an assumption that staff would ultimately adopt the new value system.

Attaining Clinical Governance

The values embedded in the Clinical Governance Strategy did align with Living Well's raison d'être of providing responsive mental health services. However, managers failed to account for the complexity of the interpretive scheme including the multiple, sometimes contradictory voices, the roles of powerful groups and the ability of key individuals to undermine change. Staff at Living Well continued to demonstrate competitive commitment towards the move to Clinical Governance post its implementation. Many staff supported the idea in principle, but continued to express uncertainty about the implications of the structural changes. This section explores the outcomes from the Clinical Governance Strategy, reflecting on the relationship between the structural changes and the values embedded in the organisation's interpretive scheme. It also considers the role of informal processes, clinical autonomy, personalities and staff's commitment to change. It is divided into sections addressing the main

components of the change: the establishment of the Clinical Governance Directorate, the Clinical Governance Unit and the disestablishment of the Unit Manager role.

The Establishment of the Clinical Governance Directorate

The Clinical Governance Directorate was set up as part of the project's implementation process, and met monthly for three months. However, its establishment was not a smooth process and after the initial meetings, the Clinical Governance Directorate did not meet again. The lack of meetings after the initial implementation period was due to a number of factors including the lack of clarity around the role of the Clinical Governance Directorate, a perceived threat to the power of the Senior Management Team as well as a lack of commitment from the Chief of Psychiatry.

O'Connor and Paton (2008) explain that a key problem around the establishment of Clinical Governance in health settings is ambiguity in the nature of the structures required to implement the principles underpinning a management and clinical partnership. The experiences of staff at Living Well would support the need for clarity around the structures, roles and responsibilities of those involved in providing Clinical Governance. Participants thought that the role of the Clinical Governance Directorate was to ensure that decisions made within Living Well aligned with national strategy and direction. Following implementation, they felt there was uncertainty around what this actually meant and how it intersected with the role of the Senior Management Team. Participants spoke at length about the lack of role clarity and subsequent tension that existed between the Senior Management Team and the Clinical Governance Directorate. Evelyn summarised the issues:

> *There seem to have been long running debates about whether one sits above the other or whether they're equal. There doesn't seem to me and presumably to lots of other people, a lot of clarity about which one's doing what. Because it used to seem quite clear to me that you know a few months ago that the*

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Clinical Governance Directorate sets the strategy, [Senior Management Team] had the role of overseeing the operationalising of it, the managing and operationalising of it. But, the [Senior Management Team] don't see themselves as doing that, they see themselves as setting the strategy, that they drive the ship. So that has kind of not been clarified really for anybody in particular. (Evelyn, 3).

As Evelyn explained, the roles of the Clinical Governance Directorate and the Senior Management Team had appeared clear in the original discussion document, but following implementation the role separation between the two groups was less clear. This is an example of what Hinings, Brown and Greenwood (1991, p.387) term the "*operational gap between the concept and the actuality*". The operational gap exists through a lack of explicit detail around the operation of the proposed change as the original proposal outlined the philosophical goals of the change and the final structure but not the processes for achieving these. This enables support for archetype transformation initially which dissipates once the true nature of the change becomes apparent (Hinings, Brown, & Greenwood, 1991). The only members in common across the Senior Management Team and the Clinical Governance Directorate were the General Manager, Operations Manager and Chief of Psychiatry. Following implementation of the Strategy the Senior Management Team were reluctant to give up their role in setting and approving strategy to take a more operational role as detailed in the original proposal. The lack of role clarity between the two groups created tension with members of the Senior Management Team appearing to feel threatened by the new Clinical Governance Directorate. Geoff, a newly appointed member of the Senior Management Team explained:

I have heard the odd muttering and there may be more going on outside the circles where I am not privy to... and I probably allude to the Clinical Directors. I think some of them some of those people at the [Senior Management Team] may have been

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disempowered to a certain extent. And I couldn't say whether

that is a good or bad thing, but it seems to be there. (Geoff, 3).

Chapters Seven and Eight discussed the power and influence of certain groups and individuals to undermine service development. Often led by senior psychiatrists, these groups greeted any proposed service development that threatened to change or limit their autonomy or authority with suspicion and at times resistance. Tom explained that the creation of the Clinical Governance Directorate had caused concern amongst Senior Management Team members due to a perceived threat to their role in the decision-making process: *This has created some angst in decision-making of course because people feel like they haven't got the power to make decisions anymore.* (Tom, 3). This perceived threat had meant there was a lack of investment from the Senior Management Team in the successful operation of the Clinical Governance Directorate and consequently they were not concerned about its failure to meet regularly.

The Senior Management Team had been further upset by an error in a copy of the Living Well's organisational chart that had positioned the Senior Management Team under the Clinical Governance Directorate:

> *By mistake a document was sent out which had the Clinical*
> *Governance Directorate sitting above the [Senior Management*
> *Team] and that caused all sorts of upset. [The members of the*
> *Senior Management Team] believe it sits side by side which is*
> *probably what it does, but the fact that somebody making a*
> *mistake on a diagram could cause so much headache.* (Paul, 3).

Certainly, a number of participants believed this chart to be correct and saw the Clinical Governance Directorate as sitting above Senior Management Team as for decisions and project proposals to be approved they now required the Clinical Governance Directorate's sign off rather than the Senior Management Team's. The release of the chart had created problems amongst the members of Senior Management Team, as they

felt the Clinical Governance Directorate had displaced them and undermined their authority. Carole explained:

> *There is a lot of tension between [Senior Management Team] and this new kid on the block called the Clinical Governance Directorate because the [Senior Management Team] in the past have all perceived themselves as being the decision makers and the power brokers and the notion of sharing that power is quite tricky for some.* (Carole, 3).

As Carole stated, the members of the Senior Management Team were struggling with the possibility that the Clinical Governance Directorate had more power and authority than they did. This is similar to the findings of previous research on archetype change, which found that powerful groups discredit or undermine proposed service development initiatives by giving priority to their own values (Denis et al., 1999; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989). The Senior Management Team were reluctant to support the Clinical Governance Directorate's ongoing operation. This also demonstrates the Senior Management Team's lack of commitment to changing the interpretive scheme to encompass Tom's vision of Clinical Governance, due to the perceived threat to their power and autonomy with regard to decision-making. Power blocs are a critical issue in service development, whether or not powerful people and groups stand to gain or lose power influences their level of support for proposals.

Across mental health services, including Living Well, gaining the support of psychiatrists is important to the implementation of any service development (Callaly & Minas, 2005, Goding, 2005). [191] As part of the Clinical Governance Strategy, gaining the support of the Chief of Psychiatry was necessary to its successful adoption and implementation. A person in this type of leadership position is able to influence others and engender support increasing the likelihood of successful service development (Hinings, Brown, & Greenwood, 1991). The role of the Chief of Psychiatry was to have

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[191] The role of Psychiatrists has been discussed in Chapter Eight.

oversight of the clinical components of strategic and operational planning, including the Clinical Governance Directorate. Tom, the General Manager, had initially set up the Clinical Governance Directorate and then upon request from the Chief of Psychiatry had shifted responsibility for its management to him. Since that time, no further meetings had occurred:

> *The Clinical Governance Directorate met on a monthly basis for the first three months and then [the Chief of Psychiatry] decided it was important that he was in charge of that, that he chaired that. So I chaired it to get it up and going and it was a measured success. ... It hasn't got back together again and that's critical and [the Chief of Psychiatry's responsibility]. Because I said that's fine if you feel that as the Chief of Psychiatry that it is your role to chair that then I am happy to stand aside and let that happen. We are working with a context of this is a system which needs to be clinically lead and management supported. But already I am seeing some of the foibles of that.* (Tom, 3).

Tom placed the blame for the failure of the Clinical Governance Directorate with the Chief of Psychiatry. He believed that the Chief of Psychiatry had not prioritised the Clinical Governance Directorate, instead appearing to collude with the Senior Management Team to undermine the Clinical Governance Directorate's ongoing operation. This finding corroborates the ideas of Karp and Helgø, (2008) and Oreg (2006) who talk about the covert mechanisms professionals use to sabotage service development. The Chief of Psychiatry had not explicitly rejected the idea of the Clinical Governance Directorate; he had just failed to schedule meetings. The Chief of Psychiatry had an established authority base as part of the Senior Management Team, which included other Clinical Directors. The Senior Management Team provided for peer discussion of key issues across senior managers and clinicians, enabling them to prioritise issues for service planning and development, which was a key feature of

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Living Well's interpretive scheme. The creation of the Clinical Governance Directorate, while clinically lead by the Chief of Psychiatry, did not include any other Clinical Directors and was rather a representative group that did not have the same level of psychiatric input as the Senior Management Team.

Despite the structural changes and the tension between the Senior Management Team and the Clinical Governance Directorate, participants reported that there had been no tangible change to decision-making processes. Jacob explained:

> *There's still the same people, there's still the same horse trading that needs to go on and the structures haven't been turned upside down, they've been modified... There has been no revolution in that sense.* (Jacob, 3).

Jacob's sentiments reflect the unaltered nature of Living Well's structural system. Despite, the establishment of the Clinical Governance Directorate, their failure to meet on an ongoing basis meant that Living Well had reverted back to the previous system of decision-making and consequently very little had actually changed.

This study confirms that dominant professional groups are able to maintain the status quo by diluting attempts by senior managers to impose change across the organisation (Denis et al., 1999). At Living Well, the members of the Senior Management Team continued to operate as they always had, ignoring the establishment of the Clinical Governance Directorate. Service development pathways remained unaltered and through a process of collusion, the reality of shifting decision-making to a model premised on Clinical Governance had not been realised.

The Clinical Governance Unit

Alongside the establishment of the Clinical Governance Directorate was the re-naming of the Quality Assurance and Business Unit. The function of the newly renamed Clinical

Governance Unit was to provide support to the business and strategic functions of the organisation administering the clinical governance model. As noted earlier in this chapter, the renaming and relocation of staff to the unit occurred smoothly. However, the ability of the unit to support clinical governance was uncertain due to a lack of direction from the Clinical Governance Directorate. This meant that the role of the unit remained unchanged from when it was the Quality and Business Assurance Unit.

Evelyn, was appointed to the role of Clinical Manager of the Clinical Governance Unit. She reflected on this 'new' business unit and its ability to be effective within Living Well. Evelyn felt that even if the Clinical Governance Directorate was up and running the unit would be ineffectual in supporting Clinical Governance due to her exclusion from many of the decision-making meetings:

> *One of the bad things the things that I think is potentially going to drive me out of the job and is going to mean that it just won't function anywhere near as well as the potential it has is the lack of communication. Now in my role I don't go to [Senior Management Team] I don't go to the Clinical Governance Directorate, right so I don't know what's going on, so I don't basically know what is going on in the service unless I make it my business to find out it doesn't actually come to me.* (Evelyn, 3).

As evident in Evelyn's statement, the absence of direction from the Clinical Governance Directorate and a lack of involvement in other decision-making and service development activities undermined the unit's ability to support the philosophical change towards clinical governance.

The renaming and relocation of the Clinical Governance Unit was another example of a structural change imposed by the General Manager, which was unaccompanied by a philosophical shift in the organisation's interpretive scheme. As discussed in the

previous section, the members of the Senior Management Team appeared unprepared to alter their approach to decision-making and regarded any attempt to change this as a threat to their authority and autonomy. A representative of the Quality and Business Assurance Unit had not attended the Senior Management Team meeting prior to the Clinical Governance Strategy and consequently an invitation to attend was not extended to the new Clinical Governance Unit after implementation. As a result, the role of the unit had not changed and it continued to perform the tasks as it did prior to 1 July 2008.

Disestablishing the Unit Manager Role

Chapter Five discussed Living Well's business structure fulfilled an administrative function and the configuration of services had little impact on the nature of services delivered directly to clients. The disestablishment of the Unit Manager role was the most visible result of the Clinical Governance Strategy involving the removal of these positions from the business structure. Alongside this, the Clinical Coordinator role was re-branded to Clinical Manager, and two extra Service Managers were appointed.

