

It is really the little things that add up to the major changes that we can make in the lives of the people we support.

A Study of the Service Reform Fund (SRF): Understanding Reform in National Systems



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Foreword

I am delighted to introduce the report “A Study of the Service Reform Fund (SRF): Understanding Reform in National Systems”. Using data collected from over 300 participant interviews across the fields of disability, mental health and homelessness this report provides original insights into how transformative change can occur across the most challenging and complex social systems. This report provides a cross-programme analysis of the SRF and provides not only the lessons learned from the work but a number of important considerations to be taken into account for those undertaking and engaging in the reform of services.

As outlined in this report, the SRF represented an ambitious national programme of change and provided resources from a fund of €45million to implement change. Key to the success of the SRF has been the development of meaningful partnerships and collaboration across all partners involved. The SRF itself was created by the Department of Health, the Department of Housing, Local Government and Heritage, the Health Service Executive Ireland (HSE), the Atlantic Philanthropies and Genio. Action research played a central and critical role in tracking and examining these reform programmes as they were being implemented, allowing space to bring barriers and challenges which arose to the fore and address them in real time. The quotes in the report bring it to life and provide realistic insights into what it takes to bring about significant change in challenging circumstances. The transformations which occurred enabled people using the services to be seen in a new light, their capabilities and strengths to be recognised and their choices respected. Seeing such transformational change inspired and energised staff to sustain and grow these new ways of working and to build upon the person-centred approaches that were central to the SRF. I would like to whole-heartedly thank each person that took the time to sit down with the action research team and to provide such honesty and reflection.

I believe this report is an invaluable resource to those working in systems reform. The lessons presented can be applied across a wide range of social systems and demonstrate how the movement towards more person-centred models of care can help the most vulnerable in our society and ensure that their voices are always heard.

Professor Brian MacCraith
Chair, Genio Trust

Executive Summary

A Study of the SRF: Understanding Reform

The purpose of this report is to examine innovative approaches to implementing the Service Reform Fund (SRF), an ambitious national programme of change helping to expand and sustain social innovation in disability, mental health and homelessness. It was created by the Department of Health; the Department of Housing, Local Government and Heritage, the Health Service Executive Ireland (HSE); the Dublin Region Homeless Executive; Local Authorities; and the Atlantic Philanthropies, in collaboration with Genio, to implement service reform in Ireland. The objectives of the SRF were selected from existing government policies and the interdepartmental and interagency collaboration drew together a range of staff to address the challenges of implementation. Drawing on an empirical evidence-base from Action Research with more than 300 participants, the report offers examples where transformative, systemic change can occur at national, local, and frontline service delivery levels within a relatively short time.

>> Whilst policy led, the reform programme took a very different approach to more traditional approaches to re-engineering structures and processes.

Funding was used strategically to create a sense of urgency and to draw staff and people using services into conversations about the types of services to be provided.

>> The reform programme fostered new ways of working by providing a space for reflection, inter-agency collaboration, planning, action, and assessment.

As stakeholders occupied this space, they began to think through the process, finding ways to navigate the system and act based on what they had learned to transform complex problems into more manageable ones [4, 5]. The development of meaningful partnerships was indicative of a more transformative change, which requires “transforming the relationships between people who make up the system” [6].

>> The reform programme promoted a redistribution of power dynamics and laid the foundations for frontline workers to engage with the people they support in a new way.

Housing First, Mental Health and De-congregation encouraged “*risk positive*” practice. Taking risks was seen as a critical step in exposing staff to the capacity of the people with which they work. The evidence-base attached to the reform provided reassurance and comfort to those who wanted to try different ways of working in systems that were deeply embedded in the medical model.

>> While training and capacity building were integral elements of the reform process, staff needed the opportunity to apply evidence-based principles in their everyday practice in order to witness the impact it had on the people they support.

Likewise, staff needed to have the opportunity to consult with the people using the services in their everyday practice for meaningful engagement. When afforded this opportunity, the reform programme paved the way for frontline staff to see the people they support in a new light.

Through this process, staff biases and assumptions about the people they support were brought to light. Across the programmes, participants expressed cases of being “*astounded*” and “*shocked*” at a change in their perception of people’s capacities and capabilities.

>> Staff discovering the capacities and preferences of the people they support was a critical success factor of the SRF. The battle for “hearts and minds” of frontline practitioners was crucial for moving the SRF from pockets of innovative practice towards embedding the reform in everyday practice into systemic changes.

The opportunity to work in new ways and redistribute power dynamics provided the chance to challenge deeply ingrained beliefs about the capacity of people who use services. The engagement with these practices led to a “*recalibration of expectations*” by staff about the capacities and capabilities of people who use the services, often contributing to a greater sense of the shared humanity between staff and the people they support.

In many cases, this shifted views positively and allowed staff to re-frame their understanding of people using services. It helped staff see people beyond diagnoses and as a “*whole person*”, “*just like us.*”

>> The reform programme criteria aligned with specific principles which proposals had to comply with to receive funding rather than a detailed implementation blueprint.

This required local planning and engagement to shape how the SRF would operate at a local level and it was seen counter to the culture. It raised questions, generated debate, caused confusion, and often provoked fear, anger, and frustration amongst some staff.

Despite initial negative reactions by some, participants agreed that the pressure created by the SRF gave rise to greater creativity, dynamism, and adaptability across the programmes. It forced national and local agencies to “*do things differently*”, often for the first time.

>> The most heavily weighted criteria to receive funding was the need for the regional structures to consult with people using services.

In some cases, the SRF was perceived to have “forced an agenda” for engagement. The SRF was regarded as a catalyst for both introducing and strengthening service user engagement. In some areas, the consultation required as part of the SRF application process was noteworthy as it was the first time service user engagement had been carried out formally. While the application process required agencies to engage with the people using the services at the initial stages, concerns were expressed regarding the continuation and sustainability of such engagement in the face of perceived tokenism, the strength of professional groups and reimbursement issues

>> Those tasked with implementing the reform programme at the national and local levels indicated that the difficulties they encountered at the proposal and early implementation stages led to stronger outcomes than what would have been achieved with a pre-designed roadmap.

The availability of an empirical evidence-base and fidelity measures helped to alleviate the fears, frustration, and disillusionment arising from uncertainty about the SRF process [1]. The monitoring element helped to keep the reform programme on the agenda and provided a pathway amidst the ambiguity. The Action Research element of the SRF offered a platform for those senior staff tasked with its implementation to make order amidst uncertainty and to make real-time sense of what was happening [2, 3].

Considerations for those embarking on systems reform

Based on a cross-programme analysis of the SRF, the following considerations could usefully be taken into account when implementing national reform programmes. Each of the individual points is effective, but insufficient alone in working towards transformative change, which requires commitment and engagement at the systemic and individual practitioner levels.

Those engaging in reform should consider how to:

- Enable champions within the systems to grow self-direction for people using the services by creating constructive pressure to engage. Often, there are potential champions within the system who face multiple, urgent demands which prevent them leading change.

Criteria-dependent, ring-fenced, multi-annual funding along with monitoring can be used as leverage to enable agencies to commit and engage with the reform and to consult with the people using the services.

- **Build strong mechanisms for the capacities and voices of those using services to be at the heart of the reform efforts.** Ensure this remains on the agenda throughout the duration of the reform programme and beyond. This may be through methods, such as formal consultations or working through person-centred programmes like Housing First or Individual Placement and Support (IPS). It is important that the services themselves are cultivating this curiosity about the experiences of people who use services.
- **Build strong mechanisms for the capacities and voices of those using services to be at the heart of the reform efforts.** Ensure this remains on the agenda throughout the duration of the reform programme and beyond. This may be through methods, such as formal consultations or working through person-centred programmes like Housing First or Individual Placement and Support (IPS). It is important that the services themselves are cultivating this curiosity about the experiences of people who use services.
- **Build in networks and structures to support and sustain new ways of working.** Mapping how the system needs to change to support staff to work in new ways.
- **Create a learning environment that supports reflection, allowing stakeholders to both pivot and adapt throughout the reform, and to practice and share learning amongst themselves through Action Research and Communities of Practice.**
- **Incorporate capacity building, which is based on empirical evidence, and fidelity measures to support staff to think and work differently.** However, training needs to be accompanied by action, and seeing the impact of the training on the people they support.
- **Sustain reform and maintain momentum for change, particularly through the sharing of “success stories” of people using services.** Such stories can play a powerful role in changing hearts and minds, along with “converted” staff members who can bring other staff members along on a journey of reform.

SECTION 1.

What is the Service Reform Fund (SRF) and why is it different?

The Service Reform Fund (SRF) was created by the Department of Health, the Department of Housing, Local Government and Heritage, the Health Service Executive (HSE), the Atlantic Philanthropies and Genio.

It was established to accelerate and enhance the implementation of models of support that place the choices of the person using the service at the core.

The scaling of these innovations and reforms involved complex collaborations across government departments, national administrative systems, local and regional structures, and Non-Governmental Organisations (NGOs) involved in service delivery and advocacy. Previous partnerships between the HSE and Genio to demonstrate and test the effectiveness of person-centred approaches provided the basis for the SRF but the focus of the project was on the scaling of models and approaches nationally.

Areas for reform were prioritised within homeless, mental health, and disability sectors. The main overarching objectives of the SRF were to:

1. Support the transition within services to person-centred, recovery-oriented, effective models of support
2. Enhance the capacity of the national and regional systems to navigate the challenges of implementing these reforms
3. Ensure the voice of those using services were at the heart of the reforms
4. Embed and sustain these approaches within mainstream service provision

Investment and Implementation

The SRF involved a total combined investment of €45 million by the HSE, the relevant government departments and Atlantic Philanthropies to re-configure existing services. The SRF built on regional and local examples of good practice which had been demonstrated to be effective, aiming to scale them at a national level.

The focus of the programme was working with the mainstream social, health and housing systems and local structures to help them implement the new models of practice at scale. Whilst the programme was funded by national offices, it was implemented by the regional health, social, and accommodation structures. These structures were tasked with implementing the programme in line with locally developed plans and agreed implementation contracts.

Specific, weighted criteria were shared with all of the participating regional structures. The criteria required meaningful consultation with people using services as part of proposal development. Rounds of funding were allocated in each of the programme areas against these criteria with the highest scoring areas receiving the most funding.

The implementation of the agreed plans and progress towards outcomes were closely monitored by Genio, with updates regularly given to an integrated governance structure involving the Department of Health, the Department of Housing, Local Government and Heritage, the HSE, the Atlantic Philanthropies and Genio. Payment of funding was contingent on adhering to the principles of the SRF.

Action Research was central to the adaptation of the process. Those implementing the programme were interviewed on the challenges and opportunities they were encountering on a regular basis with this research helping to inform future funding rounds, training, and capacity development. This report is based on analyses of these interview transcripts.

For those interested in implementing changes in complex, often contested systems, the SRF is interesting for a number of reasons:

Reform in homelessness, mental health and disability sectors are among a range of “complex challenges that cannot be solved by

simple top-down deployment of traditional policy instruments” [7].

Despite their inherent complexity, health systems often promote a top-down, policy-led, bureaucratic approach whereby leaders impose order and control and attempt to reduce ambiguity or uncertainty [8, 9]. Reform failures occur when authorities make the mistake of simplifying a problem, assuming the bureaucracy will seamlessly implement the change programme as designed by leaders or try to implement a ‘solution’ that will avoid distress in the organisation [10].

The SRF took a very different approach to traditional top-down, policy-led reform.

Whilst it was fully aligned with current policy, it required adaptive change. Adaptive change *“is required when our deeply held beliefs are challenged, when the values that made us successful become less relevant, and when legitimate yet competing perspectives emerge”* [11]. The SRF required a shift – sometimes radical, other times in small, incremental steps – to the deeply embedded, systemic ways of responding to homelessness, mental health, and disability in the Irish context.

The SRF aimed to advance evidence-based practices nationally in the Irish context, including Housing First, Recovery, Individual Placement and Support (IPS), and De-congregation which were tried and tested internationally. The programmes were introduced into areas that had a history with initiatives, pilot projects, different key

stakeholder groups and relationships, as well as diverse understandings of concepts such as “*person-centredness*.”

The SRF comprised an Implementation Group which agreed and recommended operational plans for the SRF, including identifying funding streams, specific objectives, and activities. They also analysed applications from recipient organisations, made recommendations for allocations of funding, and monitored progress, including site visits and adherence to the funding criteria.

Funding was used as leverage to encourage agencies to engage with the SRF and to ensure accountability

The SRF was different because it required the regional structures of larger systems, Community Health Organisations (CHOs), for example, to apply individually for funding which was not granted equally across all regions as is typical in nationally funded programmes. Securing funding depended on meeting criteria that required applicants to base their applications and plans for reform on fidelity measures and consultations with people using the local services.

Yet, it also allowed for flexibility in terms of changing resources. For example, as knowledge of operationalising programmes developed, stakeholders requested if they could alter their application specifications. It contained a **monitoring element** to ensure that agencies were meeting the criteria. While the SRF requires services to work in new

ways in line with national policy, it did not offer a national blueprint for local reform and provided little traditional top-down guidance or direction.

The SRF involved an **Action Research element** which surfaced implementation challenges and opportunities as they emerged in “*real-time*.” This is an attempt to address the so-called “*policy-implementation gap*” [12, 13], describing how top-down policies and interventions cannot simply be “*dropped*” into a system and be expected to take hold, despite their merits or evidence-base.

The SRF Programmes

The SRF Housing First Programme

This programme delivered Housing First supports to the regional structures of the health and housing system in Ireland. The focus of the national programme was to scale this programme nationally beyond Dublin and provide permanent housing and intensive recovery-orientated support to those experiencing long-term, entrenched homelessness, mental health issues and/or addiction.