While essentially another structural change, the removal of the Unit Manager role had been justified as part of Clinical Governance as it brought decision-making closer to the client by flattening the management structure. However, as noted earlier in this chapter, participants were sceptical about the motivations behind the change, believing it had more to do with cost savings than Clinical Governance. Tom rationalised this criticism stating that the positions were superfluous with the role duplicating tasks completed elsewhere:

> *I think there was an enormous amount of duplication that went on, so some of that stuff hasn't been picked up because it has gone, it is not being duplicated anymore…really it is giving that clinical leadership as close to the patient as possible. So getting [Clinical Managers] to say you're spending the resources,*

you're expending them, you need to make decisions about them
and you need the authority and the accountability. (Tom, 3).

A well-functioning business structure is important to the smooth operation of mental health services (Callaly & Fletcher, 2005). As a consequence, a lack of effective systems for dealing with administration has flow on affects across the organisation with potential impacts on service delivery (Callaly & Fletcher, 2005). The findings of the current study are consistent with other research, which found that staff did not resist or undermine structural changes when there was no direct impact on the way in which services are delivered directly to clients (Denis et al., 1999; Hinings, Brown, & Greenwood, 1991; Olsen, 2008). However, participants were unable to make a clear connection between the removal of the Unit Manager role and a philosophical shift to Clinical Governance. They discussed the negative consequences of the change including increased workload, fragmentation between units and duplication in resources as well as interrupting service development processes. Once again, participants displayed competitive commitment to the change reporting on the problems they had observed yet still holding on to hope that the philosophical shift to Clinical Governance would occur. Geoff explained:

> *I think it is still bedding in. ... But there are just from anecdotal sort of sources there's still people out there operating as they would have previously, so as a Clinical Coordinator, still operating as Clinical Coordinators. And so some of that resistance is still there whether that will wear down or whether some of those people will go, vote with their feet as the saying goes … Then there has been another group of people who have seized on it and appreciate the extra responsibility they had and gone with that. So the jury's still out on quite where it will go.* (Geoff, 3).

Almost all of the participants, except Tom, believed that the true impact of removing the Unit Manager role had not yet been realised. Geoff explained:

> *What's happened is you have had those Unit Manager roles, where fourteen of those and they have been split or that work has either been devolved down to the Clinical Managers, well the Clinical Managers/Charge Nurse Managers depending on whether you are outpatient or inpatient. Or it's been devolved up to the Service Manager so we are still sort of working with that. The Clinical Managers have taken on a financial aspect that they didn't have previously and so there is quite a bit more budgetary and administrative tasks that some of them are still coming to terms with.* (Geoff, 3).

As Geoff noted, tasks previously completed by Unit Managers, including recruitment and human resource processing, had shifted to other areas that were still adjusting to the new tasks. Paul also believed that the reallocated workload would prove too much for the new roles:

> *I think there are some teething problems there, I think we'll go back to a Unit Manager model at some stage because I think they were the workhorses of the organisation, they have taken all the workhorses out, those that had a view over every unit of their service and unless they either increase the number of Service Managers or reduce the size of service areas there is just no way that they are going to control them.* (Paul, 3).

Paul felt that the additional workload pressure would eventually result in the organisation reverting to its original structure by reappointing the Unit Management tier.

A finding discussed in Chapter Five, was that the business structure of Living Well acted as a barrier to services working together as each area protected and identified their locus of care with their individual unit. The diffuse nature of power across Living Well meant staff already struggled with a sense of organisational belonging and this is consistent with findings from other research on professional bureaucracies (Beetham, 1987; Kirkpatrick & Ackroyd, 2003a; Mouzelis, 1967). The removal of the Unit Manager role served to further complicate this situation, as instead of communicating and receiving feedback from 12 Unit Managers, messages needed to be delivered and information collated from 39 different Clinical Managers responsible for 39 different service areas. Evelyn described this process as chaotic:

> *It's one of the areas that is quite problematic for me in the Clinical Governance Unit. There is a lot of reporting and stuff that we do or feedback on strategic documents for corporate quality and risk. We give it to the Service Managers and say can you give us feedback. So, they just biff it out to their Clinical Managers who then bring all this stuff back. Well, in actuality it needs to go through the Service Managers who will collate it a bit so it presents how the service wants it rather than this sort of hotchpotch. Everybody makes inappropriate comments all over the place to areas where they weren't actually asked to comment. So it is a bit of a circus really.* (Evelyn, 3).

Agreeing with Evelyn, Paul stated that the increased number of Clinical Managers had also resulted in less oversight and coordination across units. Under the previous structure, a single Unit Manager in the Adult General Community service had oversight of six Community Mental Health Teams. Now each of these Community Mental Health Teams had their own Clinical Manager who was responsible for staffing including the management of over time. In the past, the Unit Manager assessed the location of resources across their areas of responsibility and shifted these to meet needs:

So it is to [each team's] benefit to fill the roster whereas the Unit Manager used to say well hold on Jo Bloggs over in this service has got extras why don't you just take two of theirs for the day. Those sorts of decisions aren't being made any longer because people make them only for their unit and that's costly, you know very costly... There is [also] a lot more risk of somebody going off and doing their own thing in their own little area and saying we've got these three doctors off and so we're not taking any assessments for the next three weeks. (Paul, 3).

As Paul noted, following the implementation of the Clinical Governance Strategy, there was less oversight as each team was concerned with filling gaps in their individual rosters without concern for overtime usage across services. A similar problem had occurred in Living Well's Acute Inpatient Service. As discussed in Chapter Five, Living Well's Acute Inpatient Service was dominated by high clinical demand and the acuity of clients. The implementation of the Clinical Governance Strategy had removed the Unit Manager and replaced this person with three Clinical Managers. This move had increased fragmentation across the entire unit. Paul explained:

So [the Intensive Care Ward] has one Clinical Manager, [Unit One] has one Clinical Manager and so does [Unit Two]. Righteo they used to have one Unit Manager who said all right get the three of them together and as Clinical Coordinators, we need to move these [clients] through here. That person would also report on the financials for each of those areas, they would look at [client] flow, they would know that there were vacancies and things so they would [coordinate recruitment]. They would ask these people to sit on the panel but they would do all of the organisation, coordination role. They would do everything, make sure there was a flow, make sure that [Unit Two] knew that [the Intensive Care Ward] had four [clients] they needed to

> *move on and they have to move through there, they'd organise*
> *the doctors, they'd organise the leave with the doctors and now*
> *we've got the consultants signing off leave, the Service*
> *Manager who may not know how many doctors are on that day,*
> *so they've lost that kind of coordination.* (Paul, 3).

The lack of oversight of the Acute Inpatient Service placed additional pressure on a system, which already prioritised operational demands over issues of long-term strategy, service planning and development.[192]

Participants' original concerns about the potential consequence for service development following the removal of the Unit Manager role appeared to be realised after implementation of the Strategy. Paul discussed the busyness of Clinical Managers, which he believed left little time for service development:

> *They lose their vision on advertising and interviewing and all of*
> *the things they used to do at that [Unit Manager] level, they are*
> *now too busy running the units and too busy accounting for*
> *every fortnight of financials and annual leave taking and all of*
> *the other things they have to do.* (Paul, 3).

The increased workload of Clinical Managers and Service Managers meant Clinical Managers continually juggled projects, administration and human resource activities alongside the daily clinical and operational demands of delivering mental health services.

This section has explored the outcomes from the implementation of the Clinical Governance Strategy at Living Well. The main features of the change were structural including the establishment of the Clinical Governance Directorate, the re-branding of the Quality and Business Assurance Unit, and the removal of the Unit Manager role.

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[192] See Chapter Five for additional information about the pressure related to the Acute Inpatient Service.

There was mixed success in the process of implementation, with tension between the Senior Management Team and the Clinical Governance Directorate resulting in the Directorate failing to meet after the first three months. The Clinical Governance Directorate was to be the overarching umbrella for Clinical Governance across Living Well. It was intended to lead the shift to an interpretive scheme premised on Clinical Governance. The failure to implement the Clinical Governance Directorate had flow on effects including influencing the ability of the Clinical Governance Unit to fulfil its tasks supporting the Directorate. The removal of the Unit Manager role, while succeeding in moving managerial decision-making closer to clients was still contentious, with participants concerned about the workload ramifications as well as increased fragmentation and impacts on the service development process.

The Outcomes of Archetype Change

As discussed in Chapter Two, in their seminal work on archetype change, Hinings and Greenwood (1989) identified different change tracks that aligned with an organisation's transformation within and between archetypes as part of the process of archetype change. These tracks included organisational inertia; aborted excursion; reorientation, successful archetype transformation and unresolved excursion (Hinings & Greenwood, 1989). Organisational inertia resulted in the organisation rejecting the new archetype thereby retaining its original form (Hinings & Greenwood, 1989). Aborted excursion involved the partial implementation of a change, which was then rejected with the organisation reverting to its original ways of working (Hinings & Greenwood, 1989). Successful archetype transformation meant the organisation adopted a new archetype through a process of reorientation. In an unresolved excursion, the organisation became torn between its original and the proposed archetype (Hinings & Greenwood, 1989). This section provides an analysis of the success of the service development at Living Well through the lens of archetype theory. It considers staff commitment, ongoing implementation and evaluative processes. It uses the change tracks identified by Greenwood and Hinings (1989) to assess the outcomes of the implementation of Clinical Governance at Living Well.

As discussed throughout this study and in accordance with international research all archetype change needs to consider the relationship between the formal structures and systems of an organisation and its interpretive scheme (Brock, 2006; Brock, Powell, & Hinings, 2007; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989; Hinings & Greenwood 2003; Powell, Brock, & Hinings, 1999). The Clinical Governance Strategy outlined a structural and systems approach that represented an example of multiple convergent archetype transformations (service development initiatives). However, the original proposal failed to address how to change the existing values embedded within the organisation's traditional ways of working. Even following the implementation of the Clinical Governance Strategy, participants still displayed competitive commitment towards the change. They expressed concerns about the implementation process thus far and yet believed the changes still needed time to embed themselves across the organisation. Tom said: "*as they say on election night, it is too early to call. And I say that because you need some maturity of the decision making*" (Tom, 3). As the newly appointed Allied Health Leader a position created as part of the change process, Carole was invested in seeing the Clinical Governance Directorate up and running. She agreed with Tom's sentiments, stating: "*I don't think things like the Clinical Governance Directorate have worked or have tried to work long enough to know whether that is going to work or not*" (Carole, 3). Both Carole and Tom believed that more time was required prior to assessing the overall success of the Clinical Governance Strategy.

The complexity of the service development and delivery environment at Living Well has been a consistent theme across this research. Multiple value systems influenced the interpretive scheme as it continually adjusted to the changing nature of its environment. The introduction of a Clinical Governance Strategy was intended to address the imbalance and ongoing conflict between management and clinical priorities evident across Living Well, prioritising clinical expertise and moving decision-making closer to the client. Paul spoke about the many unanticipated problems as staff came to terms with the new structure and their new roles:

[The Strategy] has got a lot of hiccups at present and it certainly hasn't settled down, there's the Governance thing hasn't settled down, versus the [Senior Management Team] aspect and it certainly hasn't settled down between the roles of the Service Manager and the Clinical Managers and who fill that void in between... Has it brought the decision making closer to the shop floor which was the argument in theory? Well it probably has, but is that person making better decisions by it and I'd say they are not making any better decisions by it, they are in fact just overwhelmed by the amount of work and frustration in it. (Paul, 3).

As Paul discussed, the changes addressed structural and procedural impediments to Clinical Governance, but failed to consider how individuals including members of the Senior Management Team would respond to shifting power dynamics and responsibilities including the establishment of the Clinical Governance Directorate and the removal of the Unit Manager role.

Interestingly, there was no plan in place to evaluate the changes. Paul explained:

There is no evaluation as 12 months down because it is too big to go backwards. You know if we had to go backwards now we would have to go and employ 12 more Unit Managers so what do you do if it fails you've got to do another management of change to put it back the way it was and then you are going to have to have the funds to do that you are going to have to cut people's jobs, so instead of going for thirty-nine Clinical Managers you are going to have to either reduce them or their money because their responsibility drops because you are going to give it to somebody else and centralise it. So we trap ourselves by just continuing that process I think. (Paul, 3).

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Paul was adamant that an evaluation could not occur because admitting the proposal had not achieved its intended goals would mean reinstituting the old structure, which was too difficult and too costly.

Living Well's foray into Clinical Governance can be viewed as an attempt at convergent archetype change. It adopted all of the structural changes initially, but the implementation of the Clinical Governance Directorate failed to proceed beyond the first three months. Staff at Living Well also did not embrace Clinical Governance as a method for decision-making reverting to their original processes of using the Senior Management Team meeting as the primary decision-making forum. Living Well's pursuit of change consequently represented an unresolved excursion with some aspects of the changes to the archetype being adopted and others dismissed. The transformation process highlights the dominance of the values embedded in Living Well's interpretive scheme, including the reliance on informal pathways, relationships, professional autonomy and authority. It suggests that mental health organisations need to be strategic in the process of implementing service development considering the implications of the proposed change on existing roles and relationships, thinking strategically about how to ensure professional support and how what steps are required to translate a vision into actuality.

Conclusion

This chapter explored Living Well's attempt to implement Clinical Governance. The change involved structural and process changes across the organisation including establishing a new governance group, the Clinical Governance Directorate; as well as realigning aspects of the business structure and removing the Unit Management tier. When analysed through the lens of archetype theory, the proposed change failed to recognise the complexity of altering Living Well's interpretive scheme, which was a complex system of values representing multiple sometimes-contradictory perspectives. The Clinical Governance Strategy also did not address processes required to support the

adoption of Clinical Governance as a philosophical approach. Rather, the General Manager assumed that clinical governance would be embedded in the organisation's structures and processes once the structural components of the change had been implemented.

Living Well's attempt at Clinical Governance represented an unresolved excursion where some parts of the Clinical Governance Strategy were implemented yet the interpretive scheme of the organisation continued to operate as it always had. Throughout the implementation process, staff exhibited competitive commitment towards the change, supportive of the overall goals, but concerned about the potential ramifications of the change.

The most obvious failing of the process of service development was the Clinical Governance Directorate. The Clinical Governance Directorate was to be the central feature of the new system, which would provide leadership and governance for the organisation. However, the Senior Management Team covertly undermined the ongoing operation of the Clinical Governance Directorate because of concern it undermined their autonomy and authority. While the other structural components of the change were implemented these also presented challenges such as increased workload, a lack of coordination across services and uncertainty around decision-making processes.

Post Script

In March 2011, Carole provided an update on the Clinical Governance Strategy. She stated that the appointment of a new General Manager had meant further changes to the service development process at Living Well. She discussed what happened following the last interview:

> *The Clinical Governance Directorate ran for a while although*
> *it was never very clear what went to that forum and what went*
> *to [the Senior Management Team] so a bit fuzzy. Since [the new*

General Manager] has been here both [the Senior Management Team] and [the Clinical Governance Directorate] were disbanded and we have a new Strategic and Business committee which has all of what used to be [the Senior Management Team] plus Consumer, Family, [Maori] representation. It is not a very good decision-making forum so mostly it is more about a reporting forum – a few strategic decisions. In addition we have an Executive team which is the [General Manager, Operational Manager, Director of Nursing, Chief of Psychiatry, and Allied Health Leader] and we meet every week...At the end of the day the General Manager makes the final decisions but generally [they] try to be inclusive of the relevant parties. (Carole, personal communication, 31 March 2011).*

Carole's reflection on the change process highlights the ongoing role of key professionals at Living Well including the appointment of a new General Manager who had the ability to direct and influence service development. In terms of evaluating the success of the archetype transformation, Carole's comments demonstrate that rather than reverting to the previous system, further structural and procedural changes had occurred with the establishment of different meetings and forums for decision-making. Despite this, the key determinants of Living Well's interpretive scheme remained unaltered. Service development was still premised on responding to the immediate clinical and operational needs required to deliver responsive mental health services on a daily basis influenced by informal processes, powerful groups and interpersonal relationships.

Chapter Ten: Conclusion – Discussion and Recommendations

Introduction

This study set out to understand how service development occurred within statutory mental health organisations in Aotearoa New Zealand. The research involved an organisational case study of one statutory mental health service provider, Living Well.

The investigation aimed to:

1. Assess how decisions relating to service development were made.
2. Analyse the processes that informed service development.
3. Examine the barriers and facilitators of effective service development?
4. Consider the role of formal planning mechanisms including strategy, policy, reviews and projects in service development.

The study involved both primary and secondary data. The primary data included the collection and analysis of meeting minutes, project and review documents as well as the observation of meetings and qualitative interviews. Alongside the fieldwork, secondary data including literature, research, policy and reviews on the topic were collected and analysed. The process of data collection and analysis enabled an assessment of the significance and implications of the processes that informed service development at Living Well. The findings of this case study research contribute significantly to the body of knowledge on service development and archetype transformation within statutory mental health providers in Aotearoa/New Zealand.

The focus of this chapter is to review the key research findings that have been identified and discussed throughout the preceding chapters. The chapter also discusses the implications of these findings for understanding service development within statutory

mental health organisations. The first part of the chapter begins by revisiting the context for the research, considering the key characteristics of Living Well's archetype that served as a mechanism upon which to understand the service development process. Next, the key findings from the research are presented, centred upon the development of an approach for understanding service development at Living Well. The third section moves on to discuss the implications of these findings for policy makers, managers and clinicians working within statutory mental health services. This includes a guide for policy makers, managers and clinicians wishing to proceed with service development within this environment. The chapter concludes with the limitations of the research, recommendations for future research and final remarks.

The Research Context

This research drew on archetype theory to form an approach for discovering and analysing the determinants for service development in a statutory mental health organisation, Living Well. Living Well's archetype was introduced in Figure 3, Chapter Four, p.118 and is included again in Figure 7, p.342. The use of archetype theory enabled an holistic assessment of service development at Living Well giving consideration to the structures and systems of the organisation alongside its raison d'être and the values embedded in its interpretive scheme. Understanding the role of each of these elements in the service development process at Living Well was a key focus of the research.

Living Well was an example of a professional organisation delivering statutory mental health services. Living Well's raison d'être, held consistently by managers and clinicians across the research, was the desire to provide responsive mental health services. This raison d'être became evident very early in this study. It informed the nature and scope of projects and reviews, was central to meeting activity and reflected in the content of participant interviews.

Figure 7: Revisiting the archetype of Living Well

Living Well was a composite organisation that attempted to balance the competing value systems and priorities of clinicians and managers (De La Luz Fernandez-Alles & Llamas-Sanche, 2008; Olsen, 2008). The split between these different values and priorities was represented in all aspects of Living Well's functional and symbolic organisational structures. Living Well's functional structures included the internal systems and policies as well as the physical location and organisation of services. Living Well's symbolic structure was its interpretive scheme which included the values, beliefs and ideologies of its members.

As discussed in Chapter Five, while Living Well had a hierarchical business structure evident in its organisational chart and reporting lines, it had a diffuse power structure where each of the smaller units had their own set of values, beliefs and ideologies about how work should be undertaken dependent on their service focus, client needs and staff

composition. Led by a Clinical Director and Unit Manager[193] each functional unit was also responsible for its own financial and resource management. The internal systems and policies of Living Well involved separation between clinical leadership and management tasks. Management's tasks included the operational and strategic oversight of the organisation. Clinical leadership was provided through Clinical Directorates, who were concerned with the nature and quality of clinical service delivery. Clinicians delivered services by working collaboratively in multidisciplinary teams under the oversight of a Clinical Director, who held clinical responsibility for all clients under the care of the unit, and a Unit Manager who was responsible for the operational concerns involved in the day-to-day delivery of services.

An organisation's interpretive scheme captures interaction across the organisation, the nature and location of power, as well as the ways in which day-to-day work is undertaken (Brock, Powell, & Hinings, 2007; Hinings & Greenwood, 1989). Embedded within the structures and processes of the organisation, the interpretive scheme develops from the interactions, patterns of behaviour, and expectations of the organisation's members and aligns with its raison d'être (Bennett, 1997; Hall, 2002; Hinings & Greenwood, 1989). Living Well's interpretive scheme was central to the service development process. It was complex and at times contradictory. It was the primary location for ongoing tension between clinical values including an ethic of care, autonomy, clinical expertise and peer review with management priorities of policy and strategy, risk management, accountability and efficiency.[194]

The different components of Living Well's archetype described above served as the context for understanding service development. The roles and interactions between these elements were examined in order to understand the process of service development. The

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[193] Unit Managers were disestablished as part of the Clinical Governance Strategy when the role was changed to Clinical Manager merging the tasks of Unit Managers and Clinical Coordinators, the newly created position still had responsibility for the operational concerns of the individual unit. Chapter Nine contains details related to this change.
[194] The nature and role of Living Well's interpretive scheme is discussed further in key finding 1 as part of this chapter.

following section presents an approach for understanding service development at Living Well through a discussion of the key findings of the research.

Key Findings

The main themes evident throughout this thesis demonstrate the complexity of service development at Living Well, including the multiple value systems and priorities that influence service development. Further, the findings reflect the difficulty involved in developing and delivering responsive mental health services in Aotearoa New Zealand. The purpose of this section is to review the key findings of the research through the discussion of an approach for service development giving consideration as to what would be required to progress service development within a statutory mental health organisation.

An Approach for Service Development

As noted above, the evidence from this study facilitated the development of an approach for understanding service development at Living Well. The service development approach elucidates the factors that are critical for understanding service development within this environment including competing value systems, different pathways for service development, and the role of operational and clinical priorities for service development.

The approach presented in Figure 8, p. 345 provides a pictorial explanation of service development at Living Well. It highlights the different elements involved in service development including both formal pathways utilised mainly by management and informal pathways, which are the preferred clinical change pathway. It also shows the tension between the conflicting priorities of clinicians and management and that service development which aligns with clinical values proceeds faster than the prescribed formal service development pathways. The service development initiative is allocated

priority dependent on its technical necessity; the organisation's current operational and clinical demand concerns; as well as the relationships and roles of those involved in service development. All of these changes occur under the umbrella of the organisation's raison d'être and form part of the organisation's interpretive scheme. Each element that contributes to this framework is discussed further in the sections that follow.
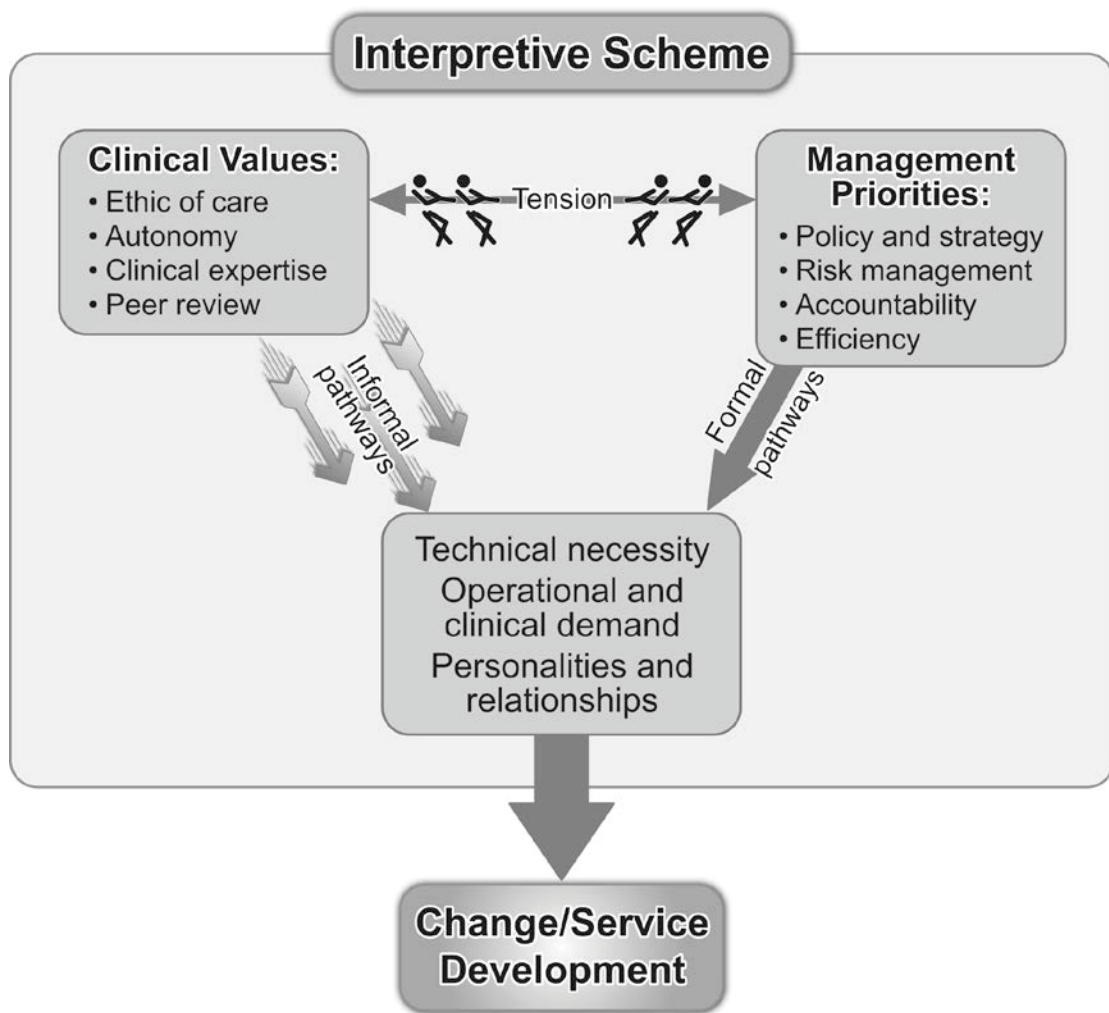