This involved integrating and enhancing the health, social integration and accommodation supports at a national level. Whereas Housing First is often delivered in specific regions by a single multi-disciplinary team, this national scaling required integration with the mainstream regional structures.

The SRF Mental Health Programme

This programme comprised three strands:

1. Advancing recovery
2. IPS (Employment)
3. Housing

This programme aimed to advance recovery practices in existing mental health services through building on and expanding the progress that has been made on Advancing Recovery in Ireland (ARI). The IPS (Individual Placement and Support) strand aimed to implement the programme nationally across Ireland, an approach which focuses on supporting people with mental health difficulties to access mainstream employment. The housing strand sought to advance non-institutional models of residential, community support for people with mental health difficulties.

The SRF Disability Programme

This programme comprised two streams:

1. De-congregation
2. Community Healthcare Organisations (CHO) service reform

The De-congregation stream focused on 10 congregated settings which were identified as 'priority sites' for a national de-congregation programme. The focus of this programme was to build self-directed, community-based services for the people moving from congregated settings to live in community settings.

The CHO service reform stream aimed to reform disability services across the Community Healthcare Organisations (CHOs). Funding was allocated under three streams: (i) Community Living; (ii) Reform of day services to person-centred services; and (iii) Alternative Respite against specific criteria.

Training and capacity-building

Provided as part of the SRF reform, training was directed at frontline staff, many of whom had previously trained in medical models of service provision. The training and capacity-building provided through the SRF was based on approaches which underpinned the policy directions which services are moving towards, including Recovery and IPS in Mental Health, and Social Role Valorisation (SRV) and Supported Self-Directed Living (SSDL) in Disability.

SSDL occurs when an individual is supported to exercise choice and control over their own life and to become a valued, participating member of society. It is an approach to facilitating access to the places where ordinary, everyday life is conducted, in ordinary ways, doing ordinary things.

SECTION 2.

Action Research: Examining change as it happens in real-time

Action Research may broadly be considered a research approach that integrates theory and action, working with stakeholders directly to surface challenges and opportunities in an ongoing, cyclical way in order to address important social issues [14].

In line with the SRF, **Action Research examined the reforms as they were being implemented**, aiming to surface important barriers and enablers in real-time, adapting the research to the “here and now”. The Action Research findings were fed back to the SRF Implementation Groups regularly to assist key decision-makers in understanding where the programme was at and the actions needed to address issues as they were arising.

More than 300 participants were interviewed at the national strategic, local implementation and frontline levels across the three programmes through focus groups and interviews. These cross-programme findings offer a unique insight into how stakeholders grappled with reform and a new way of doing things, offering opportunities for learning across a wide range of other sectors, nationally and internationally.

The various data collection cycles, dates, and participant numbers are depicted in each of the individual infographic timelines below. What is noteworthy is:

- **The breadth and depth of stakeholder participation** across the programmes, ranging from frontline staff up to national decision-makers.
- **The responsiveness of the data cycles** in terms of dates. For instance, data was collected in both the Housing First and Mental Health programmes in order to explore how the Covid-19 pandemic was affecting SRF reforms in summer 2020.
- **The significant uptake of the research across the participant groups**
Notable is the commitment of all or most of the participants across the research cycles, as well as within the latter Housing First data cycles in which participants themselves reached out to volunteer to participate, as opposed to needing to be recruited.
- **The widespread dissemination of the research findings as they emerged**
Learnings from the Action Research were regularly shared among senior decision-makers in the HSE, government departments, NGOs, frontline staff, and the SRF implementation groups through workshops, online webinars, and communities of practice.

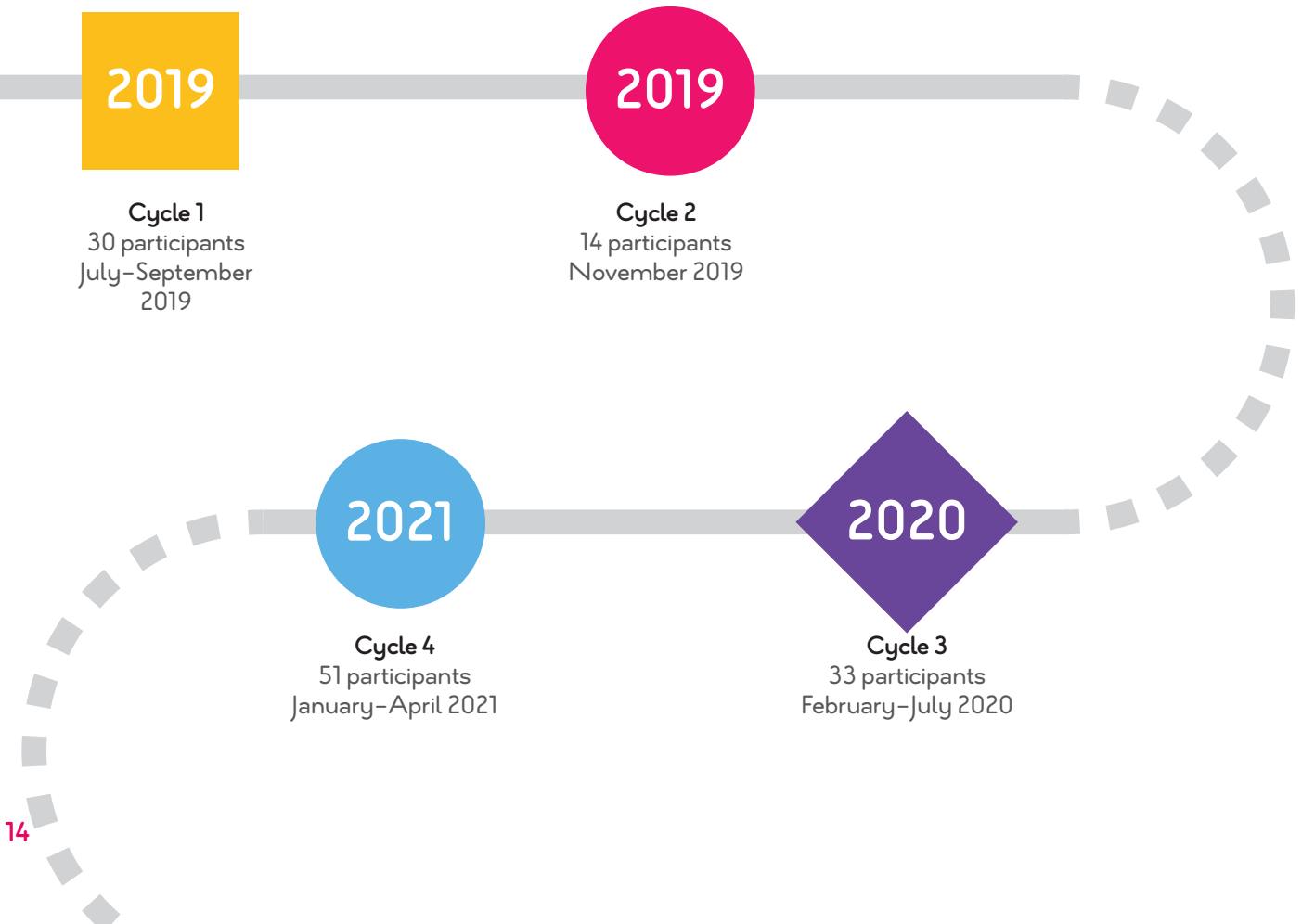
Housing First Data Collection Timeline

One hundred and twenty-eight participants were interviewed across the programme, including the Housing First Implementation Group, SRF Housing First Leads.

A wide range of HSE staff were interviewed comprising Health Co-coordinators, Social Worker Principals, Social Care Community Mental Health Nurses, Public Health Nurses, Clinical psychiatrist Clinical Psychologists, Dual Diagnosis, Addiction specialists, Homeless Action Teams (HATS), Primary Care, Social Inclusion, Clinical Nurse, Drugs & Alcohol Services, HATS.

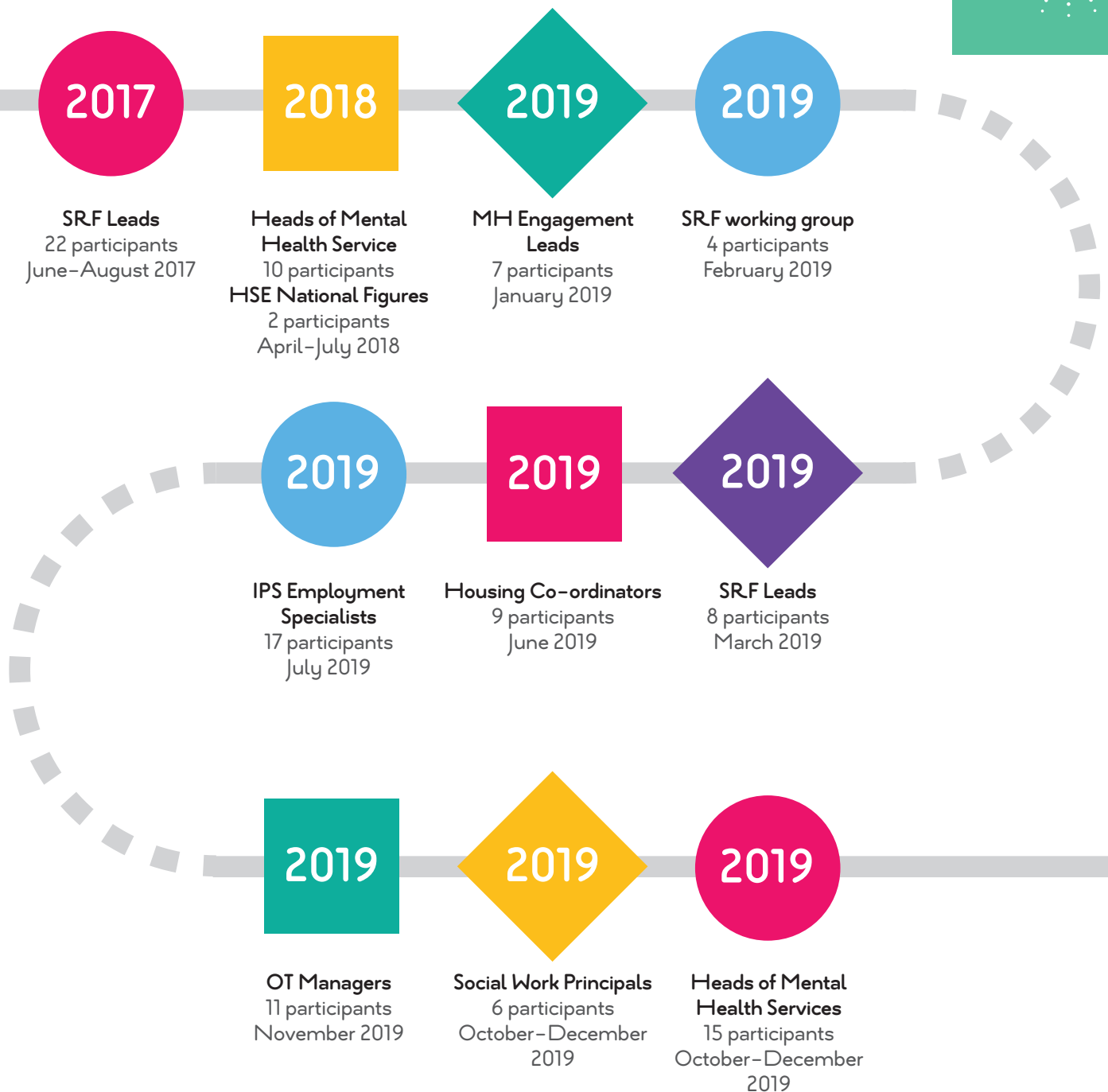
The NGO participants included a CEO, Tenancy Sustainment Key Workers, Peer Support Workers, Managers: Regional, Clients Services, HF Team Intensive Case Manager, Accommodation/Placement.

The local authority participants included Senior Executive Officers (SEO), Homeless Operations Manager, Settlement Officers, Social Workers, Outreach workers, Administrative Officers.