Figure 8: An approach for understanding service development at Living Well

1. Living Well's interpretive scheme was central to service development.

Understanding the nature of Living Well's interpretive scheme was a central concern of this thesis. A key finding of the research was that Living Well's interpretive scheme was complex and sometimes contradictory as it responded to the changing priorities of delivering statutory mental health services. The service development approach captured in Figure 8 emphasises the complex, yet central role that Living Well's interpretive scheme played in the service development process.

Brock, Powell and Hinings, (2007) write about the dynamic nature of an organisation's interpretive scheme, as over time it incorporates new ideas that align with the dominant values of the organisation. However, archetype theory's central concern is with achieving new stable organisational forms and views changes within an organisation's interpretive scheme as transitory as the organisation stabilises itself within its new archetypal form (Cooper et al., 1996; Kirkpatrick & Ackroyd, 2003a; Kirkpatrick & Ackroyd, 2003b). This study supports the findings of Kirkpatrick and Ackroyd (2003a, 2003b), who examined archetype change within social service organisations in the United Kingdom and critiqued archetype theory for its preoccupation with explaining how organisations achieve new organisational forms or archetypes. Kirkpatrick and Arckroyd (2003a, 2003b) found that the complexity of the interpretive scheme within social service organisations meant they did not achieve archetype transformation instead remaining permanently in a hybrid or transitory organisational form. At Living Well, the complexity involved in delivering mental health services meant that the organisational archetype was pulled in many directions, torn between different value systems and priorities where one was unable to maintain dominance, yet all at times successfully resisted change. This type of change represents what Hinings and Greenwood (1989) term an unresolved excursion. However, they (Hinings & Greenwood, 1989) would expect the organisation to either revert to its original archetype or transform into a new form. This did not occur at Living Well as the organisation continually struggled to

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reconcile the different values, and priorities of delivering mental health services allocating priority depending on the nature of operational and clinical concerns. Living Well consequently, did not achieve a new stable state of archetype transformation, as it continually made changes and responded to the nature of its environment.

This research found that nowhere was the complexity of Living Well's interpretive scheme more evident than in the ongoing tension between clinical values and management priorities. The tension between clinical values and management priorities influenced all elements of service planning and development as the organisation struggled to balance the need to plan services with responding to the immediacy of operational and clinical demands. Management gave primacy to responding to the requirements of policy and strategy, risk management, accountability and efficiency (Chapter Five). Management priorities related to the need to be mindful of strategic and policy responses (Chapter Six) as well as the operational requirements of delivering mental health services on a daily basis including staff cover and rosters; bed availability; maintenance concerns; risk minimisation and audit; information technology; human resource concerns; and budgetary requirements (Chapter Five). Whereas, an ethic of care, clinical expertise, autonomy and peer review governed clinicians' value systems (Chapter Five) driven by clinical responses required to meet the needs of clients with mental illness. The imbalance between clinical values and management priorities was prevalent across all aspects of the organisation influencing the consideration of strategy and policy, participation in reviews and projects, as well as the operational and clinical concerns involved in the daily delivery of mental health services. The lack of resolution between the values and priorities of these two groups ensured that the service development process was not straightforward as each group battled for primacy.

Chapter Six explored the role of strategy frameworks and policy in service development at Living Well. The research found that management saw strategy and policy in terms of highlighting political imperatives and defining the overarching frameworks required of a mental health service. However, clinicians did not allocate the same status to the consideration of strategy and policy instead focusing on their clinical values in terms of

how they responded to their clients, which left little time for planning beyond the immediate short-term needs of those in front of them. This particularly presented a tension for those managers from clinical backgrounds who struggled to reconcile the two conflicting paradigms resulting in a form of custodial or diluted management where daily clinical and operational demands were prioritised within the organisation over longer-term strategic service development (Denis et al., 1999).

The asymmetry between clinical values and management priorities was also apparent in the project and review process as each party assumed that they shared the same goals and values. Chapter Seven emphasised the different expectations of managers and clinicians when participating in formal change processes including reviews and projects. Management, including those with clinical backgrounds, assumed that project members would factor feasibility into their project plans. Clinicians placed emphasis on delivering quality mental health care with the overall goal being to improve mental health outcomes for clients. They saw feasibility and resourcing as managerial concerns and their focus was on finding best practice solutions to ensure positive outcomes for clients. The lack of coherence between the two positions meant that project and review outcomes were frequently unrealistic with managers citing resource constraints and unrealistic outcomes and clinicians blaming a lack of support from management (Best Use of Beds Project, Home Based Treatment, Understanding Acute Demand Projects). The result of this ongoing tension was that managers and clinicians often utilised different pathways for service development and change evident in the observation of meetings, minute analysis, as well as participant interviews. Managers preferred the formal pathways of projects, reviews and evaluations with clinicians more frequently utilising informal pathways to progress changes to service delivery. The next section discusses the differing use of formal and informal pathways as part of the service development process.

2. Service development involved the use of both formal and informal pathways.

This research found that generally statutory mental health organisations are torn between the requirement to act like a bureaucracy following rational/legal processes by adhering to rules and regulations with the reality of service delivery. It was also shown that at Living Well, there were both formal/planned and informal/unplanned pathways for service development. Living Well strove to find the ideal approach to statutory mental health service delivery by attempting to balance planned service development with being responsive in a changeful and volatile environment. Formal pathways existed through the implementation of national policy and strategy as well as through projects, reviews and evaluations and were most frequently utilised by management. Informal pathways were the preferred service development pathway for clinicians and emerged in response to concerns about the everyday functioning of individual units, the needs of clients and through the personal preferences of those in positions of influence. These different pathways for service development were reflected in participation and engagement with project and reviews, the progression of items in meeting minutes, discussion at meetings across the organisation as well as in participant interviews.

National policy and framework documents were part of the formal processes for service development at Living Well. The Ministry of Health and Mental Health Commission played important roles in developing and monitoring the national strategic and policy frameworks including *Te Kōkiri*, *Te Tāhuhu* and *Te Hononga* for all mental health services. However, there was a lack of connection between the national policy framework, clinical service delivery and localised service development at Living Well (Chapter Six). As with all archetype change, alignment was required between the national strategies and frameworks and the interpretive scheme of Living Well, which was rarely achieved. While management understood the importance of the national frameworks, the documents fulfilled the role of supporting the strategic vision of Living Well rather than driving the shape and nature of service delivery. This was due to the priority given to responding to operational and clinical concerns on a daily basis. It was

only in situations where the Ministry of Health worked alongside clinicians to develop particular responses that service development of this nature occurred. An example of this was the development and implementation of the Watch House Project where the two groups worked together to develop a service that would meet everyone's needs (Chapter Six).

Projects, reviews and evaluations formed the other formal pathway for service development at Living Well. Staff considered these the most legitimate and appropriate pathways for service improvement (Chapter Seven). These processes reflected the rational bureaucratic model and emphasised an hierarchical approach to planned service development, with all formal service development requiring approval from the Senior Management Team prior to development and implementation. Projects and reviews were frequently initiated and utilised by management as a response to concerns about the nature and scope of service development as well as to implement strategic vision.[195]

The results of this study show that service development as result of projects, reviews and evaluations was rarely implemented. The formal service development processes embedded within projects, reviews and evaluations were cumbersome and slow limiting the emergence of ideas and clinical participation in service development. The dynamic nature of the service delivery environment also meant that operational and clinical concerns changed quickly and new priorities were frequently identified which superceded existing project and review arrangements. This was evident in a number of the projects and reviews analysed as part of this research including the Best Use of Beds Project, Home Based Treatment, Understanding Acute Demand Projects, Priorities for Action projects including Access and Responsiveness, Inpatient Bed Management and Improving the Patient Journey.

To address the slow speed of change and lack of outcomes from formal service development processes service development generated by clinical reflection, clinical

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[195] Appendix A includes details of the project, reviews and evaluations which were analysed as part of this research.

audit and quality initiatives occurred frequently across Living Well resulting in both minor and major adjustments to clinical service delivery (Chapter Eight). These changes often occurred spontaneously in response to concerns and frustrations experienced by clinicians. These ideas emerged from within the value systems of clinicians, who consequently understood the worth of altering their practice. They did not require support from the management hierarchy and implementation occurred without any disruption to clinical practice.

The informal processes for service development included the priority given to the daily operational and clinical concerns related to the delivery of mental health services. These processes existed alongside personal preferences, professional roles, values, and the location of power across the organisation. At the Senior Management Team level, these factors influenced the response given to proposed service development initiatives and the resources attached to them. At the level of clinical delivery, informal processes engaged clinicians in the service development process, ensured alignment with clinical values, and recognised the nature of the service delivery environment.

Evidence from meetings, the minute analysis and participant interviews as well as the analysis of project and review documents supported that the use of informal processes increased the speed and likelihood of successful service development. Another factor influencing the likelihood of successful service development was the significance allocated to the change initiative amongst other competing elements. The next key finding discusses the determinants that influenced the priority allocated to service development at Living Well.

3. Service development was prioritised based on technical necessity, operational and clinical demand, and personalities and relationships.

At Living Well, the importance of being a responsive service took priority over a considered approach to service development. This limited the effectiveness of formal change processes. This research found that service development at Living Well reflected a pragmatic and responsive approach to operational and clinical demands rather than the consideration of project and review outcomes, policy objectives and broader strategic vision. Changes to the nature and scope of service delivery occurred to ensure the ongoing safety of clients and staff (sentinel reviews), out of technical necessity to guarantee the organisation's ongoing survival (funding and audit requirements), agreement between management and clinical values (Clozapine Clinic and Watch House Project), clinical pragmatism (clinical reflection) and because of personal preferences (Clinical Governance Strategy) and strategic relationships (failure of Home Based Treatment).

Both clinicians and management prioritised and implemented changes to the nature and scope of service delivery when this was required as part of the technical necessity to ensure the organisation's ongoing survival. Service development initiatives that were considered technical necessities included outcomes from sentinel reviews, the development or review of policies, financial audit mechanisms, accreditation frameworks, and Ministry of Health directives. Despite the ongoing tension between clinicians and management, these items were allocated greater significance and implemented as all staff understood the importance to the organisation's ongoing ability to deliver responsive mental health services (Chapter Five).

As Chapter Three discussed, the process of service development in statutory mental health services internationally is complex with service priorities identified by the nature of the clinical environment and operational concerns related to service delivery (Aarons et al., 2011; Braden Johnson, 1990; Butler, 1993; Callaly & Minas, 2005; Falloon &

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Fadden, 1993a; Hoge & Howenstine, 1997; Keating, 1998; Norcross, Garofalo, & Koocher, 2006; Panzono & Roth, 2006; Reay, 2010). The results of this investigation support international experience demonstrating that despite the existence of formal service development pathways and the frequency of reviews and projects, both clinicians and management struggled to give weight to service development on an ongoing basis because of the immediacy of operational pressures, clinical demand and risk factors driven by personal agendas easily dominating this process. As already discussed, the conflict between managerial and clinical priorities slowed the service development process and in response management focused on immediate operational concerns such as occupancy and staffing to minimise conflict and to ensure the technical survival of the organisation. This finding also corroborates the ideas of Mueller, Harvey and Howorth (2003) and Denis et al.(1999) who found that the lack of agreement between clinicians and management resulted in "custodial" or "diluted" management where the focus became on addressing operational issues and tinkering with minor service development rather than addressing long-term service planning issues.

The Acute Inpatient Service at Living Well, discussed in Chapter Five, exemplified the issues of responding to short term operational and clinical concerns. Despite numerous inquiries, projects and reviews the problems of over-occupancy, acuity of clients, staffing, risk and the quality of care endured. Service development was an additional burden on top of already overstretched workloads. Consequently, management focused on addressing the immediate, short-term needs of both clinicians and clients. The failure to address long-term service planning and the increased fragmentation across the unit due to the disestablishment of the Unit Manager role as part of the Clinical Governance Strategy (Chapter Nine), meant that the problems related to the Acute Inpatient Service endured.

The custodial management described above left the way open for personalities and relationships to influence the service development process. In accordance with other research on archetype change, powerful groups at Living Well were able to give priority to their beliefs and values and to discredit or undermine proposed service development

initiatives (Denis et al., 1999; Greenwood & Hinings, 1996; Hinings & Greenwood, 1989). Senior management and psychiatrists (Chapter Eight) were the main groups who were able to control service development, by either lending or withdrawing their support for an initiative. Additionally staff at Living Well had learnt to use relationships strategically to engender support and progress service development initiatives.

Living Well's raison d'être of providing responsive mental health services justified the focus on immediate operational and clinical factors across the organisation. However, it created a service development system that was difficult to predict and rendered strategic planning processes ineffective. It also meant that personalities and relationships were able to exert influence over service development processes.

The Implications of the Findings

Concerns about the quality and scope of service delivery pervade the development of statutory mental health organisations (Chapter Three). This research sought to analyse the processes that inform service development within statutory mental health services in Aotearoa New Zealand. The current study adds substantially to the knowledge of service development within statutory mental health services in Aotearoa New Zealand and has a number of important implications for the future planning, development and implementation of service development within this environment. This includes the development of a new approach for understanding the complexity of service development alongside the multiple often-conflicting factors that drive service delivery within this context. This research also enables analysis of the different factors that influence the success of service development and how to make use of these elements through the development of a guide for those working within mental health services wishing to proceed with service development.

Policy makers, managers and clinicians expect organisations like Living Well to follow formal processes thereby ensuring accountability of public money, efficient outcomes

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and equity in the treatment of clients (Blau & Meyer, 1971; Pandy & Bretschneider, 1997; Weber, 1947). Formal processes mean that clear lines can be drawn from plans, to decisions, to actions. However, the experience of service development at Living Well indicates that the use of formal service development processes did not increase the frequency of successful service development (Chapters Six and Seven) instead clinicians used informal pathways to engender support and speed up the service development process. This study has shown that formal service development pathways were resource intensive, placed additional workload burdens on already overstretched clinicians, and were unable to keep pace with the changing clinical and operational demands of delivering statutory mental health services. Clinicians were frustrated that formal processes were not followed, their slowness and the lack of tangible outcomes that resulted. This meant that clinicians lacked commitment to the process, resented the imposition on clinical time and preferred informal methods to achieve their own goals. Informal pathways included responding to concerns about the everyday functioning of the organisation, the needs of clients and through the personal preferences of those in positions of influence.

The service development approach presented in Figure 8, p. 345 enables analysis of the different factors that influence the success of service development and offers policy makers, managers and clinicians a mechanism for demystifying the service development process within statutory mental health services like Living Well. Based on these considerations Figure 9, p. 356 presents a guide for those working within statutory mental health services wishing to introduce a new service development initiative. While not the only factors influencing successful service development consideration of these elements greatly increases staff commitment, reduces opposition and assists to elevate the proposed service development to a priority within a changeful environment. The key consideration of the guide involves attempting to attain alignment between the core features of Living Well's interpretive scheme, including the organisation's raison d'être and the priority given to operational and clinical demand, by utilising informal processes to engender support and to minimise opposition for service development. Each point in the guide is explored further as part of this section.
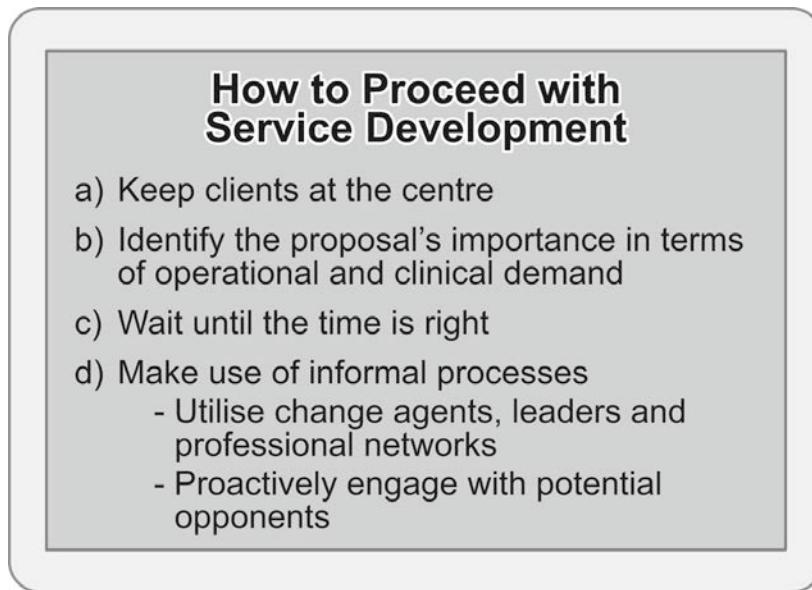
Figure 9: A guide to service development

a. Keep clients at the centre.

Figure 9 above presents a guide to service development. The first key consideration of the guide is that any service development proposal must be focused on client care. The findings of this research clearly identified that sustained service development requires alignment with the interpretive scheme of Living Well including its raison d'être. These values, beliefs and ideologies filtered all service development. Keeping clients at the centre of proposed service development aligns with the raison d'être of providing responsive mental health services as well as the core values of the interpretive scheme. Ensuring that any new service development remains focused on improving the quality and effectiveness of client care increases both clinicians' and management's commitment to the idea thereby minimising opposition. This should therefore be the key focus of all new service development proposals within statutory mental health organisations.

b. Identify the proposal's importance in terms of operational and clinical demand.

A key challenge of service development within statutory mental health organisations is to identify its importance amongst other competing priorities. The findings of this research consistently show that the immediacy of issues related to operational and clinical demand such as staffing, occupancy and client acuity take precedence over planned service development (Chapter Five). These concerns influence the pace of formal service development, the implementation of outcomes and the ability to plan strategically (Chapter Six). An assessment of any new service development proposal's ability to address operational and clinical concerns should be a critical concern of those proposing service development. This process should identify the benefits of the proposal to the daily operation of the organisation as well as the quality of client care thereby demonstrating the worthiness of investing valuable resources and clinical time.

c. Wait until the time is right.

Statutory mental health services are delivered within a changeful and volatile environment. Timing is therefore another consideration when introducing service development. Changing government priorities and philosophies, the media and the stage of the electoral cycle shape mental health services' ability to plan and implement service development (Chapter Six). The timing of introducing a new service development proposal is therefore important. Funders' and managers' willingness to take risks and invest in new service development initiatives is influenced by politics and the potential for negative attention tempers service development decision-making to ensure it is politically and publicly acceptable. Changing political imperatives influence the availability of external resources. The investment in Primary Health Liaison roles at Living Well and their subsequent shift to the NGO sector were examples of service development following national priorities around investing in primary care, this was also reflected in Living Well's changing strategic priorities, and created a willingness to

invest in areas that supported this agenda. The Improving the Patient's Journey Project was an example of a project that did not achieve its intended goal. It involved a huge amount of clinical resources, had robust processes and yet did not achieve its intended outcomes involving packages of care to enable high need clients to be discharged and supported within the community. The changing priorities of the funder meant that additional resources were unavailable to support this project's outcomes meaning they were not implemented with the flow on impact of reducing staff willingness to participate in other service development activities.

d. Make use of informal processes.

The findings of this research support that informal processes for service development are faster, and achieve results more frequently than formal processes. Staff commitment to a service development initiative increases its likelihood of sustained implementation. The guide for proceeding with service development (Figure 9) recommends the use of informal processes including utilising change agents, leaders and professional networks to build support as well as proactively engaging with potential opponents to gain access to those who have the ability to progress service development. The nature of professional groupings at Living Well meant that by using professional relationships and strategic alliances, support could be garnered for proposed service development initiatives increasing the likelihood of success. The Watch House Project and the establishment of the Clozapine Clinic were examples of service development projects that had support from across the organisation and were successfully implemented. Home Based Treatment, the Best Use of Beds Project, the Community Integration Project, and the Clinical Governance Strategy were examples of projects that lacked support, and consequently did not proceed.

There were numerous examples of clinicians using their informal networks, change agents, leaders and professional relationships to elevate service development ideas within Living Well. By using these informal mechanisms, clinicians were able to short cut the very slow and cumbersome hierarchical process of gaining approval for service

development (Chapter Seven). In accordance with other research, this study found that change agents and leaders are not necessarily the decision-makers within the organisation but were the people who had the ability to navigate the organisation's hierarchy, with direct paths to those with the most ability to shape, and influence service development (Hinings, Brown, & Greenwood, 1991, Powell, Brock, & Hinings, 1999). The use of change agents, leaders and professional relationships also enables engagement with powerful groups across the organisation who would otherwise oppose or sabotage the change. At Living Well, psychiatrists were the professional group with the most power to influence service development, without their support service development failed (Chapter Eight). To minimise opposition those proposing a new service development initiative must engage with this professional group early. Facilitating their input into the proposed project as well as addressing their concerns about the potential impact on their autonomy, power and ability to deliver treatment to their clients.

In summary, this research offers an approach for understanding the process of service development within statutory mental health organisations like Living Well and provides a guide for those wishing to initiate service development within this environment. The findings of this research emphasise the challenge of creating alignment within the organisation's interpretive scheme and supports that if achieved successful service development is possible. It recommends that staff within statutory mental health services utilise a considered approach to initiating service development. To increase the likelihood of success service development proposals need to keep client care as the central focus, consider the implications for operational and clinical demand, the project's timing as well as making use of informal processes including utilising change agents and professional networks to engender support and proactively working with opponents.

Limitations of the Research

A caveat needs to be noted with regard to the present study. While the use of an organisational case study facilitates an in-depth analysis of service development within one statutory mental health provider, there are concerns about the ability to generalise the findings of this type of research (Crowe et al., 2011; Noor, 2008; Yin, 1999). This study has examined service development within one statutory mental health organisation. It provides a foundation and becomes an exemplar for further case studies examining the nature and process of service development in other statutory mental health organisations. Therefore providing for replication logic and addressing concerns related to the ability to generalise the findings of this research (Yin, 1999). It further contributes to knowledge building and theory development in the area archetype transformation and understanding with regard to the nature of statutory mental health providers. [196]

Future research

The raison d'être of Living Well was about improving client outcomes through delivering responsive mental health services. Considering how to develop services to achieve this raison d'être is not a straightforward process. While this research aimed to understand the process of service development within statutory mental health services in Aotearoa New Zealand, further research is required to replicate and further explore the findings of this study including the mechanisms for creating alignment within the interpretive scheme of individual mental health organisations.