Mental Health Data Collection Timeline

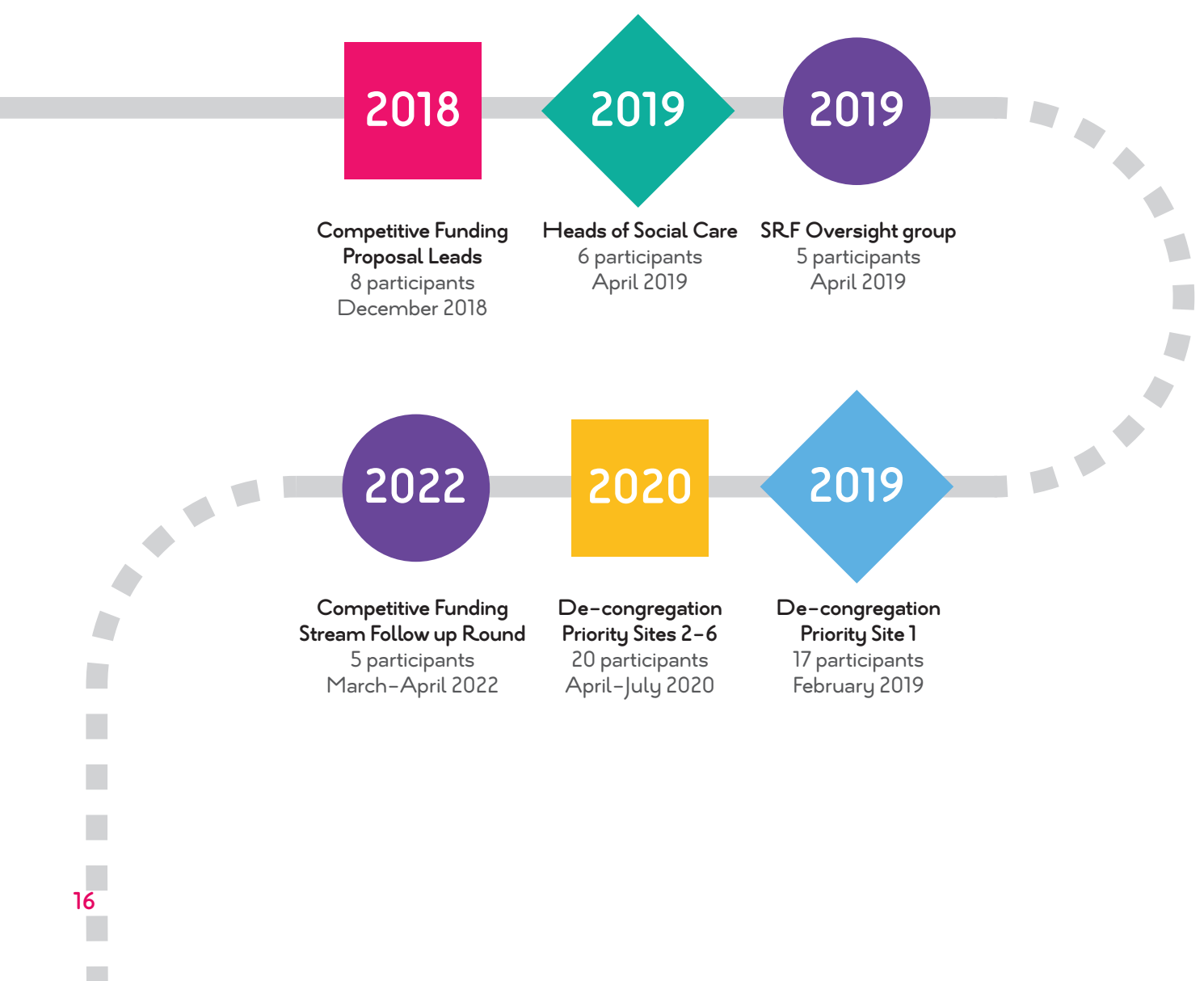
One hundred and eleven participants were interviewed across the Mental Health programme, including HSE national figures, the SRF Mental Health Working Group, Heads of Mental Health Services, SRF Engagement Leads, SRF leads, OT Managers, IPS Employment Specialists, Housing Co-Ordinators and Social Work Principals.



Disability Data Collection Timeline

Sixty-one stakeholders were interviewed across the de-congregation and competitive funding strands of the disability programme. Data was collected across 6 priority sites for the de-congregation strand.

This included a range of stakeholders: frontline staff comprised nurses, social care workers and speech and language therapists, managers included persons in charge of the service, team leaders, community transition coordinators, and a board member. The Competitive Funding Stream participants included SRF proposal leads, heads of social care, and the SRF oversight group.



SECTION 3. Findings

The findings of this report provide a unique insight into how a complex system reacted to an unconventional approach to reform, from the perspective of those who were tasked with its implementation at the national strategic, local implementation and frontline levels.

Participants often described their role as “fire-fighting” crises. In this context, reform efforts were seen as a “lovely luxury” and, therefore, “get neglected” (Disability, CHO service reform), as services react “to the pressures rather than being proactive” (Mental Health). Within this context of an over-abundance of initiatives, pilots, projects, and programmes, participants across Housing First, Mental Health and Disability portrayed the health services as reactive, and “preoccupied with the here and now...the latest scandal, scuffle, challenge” (Mental Health).

Despite seemingly insurmountable challenges and unfavourable conditions, the cross-programme findings offer an insight into how space was created for the SRF to get a foothold in a system that was perceived as incompatible with transformative change.

This section covers four major themes that emerged from cross-programme analysis of the Housing First, Mental Health, and Disability Action Research Programmes:

1. how the system reacted when the SRF put pressure to do reform differently;
2. how the SRF fostered new ways of working
3. how the SRF paved the way for staff to witness the capacities of the people they support; and
4. how the SRF changed the hearts and minds of frontline workers at the service delivery level.

Finding 1: Putting pressure on the system to do things differently

“What gets prioritised is what’s on fire, so if you’re on fire you’ll get prioritised.”
(Disability, CHO service reform)

This section outlines how the system reacted when the SRF put pressure on the system to do things differently. There were specific, weighted, and ring-fenced funding criteria that aligned around the principles of the SRF, but the absence of clear guidelines on how to implement the reforms caused tensions across all the programmes.

Yet, it was also seen as a catalyst for reform and a way for stakeholders to meaningfully engage with the change process and to feel ownership over the reform programme. From the outset, uncertainty, and confusion with the SRF process generated debate, and often provoked emotional reactions including

frustration, stress, and anger in a system with a tendency to “look up” nationally for clear direction.

A member of the implementation group described a balance between “stretching people but not to the point where the elastic snaps” by trying to create tension in the system. This strategy was considered necessary to “provoke a crisis”, manufacturing a sense of urgency, to keep focus and momentum from key stakeholders to direct the system directed towards reform. The SRF Working Group acknowledged that the HSE has “structures which we know aren’t suited to this type of change” and that “...the [HSE] structures do not support this kind of work” (Implementation group).

Despite initial negative reactions, those tasked with implementing the SRF at the national and local levels indicated that the difficulties they encountered led to stronger outcomes than would have been achieved with a clear roadmap.

“We’ve had early challenges and have worked through them constructively. I think it’s a stronger relationship than it would have been had we not had the challenges.”
(Housing First, NGO)

Later in the process, there was more acceptance that the early challenges were part and parcel of “an evolving process” (Mental Health).

“I suppose one thing I’d be saying to myself, it’s a process. It’s not a perfect process. It’s something that’s not linear. It’s chaotic. It’s messy. It’s unpredictable and that’s okay. That still means you’re doing a really good job when you’re in the middle of a mess because it means that you’re making traction somewhere.”
(Disability, CHO service reform)

The criteria-dependent funding element of the SRF process raised tensions in the system. Such a process was wholly different from traditional funding. As one participant explained, “up to now we wouldn’t have had that in a public system, any kind of a competition around resources and everybody expects a little bit for everybody, so I think that was quite a shift” (Disability, CHO Service Reform).

Criteria-dependent ring-fenced funding among the Community Health Organisations (CHOs) was seen as an effective way to elicit a crisis of peer embarrassment, provoking “embarrassment, peer let down and ambition” if the CHO failed to secure funding (Disability, CHO service reform). It created a “fear factor” where those in positions of power took the application process seriously out of fear of being seen not to secure funding. For example, a SRF Proposal Lead in the Disability Programme explained:

“They didn’t want...be the last CHO at the table and having that level of embarrassment... We’ve representatives

from the national panel, from all the specialists, this is being looked at a national level. So, it's...a little bit a of a fear factor that I felt worked from our perspective.”
(Disability, Competitive Funding Stream)

Failure to secure funding was said to provoke frustration and anger among senior decision makers. The allocation of funding drew criticism in many areas. For instance, some participants were concerned that those who are most in need of funding simply did not have the time or the capacity to develop proposals amid the crisis.