The focus of this thesis was on understanding local service development within one statutory mental health provider. In order to fully understand how services are developed across statutory mental health services in Aotearoa New Zealand further research should be undertaken across services to assess regional variances. The analysis

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[196] Chapter Three contains further information about the limitations of this research.

should give consideration to informal as well as formal pathways to service development to assess whether there is any difference in the interpretive scheme of statutory mental health service providers across the country.

The present study considered the role of national policy as a variable influencing local service development. At the time of completing this research the Ministry of Health was consulting on the development of the third mental health plan. This study found that there was a disconnection between national policy and local service delivery. The development of mental health policy presents the opportunity to research the process of national policy development giving consideration to how the goals embedded within these documents can be translated into the service delivery environment of local mental health providers. In particular, research is needed to explore mechanisms to support local service delivery and development alongside the implementation of national policy objectives.

Concluding remarks

In closing, this thesis was concerned with understanding service development in statutory mental health organisations. It has found that service development is complex, involves multiple stakeholders and is subject to influence from internal and external factors. The findings indicate the need to build alignment between the goals and priorities of managers and clinicians in order to ensure the development of services that are responsive to the needs of clients with mental illness.

Clinicians and managers within statutory mental health services strive to deliver the best services they can. Unfortunately, the pace of formal service development and a lack of tangible outcomes means that at times, the process of service development can be co-opted by broader political and personal agendas with sometimes tragic consequences. In considering the implications of this research, it is important to recognise the complexity of the service development environment, with its conflicting priorities and demands; and to understand the importance of delivering clinical care in a resource limited, risk averse

environment. Mental health services in Aotearoa New Zealand provide valuable services to clients with mental illness, this research offers a mechanism for understanding how to improve service development to further assist clients with their recovery.

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Appendix A: Table of reviews and projects

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
Aug 02	Resectorisation Project	Internal (with assistance from Crown Public Health)	Project	Research and Mapping project: to provide a background context for the consideration of the current sector boundaries and their possible re-formulation	No explicit recommendations – called for a consideration of the key findings.
Aug 02	Day Programme review	Internal	Review	Consideration of the future of the Day Programme, due to poor utilisation of the resource.	1. The Day Programme should be phased out. 2. The phase out period should allow time for those patients currently attending the programme to be found suitable alternatives. This is to be a collaborative process involving the patient, Case manager and Day Programme staff. 3. Those staff currently involved in the Day Programme to be consulted with to determine their wishes as to how to best utilise these skills. 4. The FTE currently utilised in running the Day programme is returned to the Community Psychiatric team from which it is allocated. 5. Teams co-operate in providing specific, short-term groups on the basis of demand, such as the "healthy eating group" or "Medication Education".

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
					6. Current Day Programme staff who choose to remain with their CPS team as Case Managers together with current experienced Case Managers and PDN's should be utilised more by their colleagues who have less knowledge or understanding of existing NGO and other community resources including non-CDHB Community Support worker. Formal methods for achieving this may need to be devised by CC's. 7. A working group of interested and enthusiastic people should be brought together to develop the Day Hospital proposal with a view to seeking funding for implementation.
Dec 02	Consideration of issues at Family Mental Health Service	Internal	Review	Generated in response to concerns of a staff member. Focus Acuity of patients, workload and the model of care.	1. Review the SPF with particular attention to: Defining the role and boundary of clinical responsibility of psychiatrists working at FMHS. Defining the clinical responsibility of the GP Defining the clinical responsibility of the Case manager. Defining the roles and responsibilities of the Clinical Head, Unit Manager, and the clinical Coordinator. Outlining the clinical review processes in place. Developing a clearer definition of acceptance criteria. Developing guidelines for transferring cases onto other services. Developing guidelines for needing a psychiatric review. Defining the interfaces between FMHS and other internal and external services. 2. Develop an orientation process for psychiatrists which includes

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
					outlining the role and boundaries of their clinical responsibility, the system of case management and the clinical review processes in place.
					3. Review systems with GP to ensure that there is clear understanding of their responsibility in the management of clients, the role and responsibility of the psychiatrist and that they are receiving adequate information in order to carry out their role.
					4. To review system of caseload review to ensure supervisors have oversight of the total case manager caseload.
					5. To review the system of psychiatric consultation to include the opportunity for the psychiatrist to meet with the case managers as a group for case discussion in addition to individual case reviews.
					6. To review the role and format of the weekly clinical meeting in relation to Mental Health Standard requirement for MDT input in all cases.
					7. To consider a fuller review of the Refugee and Migrant area and its direction for the future.
Dec 02	Eating Disorders Review	Internal	Review	Review of the delivery of a tertiary level specialist Eating disorders service at four levels: within the	1. National service to be ratified, appropriately funded and official with Director and University involvement.

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
				strategic direction of the [Living Well]; within a regional South Island framework; within current national context and intended purchasing frameworks; in accordance with international evidence and best practice.	2. Efficiency and function within the unit and its extensions to be improved particularly with respect to throughput. 3. Day programme to be funded through staff and service development initiatives. 4. Existing services to be supported, developed and integrated so as to provide a full range of services complementary to the service and to the National service provision for Eating Disorders. 5. Services for Eating Disorders other than anorexia nervosa (including bulimia nervosa, binge eating and eating disorders not otherwise specified) to be developed. 8. Eating Disorders and treatment needs in Maori and Pacific Island peoples to be researched and services developed.
Jan 03	Residential and Respite Review	External Funding and Planning review	Review	Purpose: to review the services delivered to people who experience mental illness and who require residential accommodation and/or respite services to support their recovery.	1. Encourage stakeholder involvement within all activities of [Living Well]. • need to identify the mental health community • relationship within and across sectors • examine role of the Regional mental health network

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):

					• Develop a Funding and Planning strategic plan.
					
					2. Validating the experience of consumers/ tangata whaiora and family/whanau and incorporate into the planning and delivery of services.
					
					   • culture of partnership
					
					   • foster capacity
					
					   • share training opportunities
					
					3. Implement Kaupapa Maori services that meet crown obligations under the Teary of Waitangi.
					
					4. Encourage best practice.
					
					   • encourage exchange of ideas between services
					
					   • introduce outcome measures
					
					   • promote research
					
					5. Workforce Development
					
					   • value, support and grow capacity and capability

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
					6. Develop capacity for flexible, innovative services. • Communicate expected people centred outcomes of accommodation, residential rehabilitation and respite services. • Reconfigure the way in which services are funded to maximise flexibility and minimise dependence on beds. • Reconfigure the Residential Rehab service with a view to retaining expertise to deliver services in a less restrictive physical setting and maximise their availability to NGO rehabilitation services in the community. • Review current contracting arrangements with a view to introducing incentives that encourage providers to work collaboratively towards consistent, coordinated seamless services by decreasing the emphasis on specified funding allocations and increases flexible support arrangements within available resources and good quality monitoring systems in place • Ensure that there is a system of needs assessment and service co-ordination that takes into account the unique characteristics of the district and more effectively meets the needs of the consumer/tangata whaiora.

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):

Aug 03	Best Use of Beds Project	Internal	Project	To investigate opportunities to provide a better service to patients with complex needs and to identify mechanisms to manage [Living Well]'s bed-state	1. Promote core values
					
					   - operationalise the strategic plan
					
					2. Develop systems for improved communication with Funding and Planing, intersectorally and with the NGO community.
					
					3. Develop designated subacute beds in [Rehabilitation] and/or secure continuing care beds
					
					4. Investigation the option of Acute Observation beds
					
					5. Ensure service development is premised on ongoing research and evaluation
					
					6. Investigate feasibility and cost effectiveness of a Day hospital
					
					7. Develop closer internal relationships
					
					   - through the implementation of the interface model
					
					8. Undertake an analysis to [Living Well's] current response to patients who have comorbid psychiatric and alcohol and drug issues
					
					   - develop a training response to this
					9. Align non-regional forensic beds with Rehab

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
					10. All units should have a therapeutic day programme 11. Implement a generic referral letter across [Living Well]. 12. Develop an organisational response to the issues of Overflow and sleepover 13. Undertake an analysis of the SPF to identify gaps and overlaps in acceptance criteria 14. Place ongoing priority to issues of workforce development - including recovery training
Dec 03	Understanding Intellectual Disability Inpatient Services Activity	Internal	Project	To assess the gaps between current service capacity, the original and actual provision of services and demands for intellectual disability services. To examine trends associated with the recent increase in incident numbers in the Unit	1. Further review is required of community and service providers to examine the lack of availability of suitably resourced residential options, and also issues related to accessing suitable vocational, recreational and social options for this client group. 2. Further review is required of current community residential options in terms of their availability to effectively manage clients with severe challenging behaviours in the community. Such a review would examine environmental issues such as residential client numbers and mix, staff competency, and resourcing. 3. A tighter and clearer set of expectations regarding provider

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
					responsibility throughout the process of contact with the Unit is required.
					4. A tighter and clearer set of admission and exclusion criteria is required prior to admittance.
					5. Further evaluation is required of the implications of managing clients with varying levels of acuity co-existing together on one ward. One option would be to have one acute/assessment ward and a separate treatment/rehabilitation ward for all intellectually disabled clients.
					6. It is vital that sufficient resources be provided to maximise the goals of the Unit, particularly in regard to the establishment of a complete MDT, and in providing greater access to meaningful activities for clients on the unit.
					7. Implementation of an outreach model whereby staff would ensure that community providers are supported in implementing discharge or crisis plans for a limited time.
					8. Consider the re-adoption of a waitlist system to allow planned admissions.
					9. A comprehensive literature review be conducted to examine other models of service delivery for this client group, in particular the ideal staff size, discipline composition, and models of care based on the

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
					prevalence of intellectually disabled clients in the community with a need for such a service.
Dec 03	Understanding Acute Demand	Internal	Project	To assess trends and anomalies in patient characteristics and treatment factors relating to the high demand for acute inpatient beds.	1. That processes are put in place for ongoing data collection and analysis within the inpatient unit. 2. That further analysis is undertaken in areas such as referrals to the inpatient service from [Crisis Service] and the management of patients by the Adult Community [Team]. 3. That processes are in place to recognise, monitor and manage alcohol and drug issues and the contribution these factors may have on the resolution of patient symptoms and patient length of stay within the inpatient unit. 4. That clinical review is undertaken on patient files who had an inpatient stay of less than 5 days per admission. 5. That processes are put in place to enable the benchmarking of data with other District Health Board Mental Health Services nationally. 6. That the "Understanding Acute Demand" project is repeated on an annual basis to reflect on trends and anomalies in patient characteristics and inpatient stays over time.
2003 –	Knowing the	Internal	Project	To explore who its long-	1. Leadership review information and decide how implementation of

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
ongoing	People Planning			term service users are and how the service might better deliver care to this group	recovery principles/KPP fits with other Strategic planning initiatives underway and clinical governance 2. Planning and Funding and District Advisory Group given access to information for sector discussion and planning 3. Reinstate KPP Field Activity at the ... Centre Or Plan new service with recovery approach as founding philosophy and develop teams using KPP principles
2003-2006	Reorganisation of Inpatient rehabilitation Services	Internal	Project	Reorganisation of Inpatient rehabilitation Services • For Delivery of sub-acute and complex extended care beds	To reconfigure inpatient rehabilitation services with the aims of: a) Enhanced movement of patients currently referred to the Rehab service out to the community b) Provision of extra beds for Acute Inpatient Service, without compromising their care, which would lead to early re-admission c) Reviewing the mix of patients in the units
Apr 04	Review of Reviews	Internal	Review	To analyse past projects and reviews undertaken within [Living Well] between 1997 & 2004	No recommendations were made as part of the report.
May 04	[Crisis Team]/ED	Internal	Project:	To gain understanding and	Project plan and timeline development – no final project documents