“Often the ones that you most need to change...They're firefighting, they're the ones you want to innovate...sometimes the innovation funds end up going to the people who are good at the process but not the people who most need it.”
(Mental Health)

The monitoring and scoring elements forced a protected space for the SRF amongst competing priorities within the services. SRF monitoring was considered critical for keeping the reform on the agenda. For instance, a proposal lead in the Disability CHO service reform described how they leveraged the monitoring of the SRF to allocate more time towards the reform.

Monitoring was also seen to provide financial accountability, preventing “*financial drift*” (Mental Health), and “*not to be absorbed into just the swamp*” (Mental Health). The regular

updates and reports required by the SRF monitoring structure were said to put pressure on the various stakeholders to deliver what was promised in the application process.

“The pressure in a way is coming from the SRF... [Housing First leads] need updates on a regular basis and if stakeholders are not doing the job, they're supposed to be doing we have to report... So, in a way it's good what [Housing First leads] is doing, they're keeping them on the ball and they're putting pressure on us.”
(Housing First, NGO)

A senior manager described the reaction to what were considered negative monitoring reports.

“This kind of negative report comes back, and I know from talking to other Heads of Service around the country is that they felt very, very angry about it...It kind of got people's backs up.”
(Mental Health)

There was evidence that negative reports caught the attention of the key decision-makers in the system. For instance, reflecting on negative reports, some senior decision-makers said that they had “*taken their eye off the ball*” and this had led to the failure of proposals – something many of them pledged would not happen again.

Monitoring provided a pathway amidst the uncertainty. Accountability and expectations were set throughout the SRF process through monitoring. This was welcomed by many

CHOs, in which it was described as “a contract of behaviour” contributing to accountability and as a significant ally in safeguarding reform efforts (Mental Health).

While accountability to the SRF process and finances were welcomed, criticism was expressed in terms of the “inspection process” associated with the SRF monitoring and site visits (Mental Health):

“I couldn’t see what it [scoring] was going to achieve or how it was going to improve anything and if anything it kind of got people’s backs up in relation to the SRF... I can understand where it’s coming from... it’s inclined to rub people up the wrong way...” (Mental Health)

There were also concerns related to the monitoring processes becoming over-burdensome in terms of reporting, with one participant cautioning developing a monitoring process that over-burdens people, suggesting that intense monitoring may compel people to ask why they should “be bothered” with the funding at all (Mental Health).

The Action Research interviews were seen as “safe spaces” outside of the funded reform work, monitoring and evaluation processes, where participants could discuss the ‘undiscussable’, protected as well by university ethics, confidentiality, and data protection. Participants described how such spaces allowed them to raise local issues related to the reform at the national level in a confidential way: “A massive bonus for us that it’s being

heard, we know it’s going on record” (Housing First). Due to the quick turnaround of findings and ongoing dissemination points, it was positioned as a process for ‘learning on the go’, allowing an opportunity to adapt and pivot in real time.

“In a way, Action Research acts like a smoke detector. It will tell us when things are going wrong so that we can take corrective action to make sure the programme stays on track.”
(Housing First)

Finding 2: Fostering new ways of working

The SRF forced new ways of working, including the development of new networks, relationships, and structures within and across the services.

The SRF was the impetus for the development of meaningful partnerships developing between a range of bodies including the recently formed CHOs, local authorities, diverse service providers, NGOs, clinicians, senior management in the HSE and frontline staff. In some cases, the SRF was seen as coming at an opportune time for the relatively newly formed CHOs due to “the fact that the CHO has come together for the first time because of the SRF” (Mental Health).

Hence, the SRF facilitated the scaling of some of these pockets of practice at a national level.

“Nobody in that room, nobody had ever before sat in a room, all of them together... the enabler for getting that to happen was the SRF... We spent a full day going through shed loads of stuff.”
(Mental Health)

In some cases, the SRF was the impetus for creating more cohesive organisational structures among previously fractured bodies.

“The national implementation plan... brought in the health side, the local authority side, the voluntary sector, made it everybody’s business to work together to make this happen which is just a godsend.”
(Housing First, NGO)

The SRF tendering process was seen as a catalyst, creating a reason for people to work together, “for different disciplines to get together and think outside the box” (Mental Health) and helped in “breaking down the barriers” (Mental Health) across local systems.

“I suppose the SRF, to be fair to it, was the catalyst for all of that, to push us to do these sorts of things... money being the carrot at the end of it.”
(Mental Health)

It was acknowledged that there were exemplary pockets of self-directed services operating locally throughout Ireland. However, these local pockets were rarely in contact and seldom had an opportunity to exchange information.

“I think what it [SRF] has done is given the service a chance to think about recovery and engagement [with people using services]. It’s given a forum for that. Whilst I think, it’s happening in pockets around the service I think it’s given the service of the CHO a push in maybe addressing it...more globally than just isolated pockets of interested clinicians or service users or both.”
(Mental Health)

Interagency relationships built on “openness and honesty” and previous “joint project” collaboration was seen to create familiarity between stakeholders. Coming together to merge the service was described as “positive problem solving” often involving “frank conversations” (Housing First, NGO) about competencies and accountability.

These conversations required stakeholders to manage their expectations of what could realistically be delivered by each agency. It also drove the development of new partnerships in the context of stakeholders submitting separate tenders, consequently feeling ownership of the model having spent the time working out how it would operationalise, and then having to come together to merge.

“I’ve got homeless services that are saying, ‘Well, mental health is the issue’. I have mental health saying, ‘Well, the homeless service is an issue’ and I’m like, ‘Well, let’s get into the room and let’s find out who has the issue.’”
(Housing First, HSE)

A key part of the process was mandating local services to engage in consultation with people using services to inform the development of their proposals and plans. The consultation required as part of the reform process was noteworthy as it was the first-time such engagement had been done in many areas. By engaging with the reform process, the voice of people using services was further brought closer to the system through formal engagement structures. Such engagement was felt to lend credibility to a service's plans for reform.

“There’s nothing more powerful than someone telling you, ‘This is how it is for me’.”
(Mental Health)

While this service user engagement occurred and was welcomed during the application phase, there were concerns expressed regarding the ability to continue such engagement during the implementation stage of the SRF. Key considerations raised included questions around who was representing the service user, the professionalisation of the service user voice, tokenism, and if, and how, to reimburse people for their time. Concerns were also raised about who was engaged and the exclusion of the “most vulnerable”.

“They have not engaged with most vulnerable, with the people who have the weakest voices who are not going to be heard, not developed relationships, you know, with these people to say ‘I’d like to know what you think about this’.”
(SRF Working Group)

Finding 3: Paving the way for staff to witness the capacities of the people they support

Scaling the reform involved dedicated positions, but as the programme evolved, embedded actors from within the organisations became critical champions of the reform. Initially, the key change champions were the proposal leads, those who were responsible for the roll-out of the SRF programme. In many areas, they had to “sell” the SRF to a wide range of stakeholders, including senior decision makers, clinicians, services, and frontline staff. They laid the groundwork, building rapport, trust and created linkages with local services.

“[We] went around to the different services, the different day hospitals and met with OTs and physios and psychiatric nurses and public health nurses and you know. And we would have explained what Housing First is and what we’re here for and if they’ve any questions or if they’ve anyone that they feel like they could flag with us that, making that connection. So, I think that that was very important as well and we’ve really got a good reception so far”
(Housing First)

However, as time went on, and the SRF evolved, other staff, including clinicians began to take on the role of change champion. Many of these staff were deeply embedded in the existing organisations, and could use their expert knowledge of the system, and their connections with other stakeholders

to drive the change. They were described as having a “vision” for a new model of service provision. For instance, in the de-congregation programme, ‘credible’ frontline staff were strategically chosen to influence others.

“Identifying champions... who are the key people that can deliver what you want to say, to the people who will listen to them. So, we would have had some senior staff here who are fully on board, who are credible. As in, staff have known them forever.”
(Disability, De-congregation)

Some participants in the disability programme also described a snowball effect whereby staff who were not inclined to change were inspired by the work of the staff in the community: For instance, a frontline staff member observed that *“the staff that were resistant would have seen the achievements that other staff have done because of helping lads out in the community and everything”* (Disability, De-congregation).

The SRF encouraged a totally different way of working and a redistribution of power dynamics and laid the foundations for frontline workers to engage differently with the people they support.

Powerful implicit, and sometimes explicit, assumptions and biases about the capacities of people engaging with social services or living in institutional settings were evident across all strands of the reform programme. These often reflected the wider biases and stigma of society towards people with disabilities,

people with mental health difficulties, and those experiencing homelessness. These assumptions were characterised by ideas that people engaging with services were the culmination of their disability or mental health difficulty, had limited or no capacity, and were not capable of living self-defined lives.

“Oh, sure they [people with mental health difficulties] can’t work. They’re not able to. They’ll never be able to.”
(Mental Health)

These beliefs comprised the backdrop which allowed the medical model to become firmly entrenched across the social system. The medical model was characterised throughout the SRF by the views that the role of staff was a pastoral one of care and protection for people using services, guided by clinician-led decision making. This hierarchical model was described as systemic across the programmes, with some staff members described as *“stuck in the past”* (Mental Health).

Within this, the clinical, professional voice was privileged over that of the people they support, with one participant describing how some staff in the services assert, *“I’m the professional’, ‘I know best’, and ‘if I want your opinion, I’ll give it to you”* (Mental Health).

Housing First, IPS in mental health and De-congregation in disability were tried and tested internationally. This evidence-base provided reassurance and comfort to those who wanted to try different ways of working in systems that were deeply embedded in the medical model.

“It’s about changing people’s mindset that we learn from different people’s experiences both globally, nationally, and what works well for people because there is comfort in an institution. There’s comfort in...nurses looking after you as opposed to social care staff.”
(Disability, De-congregation)

“I would feel quite confident sitting in front of a coroner, sadly obviously if something like that were to happen, but with the principles of the model and the clear policy directive around implementing the model and saying, ‘This is the basis on which we made that decision, and the alternative was that the person would have died while living rough. Instead, they died in their apartment’.”
(Housing First, NGO)

Such person-centred practices were considered as respecting the capacity of the individuals and encouraging or assisting with decision-making. Working in a person-centred way was further perceived to shift the focus from staff to the people they support. Such a shift away from the “old ways of working” the traditional “crisis, crisis, crisis”-led support provision model (Housing First, HSE).

In addition to the strong international evidence base, frontline practitioners drew on the fidelity measures that accompanied Housing First and IPS in mental health. Fidelity measures offered guidance and reassurance to those who embarked on new ways of working.

“We all want to do the best by the client and support them in the best way that we can, using the principles of Housing First and what helps me sometimes when I am feeling frustrated.”
(Housing First, HSE)

Within both Housing First and Mental Health, the fidelity measures helped orient staff and keep them focused on implementing person-centred practice. Here, one staff member describes the strength such measures gave them in terms of implementation, the ability to ‘take risks’, and the ability to defend their decisions.

“To me the biggest difference when I’m working in Housing First is the ability that we have to engage with positive risk taking and to be wholly...client-led...the model being built on that and the model ensuring that we don’t move away from it. I think the HSE, you know it responds to the needs, but what’s missing and what’s absent... it’s the ability for us to be client-led.”
(Housing First, HSE)

Participants warned of the dangers of embarking on new programmes without adequate awareness-raising and training. For instance, a Housing First participant explained the need for cohesive training.

“We all need to be working to the same definition, the same fidelity of the model. What falls down for me is we’ll work one way, someone else will work a different way, somebody else takes a different approach and there’s no sort of cohesion...”

– if we had a training piece where everyone knew the same guidelines and policies and fidelities, the model we all worked from the same sort of process that would be the same principles”
(Housing First)

But yeah, you have to do that often enough...kind of nearly defend your clients and defend the stance that you’ve taken and the approach that you’re taking and why you’re taking that”
(Housing First, NGO)

Similarly, participants in the Mental Health Programme warned of the negative implications for the reform programme if there is a lack of understanding around Housing First, Recovery, IPS:

“I would like for the multidisciplinary team maybe to do some more training around IPS just to get an understanding of what it is... It has to be client-led, not clinically led. You know?”
(Mental Health, IPS)

A lack of awareness about the models was said to be having a detrimental effect on the implementation of the programme, with those responsible for the reforms having to justify the programme. For instance, in Housing First this resulted in those implementing the model having the responsibility to “defend the stance” and approach taken.

“I’ve definitely found in the last year that like you’re having to do kind of an education piece and a bit of an intro into Housing First, and sometimes with people who you think would understand and would kind of be on board with it, you’re still having to kind of give that education and the background, and like that, the ethos of it and what it’s about.

Training and capacity building were an important parts of the reform process. That said, staff needed to be afforded the opportunity to apply evidence-based principles in their everyday practice to witness the impact it had on the people they support.

Without the opportunity to apply the principles in everyday work, there were fears that there would be a disconnect between the evidence base and the practice:

“I can easily give you metrics, I can tell you how many people did Recovery Principles Training. What I can’t tell you is how many people have actually taken that training on board and that they come into work every morning with a philosophy that’s underpinned by recovery and nothing else.”
(Mental Health)

Participants emphasised the need for not just a once off, but “constant training” (Disability, de-congregation) at all levels of the system, including those in senior management and decision-making positions.