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
	Project	Access and Responsiveness		clarity regarding psychiatric patient contacts undertaken at hospital ED	located as part of this research
Oct 04 – June 06	Family Mental Health Service Review	Internal Access and Responsiveness	Project	To identify, examine and develop a plan to position FMHS within the existing structure and framework of [Living Well]	The FMHS was dismantled and integrated into other parts of [Living Well] with the bulk of the service going into the Child Adolescent and Family Mental Health Service.
October 2004	Understanding Acute Demand 2004	Internal	Project	To assess trends, anomalies in patient characteristics, and treatment factors with relation to acute inpatient care	1. The Understanding Acute Demand project should continue to be undertaken on an annual basis 2. An historical analysis should be undertaken to assess the gendered use of the acute inpatient service 3. A further analysis should be undertaken of patients with a history of more than 25 admissions to assess the efficacy of their current treatment regime 4. A process of service analysis should be considered alongside the acute demand project in order to assess other factors that may have implication on inpatient activity 5. Clinical outcome measures should be viewed as a critical part of any consideration of service evaluation and development
Nov 04 –	Client Journey	Internal	Project	To identify the	Funding approval be provided to support the provision of individual

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
Nov 05	Improvement: Priority for Action Inpatient Bed Management			individualised care needs of 12 patients with chronic and severe mental illness who are in [Rehabilitation] clinic in order to facilitate their reintegration into the community	packages of care for the patients included within the project
Nov 04	[Crisis Team] & CMHT Component	Internal Access and Responsiveness	Project	To ensure consistent access and provision of service to all new and existing clients of SMHS and immediate access to information/triage 24 hours per day	Project plan and timeline development – no final project documents located as part of this research
Dec 2004	Review of Information Technology relating to the provision of ECT	Internal	Review	To assess and respond to the IT requirements of the Clinical Services unit with regard to the provision of ECT	Project approved and forwarded to IT services to respond to.
Dec 2004	Clinical Pathways of Care	Internal: Priority for Action 2 – Inpatient Bed management	Project	To ensure smooth and seamless transition of patients across inpatient unit boundaries through the determination of clinical pathways within [Living well]	Project plan development – no final project documents located as part of this research
Dec 2004	Winscribe Pilot Evaluation	Internal	Evaluation	To evaluate the success of the Winscribe Pilot	1. Winscribe should not be adopted throughout the entire DHB at this

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
					time
					2. Any adoption of Winscribe within the DHB should occur within a staged and closely monitored environment to ensure all technical difficulties are resolved quickly
					3. Consideration should be given to the following options:
					a. Maintaining the current dictation system
					b. Exploring the merits of other digital dictation systems
					c. Investigating whether Winscribe could be purchased through another provider
					d. Undertaking a further Winscribe pilot within the DHB, outside of MH.
March 2005	[Crisis Team]: Night Shift Evaluation	Internal	Evaluation	Evaluation of a pilot where a Night Shift staff member was located in ED	1. Extending the parameters of the night shift to enable cover seven days per week.
					2. Ensuring annual, sick and study leave cover is available to the position
					3. Addressing potential gender safety issues
					4. Widening the scope of the role to enable the development of closer

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
					relationships with ED
May 2005 – June 2006	Access and responsiveness: Single Point of Entry	Internal	Project	To ensure consistent access and provision of service to all new and existing clients of SMHS and immediate access to information/triage 24 hours per day	Consideration of two scenarios: 1. Front of Office Changes • triage team established at … • works in conjunction with [Crisis team] • receives all referrals by fax, email, mail etc • Consists of 2 clinical staff, 1 admin assistant and 0.1fte medical time • Operates in extended normal business hours (0800 – 1800) Monday to Friday. Closed weekends and Public Holidays • Straight triage, pass on referrals, confirms initial appointments, no contact with consumers/referrers between allocation to appropriate team and pick up 2. Process Changes Both Front and Back Office • Triage team established at … • Works in conjunction with [Crisis Team]

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
					• Receives all referrals by fax, mail, email etc
					• Answers telephone queries and gives advice as appropriate
					• Consists of 6.8 clinical staff, 1 admin assistant and 0.2 FTE medical time
					• Operates 7 days a week, 4 FTE on 10 hour days Mon- Fri and 1 FTE on 10 hour day weekends and public holidays
					• Triage referrals, passes on as appropriate, confirms initial appointments
					• Provides telephone contact follow-up after triage and assignment until appropriate team picks up consumer
August 2005	[Rural location] Review	Internal	Review	To assess FTE levels in relation to service requirements	1. Further consideration of the psychiatrist FTE level available to the Team
					2. MDT reviews include a psychiatrist
					3. Reviews with GPs should not include Team members who do not have mutual clients with the GP
					4. Discussion with … regarding service priorities, for example discharge planning and implementation, and the impact of the Team's rapid

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
					response to GP referrals
					5. Acceptance and discharge of patients to the Service is consistently implemented as specified in SPF
					6. A further review of caseloads should be completed in 6 months times.
					7. Ongoing monitoring of the Team's [Crisis] service
Sept 2005	Home Based Treatment	Internal Priority for Action 2 – Inpatient Bed management	Project	To look at alternatives to admission for consumers and work in a proactive way	1. [Living Well] needs to endorse the need to look at alternatives to admission for consumers and work in a proactive way.
					2. [Living Well] needs to evaluate carefully its current service delivery to see where funding for new initiatives might be drawn from
					3. The community review needs to have a systematic plan of what direction it will take after the SPOE project is in place as any other changes will have implications for that project
					4. SMT will need to decide whether this project should take precedence over, or wait for, any further rearrangement of community services
					5. A group of interested people needs to explore the concept and put together a more detailed proposal

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
Feb 2006	Alcohol and Drug Service: Increased Attendance Project	Internal	Pilot	To address patient non-attendance at CADS	1. Use of cellphone texting for appointment reminders 2. Creation of an Evening Clinic at the Community Alcohol and Drug Service
March 2006	Borderline Personality Disorder Project	Internal	Project	To provide specialist training and expertise in the area of BPD	1. That the training unit be authorised to make the CM training available to other [Living Well] Teams 2. That approval is given to allow the CM training to be provided to other DHB MH Services – fees to cover training materials and replacement Clinician time 3. That approval is given to commence training of specialist therapists for the second phase of the project 4. That approval is given to support 10 -15 staff attending the MBT training with … in September; in order to establish a local cohort of MBT trainers and Clinicians 5. That approval is given for the MBT Training working party to continue developing training material for the creation of a local MBT training course for ongoing Phase II maintenance 6. That the decision be taken to establish a specialist personality disorder service – either through reallocation of resources/structures in MH or through MOH liaison to develop regional service

When	Name of "review"	Internally or External generated	Type ie. Review etc.	What it was/ Focus:	Summary Recommendations/Outcomes where recommendations unknown (for full recommendations please refer directly to each project/review document):
					7. That in the interim, a specialist personality disorder service be created as a "virtual team" – a team within teams
					8. That a working party be formed to determine the organisational requirements and Service provision Framework for this virtual team.
April 2006	Understanding Acute Demand Project 2005	Internal	Project	To assess trends, anomalies in patient characteristics, and treatment factors with relation to acute inpatient care	1. The Understanding Acute Demand project should continue to be undertaken on an annual basis. Resource planning should occur prior to the projects delivery to ensure every attempt is made to minimise delays in report production
					2. The factors associated with the decrease in the number of patients referred for General Practitioner follow-up post discharge should be examined
					3. A more in-depth investigation should be undertaken to uncover factors associated with length of stay
					4. Clinical outcome measures should be integrated with the data retrieved as part of this project to facilitate a greater understanding of inpatient activity and outcomes.

Appendix B: Meeting schedule

Meeting	Date Attended	Frequency of meeting	Minutes received and analysed
Senior Management Team Meeting[197]	14/2/07 21/2/07 Cancelled 28/2/07 Cancelled 7/3/07	Weekly	07/06/2006 1/11/2006 7/2/2007 17/1/2007 20/12/2006 20/09/2006 21/03/2007 21/02/2007 28/03/2007 29/11/2006 31/01/2007
Adult General Unit Managers	Cancelled 13/2/07 27/2/07	Monthly	24/08/06 27/10/06 9/11/06 1/12/06 26/01/07
Acute Inpatient Service (AIS) Executive (Exec)	20/2/2007 6/3/2007	Fortnightly	
AIS Quality	28/2/07 13/2/07	Fortnightly	
Community Exec	21/2/07 7/3/07	First and third Wednesday of month	5/7/2006 19/7/2006 6/9/2006 18/10/2006 1/11/2006 6/12/2006
Rehabilitation Exec	14/2/07 28/2/07	fortnightly	05/07/2006 19/07/2006 2/08/2006 30/08/2006 12/09/2006 27/09/2006 11/10/2006 8/11/2006 15/11/2006 22/11/2007 6/12/2006 17/1/2007
Unit Managers Meeting	Was not scheduled while I was present	monthly	24/8/2006 27/10/2006 1/12/2006 26/1/2007
Community mental health team meeting	14/2/07 28/2/07	weekly	28/2/07

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[197] Nineteen Senior Management Team meetings occurred in the period of this research. Minutes could only be located for eleven of these meetings.

Appendix C

INTERVIEW SCHEDULE

The interviews undertaken will be semi-structured, the type typically used in qualitative research. This interview schedule will be used as a guide to ensure that all areas of interest are captured during this time.

INTRODUCTION:

1. Purpose of research:
    - ➤ To investigate the processes, including service reviews that currently inform service development and delivery within a mental health provider.
    - ➤ To explain the role which evaluation plays in service planning and the development of mental health services.
    - ➤ To explore the key barriers to effective service evaluation and implementation within mental health services.

2. Issues of informed consent
    - ➤ If any of the questions make you feel uncomfortable, if you wish to stop the interview at any time or have the recorder switched off, please ask.

3. Length of interview
    - ➤ It is anticipated that this will be the first of two one-hour interviews. Do you have a time limit or anything you wish to make me aware of before we begin?

GENERAL INFORMATION:

At the beginning of the interview the following information will be asked of participants:

4. Name:

5. Employment Role:

6. Length of time employed in that role:

7. Length of time employed by the DHB:

8. Other role previously employed in within Mental Health Services:

9. What are the main tasks of your current role?

10. What do you like most about your current position?

__UNDERSTANDING NATIONAL MENTAL HEALTH SERVICES:__

11. How would you describe the service delivery environment within Mental Health Services in NZ?
    - ➢ Current strengths, gaps, problems etc

12. What would you consider are the main barriers to providing the "best quality" mental health services in NZ?

13. In your opinion, what role does the Ministry of Health play in the provision of Mental Health Services?

__UNDERSTANDING [LIVING WELL]__

14. How would you describe the service delivery environment within [Living Well]?
    - ➢ Current strengths, gaps, problems etc

15. What would you see are the main barriers to providing the "best quality" mental health services in [Living Well's area]?

   ➢ How could these barriers be addressed?

16. What would you describe as the main pressures of your role?

   ➢ What could be done to alleviate these pressures?

SERVICE DEVELOPMENT AND CHANGE:

17. What is the typical process for bringing about change within [Living Well]?

   ➢ How are issues requiring attention identified?

   ➢ What are your general impressions about this process?

18. Within [Living Well] how are decisions relating to Service Development made?

   ➢ Where are these decisions made?

   ➢ Who has input into them?

19. What information is usually considered prior to any service development/delivery decision?

20. How many meetings would you attend on average each week?

   ➢ What are the nature of these meetings?

   ➢ Which of these meetings is the most valuable to you?

      - Why?

   ➢ Which is the least valuable to you?

      - Why?

21. How do you feel about participating in service development and change?

22. Are you aware if there is a strategic plan for your area of work?

   ➢ Have you seen this plan?

   ➢ Do you know what timeframe it covers?

➢ How relevant is a strategic plan to your work?

23. If you wanted to implement change within a particular area how would you go about doing this?

➢ What would be the main barriers to this?

24. What factors do you believe need to be considered in service development and who should have input into these decisions?

25. Do you feel these factors are always considered within your work area?

➢ What do you feel could be done differently?

EVALUATION:

26. What do you consider the function (if any) of evaluating services?

➢ Why should we evaluate services?

27. Do you believe [Living Well] evaluates its services?

➢ What form does this evaluation take?

➢ What are the outcomes/consequences of these evaluations?

28. Do you see that there is a role for evaluation within [Living Well]?

➢ How would you describe this role?

29. Have you heard about MHINC?

➢ What do you know about MHINC?

➢ What are your impressions of the usefulness of this data?

30. What value (if any) do you see in the MHsmart project?

Appendix C

PERSONAL EXPERIENCE WITH SERVICE DEVELOPMENT:

31. Within your work area are there regular (annual) planning days/meetings?
    - ➢ Who attends the meetings?
    - ➢ What generally occurs?
    - ➢ What are your impressions of the usefulness of this time?

32. Have you had the opportunity to observe and/or participate in service development decisions? That is, to implement a new programme or restructure/reconfigure an old one, review a service area, develop a strategic plan?
    - ➢ In what capacities have you been involved?
    - ➢ When was this?
    - ➢ What was/were your role in this process?
    - ➢ What were you personally required to do?

33. Choose one of these times and describe this experience?
    - ➢ If more than one, were there any things in common across the experiences?
    - ➢ Thinking about one of these projects, who initiated the project?
    - ➢ What was the main goal of the project?
    - ➢ What was your impression of the need for the project?
        - How was this need/problem identified?
        - Who first identified this need?
    - ➢ Who was involved in the project?
    - ➢ Describe what happened while you were involved in the project?
        - How was the project implemented?
    - ➢ Was there a project manager?
        - What was the role of this person?

34. Were there any project documents produced to guide the project?

> ➢ Who developed these?

> ➢ What input was there into the development of these documents?

> ➢ Were they followed?

35. What were the positive things about this experience?

36. What were the negative things about this experience?

37. What factors were taken into consideration when considering the need for change?

38. Who was input sought from?

> ➢ What form did this take?

> ➢ Was there a communication/consultation strategy in place alongside the project?

>> - What was this?

>> - How did it work?

39. Were there any recommendations made as part of this project?

> ➢ How were the recommendations for the project decided on?

> ➢ What information was considered and where was it sourced from?

> ➢ What were the main barriers?

> ➢ What happened to these recommendations?

40. Have there been any observable consequences from the project?

41. In your view, what has/did this project achieve?

42. What could have been done differently?

43. Was the project ever evaluated or reviewed?

Appendix C

CONCLUSION:

44. I want to acknowledge and thank-you for your time and honesty in meeting and discussing these issues.

45. Discussion as to where to from here for the research and the potential outcomes of the research.

46. Do you have any questions for me?

47. I can be contacted at anytime if you wish to discuss or amend anything you have said or withdraw from the research.

48. You have my assurances that the information you have provided will not be used for evaluating your employment performance and every attempt will be made to keep your identity confidential.

Appendix C

INTERVIEW THREE

17 November 2007

This interview will be undertaken in the same format as the previous two interviews, it will be semi-structured, the type typically used in qualitative research. This interview schedule will be used as a guide to ensure that all areas of interest are captured. The themes identified in this report will build on areas explored in previous interviews.

INTRODUCTION:

1. Purpose of the follow-up interview:
   - To gain participants' insight into any service development changes that have occurred at [Living Well] over the past 12 months

2. Issues of informed consent
   - If any of the questions make you feel uncomfortable, if you wish to stop the interview at any time or have the recorder switched off, please ask.

3. Length of interview
   - It is anticipated that this interview will take approximately one-hour. Do you have a time limit or anything you wish to make me aware of before we begin?

GENERAL INFORMATION:

At the beginning of the interview the following information will be asked of participants:

4. Have there been any significant changes to your employment role over the past 12 month?

> ➤ If yes, please describe

UNDERSTANDING NATIONAL MENTAL HEALTH SERVICES:

5. What is your current view of the service delivery environment within New Zealand?

   > ➤ Has this view changed over the past 12 months, if so how and why?

6. What relevance do you think Ministry of Health Policies such as the Mental Health Framework have to your role?

7. What do you think are the critical success factors in implementing National policies and strategies?

   > ➤ What are the key barriers to this?

8. What do you believe would improve the relevance of policy to clinicians?

UNDERSTANDING [LIVING WELL]:

9. What is your current view of the service delivery environment within [Living Well]?

   > ➤ What have been the key achievements within [Living Well] over the past 12 months
   > ➤ What have been the key challenges?
   > ➤ What do you think are [Living Well's] priorities for the next 12 months?
   > ➤ Is this what you think they should be?

Appendix C

SERVICE DEVELOPMENT AND CHANGE:

10. What do you think are the critical success factors when implementing a new service development strategy or initiative?

    ➢ What makes one proposal succeed and others not?

    ➢ Can you provide examples to support this?

11. What are typical barriers to successfully implementing a change within [Living Well]?

    ➢ How can these be overcome?

12. What role do you think professional identity and allegiances play in the service development process?

    ➢ What are the likely consequences if support can not be gained from a professional grouping?

    ➢ Are there any key groups who need to be 'onboard' for a change to be successful?

13. What role does the service users' voice play in implementing a change within [Living Well]?

14. What role does the configuration of services, i.e. the business structure, play in the services delivered to clients?

    ➢ Does it change the nature and quality of these services, if so, how?

RECENT CHANGES WITHIN [LIVING WELL]:

15. At the time of our last interview a new service configuration had been proposed with a focus on clinical governance. Has this new configuration been implemented?

    ➢ How was this done?

    ➢ What have been the consequences of this change?

16. What are your current views of these changes and how they were implemented?

17. What do you think was the original intention of this change?
    - ➢ Do you think it has achieved this?
        - i. Why/ why not

18. Have these changes had any direct bearing on your work?
    - ➢ Please explain.

19. Do you believe these changes have affected the way decisions are made within [Living Well]?
    - ➢ Please explain

20. Are there any other issues you think are important in relation the process of service development decision making mental health services over time?

CONCLUSION:

21. I want to acknowledge and thank-you for your time and honesty in meeting and discussing these issues.

22. Discussion as to where to from here for the research and the potential outcomes of the research.

23. Do you have any questions for me?

24. I can be contacted at anytime if you wish to discuss or amend anything you have said or withdraw from the research.

25. You have my assurances that the information you have provided will not be used for evaluating your employment performance and every attempt will be made to keep your identity confidential.

Massey University

COLLEGE OF HUMANITIES AND SOCIAL SCIENCE

Understanding the Role of Evaluation in Mental Health Organisations

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read the Information Sheet dated 20 November 2007 and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet.

I agree/do not agree to the interview/meeting being audio taped.

I wish/do not wish to receive a copy of the study's results at the conclusion of the research

Signature: _____ **Date:** _____

Full Name - printed _____

Appendix E

Massey University

COLLEGE OF HUMANITIES AND SOCIAL SCIENCE

Understanding the Role of Evaluation in Mental Health Organisations

MANAGEMENT DISCLOSURE CONTRACT

This document authorises Nicola Stanley-Clarke to conduct research looking at the role of evaluation in service development at [Living Well][198] (hereafter "the organisation") during the period 1 November 2006 to (31 March 2007).

All data collected as part of the research will be kept confidential so that neither individual nor organisation can be identified. The research will form the basis of the fieldwork component for a PhD and may also be used as the basis for scholarly publications.

The organisation agrees that the research findings will not form the basis for evaluation of individual employees, but may be used in a developmental way to improve the functioning of the organisation.

The researcher will furnish the organisation with a copy of a summary of key findings of the research prior to completion of project.

Signature: (on behalf of Living Well)		**Date:**
Full Name – printed		
Signature: (Researcher)		**Date:**
Full Name – printed		

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[198] The organisation's name has been change to its pseudonym to protect confidentiality.

Appendix F

Massey University

COLLEGE OF HUMANITIES AND SOCIAL SCIENCE

SCHOOL OF HEALTH AND SOCIAL SERVICES
Private Bag 11 222
Palmerston North
New Zealand
T 64 6 356 9099 extn 2821 or 7877
F 64 6 350 5681 or 5627
sspsw@massey.ac.nz
Text "sspsw" to 5222
http://sspsw.massey.ac.nz

Understanding the Role of Evaluation in Mental Health Organisations

INFORMATION SHEET

My name is Nicky Stanley-Clarke. I am currently undertaking a PhD in Social Work. I have worked as a social worker in child protection, general health and mental health. During the last five years I have been employed by the Mental Health Division of Canterbury District Health Board, more recently as a project worker.

My research looks at how service development decisions are made within Mental Health Services in the District Health Board environment. It aims to understand the function and utility of evaluation in the mental health sector. The research will offer a new perspective with which to understand the nature of mental health service delivery in New Zealand.

This study has received ethical approval from the Upper South A Ethics Committee

The research involves the recording of strategic and operational meetings as well as interviewing eight participants from various levels of the [Living Well's] hierarchy.

The meetings which will be digitally recorded, using an audio Dictaphone, will be selected following discussion with senior management. If you are part of a meeting that is being recorded as part of this research you are under no obligation to participate. If you decide to participate, you have the right to:

- withdraw from the study at any time prior to the completion of the project; this can be done through contact with the researcher via e-mail (n.stanley-clarke@massey.ac.nz) or phone (Ph: 06 356 1920);
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded;
- ask for the audio tape to be turned off at any time during the meeting.

Eight people will also be interviewed as part of this research. During the interviews participants will be asked to reflect on the processes of service development and change within [Living Well].

If you agree to be interviewed as part of this research it will involve participating in two interviews of approximately one hour long each. With your permission the interviews will be digitally recorded using an audio Dictaphone. All information will be treated confidentially.

Appendix F

You are under no obligation to participate in this process.   If you decide to participate, you have the right to:
- decline to answer any particular question;
- withdraw from the study at any time prior to completion of the project; this can be done through contact with the researcher via e-mail (n.stanley-clarke@massey.ac.nz) or phone (Ph: 06 356 1920);
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission;
- be given access to a summary of the project findings when it is concluded;
- ask for the audio tape to be turned off at any time during the interview.

A Management Disclosure contract has been signed with management to ensure that information provided during the course of the research will not form the basis of any employee evaluations.

Confidentiality of information will be protected throughout by the following measures:
i)   The meeting and interview recordings will only be heard by the researcher.
ii)   Any data that is transcribed will have identifying characteristics removed and pseudonyms will be provided.
iii)   Material from the transcripts may be used in the final thesis and in academic publications. However, all information will be presented anonymously and it will be not be possible to identify you in any information that is presented as a consequence of the research.

The meeting and interview recordings may be transcribed by transcriber. Should this occur this person will be selected from a pool of transcribers used by Massey University. This person will sign a confidentiality agreement to ensure confidentiality of the information.

As the research forms the basis of a thesis for a PhD in Social Work at Massey University it is a supervised piece of work. If there are any concerns about the research they can be conveyed to my supervisors at the following phone numbers:

Dr Jackie Sanders   (06) 356 9099 ext 7596
Dr Catherine Brennan   (06) 356 9099 ext 2620
Dr Carole Adamson   (04) 801 2794 ext 6481

Please do not hesitate to contact me about any aspect of the research. I can be contacted through the School of Sociology, Social Policy and Social Work at Massey University in Palmerston North on phone: (06) 356 9099 or by email at: n.stanley-clarke@massey.ac.nz

Thank you for your assistance

Appendix G: Living Well's structure 2006

General Manager

Chair of Psychiatry

Operations Manager

Senior Management Team: Clinical Directors, Service Managers, Director of Nursing

Adult Inpatient Service

Adult Community Service

Maori Mental Health

Forensic Services

Intellectually Disabled Persons Health

Rehabilitation Services

Specialty and Addiction Services

Child, Adolescent & Family Services

Quality Assurance & Business Unit

Appendix H: Living Well's post 1 July 2008

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Clinical Governance Executive Directorate

General Manager

Cultural Representative

Allied Health Professional Leader

Chief of Psychiatry

Director of Nursing

Operations

ADULT COMMUNITY SERVICE

ACUTE INPATIENT SERVICE / DUTY COORD / CASUAL POOL / ROSTERS OFFICE

CHILD ADOLESCENT & FAMILY SERVICE

Maori Mental Health

ALCOHOL & DRUG SERVICE & SPECIALTY SERVICE

REHABILITATION SERVICE

INTELLECTUAL DISABILITY SERVICE

FORENSIC SERVICE

CLINICAL GOVERNANCE RESOURCE UNIT

DAMHS / INFORMATION

FINANCE

TRAINING UNIT

NURSING

MEDICAL

AHP