“The training through the SRF has been invaluable, because that really embeds learning. Again, I would have loved more on that... We should have had funding for all of our managers to do it, because it’s nice frontline staff are doing it,

but they don't have the authority to influence the change. So, I would have kind of made it mandatory for all our team leaders and managers to do it, because that's the piece, and have the time freed up so that you could do it properly.”
(Disability, De-congregation).

Furthermore, participants expressed the need to move beyond training for training's sake with an expressed need for training to be applied in everyday practice:

“Training is essential in terms of bringing people along with having designated time... each week that they would have designated time to reflect on their practices during that week, reflected on the tools and reflected on different people and that stayed in their diary... You're embedding a process within a system that allows them to reflect, to think and there's training allocated for them to constantly think about the practices, their roles, their change in approach.”
(Disability, CHO service reform)

Finding 4: Changing hearts and minds

Housing First, IPS in Mental Health and De-congregation encouraged “risk positive” practice; a critical step in exposing staff to the capacity of the people they work with.

Assumptions about the capacity of the people using the services was often posed a barrier across all the reform programmes. Mental

health professionals described “wrestling” with their perception of the capacity of the people supported in contexts of independent living (Housing First, HSE) where the Housing First model of working was described as “anti-nursing” (Housing First, HSE).

A shift to new ways of working across the programmes meant balancing risk-aversion and clinician-led services with people's involvement in decision-making that affects their lives. Fundamentally, such a transition was perceived to bring a “risk, this is a whole new thing to Ireland, this level of risk management and accountability” (Housing First, HSE).

Some of the earlier interviews with practitioners capture how radical the SRF was perceived to be, particularly by those in the medical profession.

“It demands a shift in mindset in healthcare...it's evidence-based lunacy... It doesn't make sense from the healthcare side of things in the provision of healthcare for somebody, ‘Okay, you're most vulnerable. You've got the most complex needs. You're under the effect of drink or drugs pretty much 24/7. Here you go into your own gaff, independent living...’ That jars with Mental Health's training, with medical training.”
(Housing First, HSE)

Reluctance and scepticism towards the reform programme was often linked to those with a more medically-oriented roles, such as consultant psychiatrists and certain members

of multi-disciplinary teams. A hierarchical model of service provision was said to provide comfort and reassurance for staff in contrast to respecting the capacity of the individuals using the service which was perceived by some as high-risk from a clinical standpoint.

“I think the HSE, there was this sense of kind of being risk averse around it and what they call defensive practice... Where it’s kind of if you don’t get involved, you can’t be blamed for the outcome.”
(Housing First, NGO)

For those tasked with implementing the SRF, working in a person-centred way provided an opportunity for being “*risk positive*”, lessening the focus on risk-aversion and safeguarding.

“It is truly putting the person at the centre of every single thing that you do... It’s about people being able to take risks and us supporting them in that, so really, it’s about seeing what is possible for that person and holding onto it for them until they can see it for themselves.”
(Disability, De-congregation)

However, this approach often went against the training of staff in the services. For instance, Housing First was described as “*completely counterintuitive to our training*” (Housing First, HSE).

Seeking clinical permission to move away from a medically-oriented model of practice is a paradox that faced many frontline practitioners who wanted to engage with person-centred practices. Many frontline staff and practitioners

sought clinical sign-off “*for backup*”.

Specifically, staff perception of the capacity of the people they support was an area that was highlighted as difficult to navigate for clinical staff, particularly in cases where staff were previously working in accordance with very different standards, such as in Housing First and the Mental Health Act.

The ability to take more risks in everyday practices allowed for the transformation of ingrained beliefs and practices when staff saw the people they support in a new light.

Housing First, IPS, mental health engagement, and the community engagement aspect of the De-congregation programme were all described as bringing the voice of the people using services closer to staff, providing opportunities for staff to get to know people who use services in a different way, by focusing on people’s capabilities and strengths, “*letting the skills of the person shine*” (Mental Health).

Similarly, Housing First was perceived as bringing “*a deeper layer to what this work is for*”, and for some staff this entailed “*bringing that person out of that trauma story from the past, or to live alongside it*” (Housing First, LA). The practitioners said that by moving away from crisis driven support, they can see what the people they support are capable of:

“When all you’re used to seeing is crisis, crisis, crisis, and you’re seeing them in the dirty clothes with nowhere to go, you lose sight of what they are capable of...And where their strengths are.”
(Housing First, HSE)

Within disability, staff were taken on “a journey of discovery” whereby they could get to know people as individuals for the first time. In both Disability and Housing First, participants described how spending a greater amount of time with people outside of their typical clinical settings allowed the opportunity for staff to get to know and relate better to those they support. For instance, a participant from the Housing First programme described the outreach into homes to illustrate the person-centred practices and the implications for the service users; “There’s a psychologist in my sitting room and it’s not scary” (Housing First). Such ways of working were also seen to “create a level playing field” between staff and the people they support (Mental Health).

“I really believe the IPS model is very well designed and all the parts in it are so person-centred... The strengths-based focus is hugely empowering...that you kind of create a level playing field because they’re so used to this kind of slightly disempowering medical, clinical power balance in the MD [Multi-Disciplinary] Team.”
(Mental Health)

Through this process, staff biases and assumptions about the people they support were brought to light. Across the programmes, participants expressed cases of being “astounded” and “shocked” (Housing First, HSE) at a change in their perception of people’s capacity and capabilities. As a result, within the IPS programme, participants described “a recalibration from the team about their own expectations about what the service user is

capable of” (Mental Health), with a focus on skills and capabilities.

“What I’ve noticed is that the MDT members...their eyes are opened as well... They weren’t aware actually at how capable people are and that was the biggest thing for me...but I think what the team are saying is that they just weren’t aware of that the capability was actually there.”
(Mental Health)

Within Housing First, one participant noted the “huge learning curve” with the programme, reflecting how “I didn’t realise really how institutionalised I’d been in my thinking and that has had to, that’s been chipped away constantly and daily” (Housing First, HSE).

In many cases, this shifted views positively and allowed staff to re-frame their understanding of people using services.

It helped staff see people beyond diagnoses and as a “whole person”. Deeper personal relationships and emotional connections between staff and the people they support contributed to this. Within Housing First, practitioners reported developing emotional connections with the people they support. Within mental health, there was a sense within some narratives that IPS enabled the MDT to see people beyond the “service user” label or diagnosis.

Within disability, at the individual level, frontline staff and management shared the ways in which their beliefs and practices changed over the course of the SRF.

Witnessing the positive outcomes for the people they support was a driving force behind changing a lifetime of habits and adopting new models of person-centred practice. Many participants shared how their doubts and scepticism were challenged when they began to see the changes in the people they support.

“I would have had doubts about certain residents and how they’d adapt to the community...At the start I would have kind of thought, ‘Gosh I don’t know how this is going to work’ and I would have had doubts... Something I’d bring with me...is give everything a go and the positives that I have seen from the community moves.”
(Disability, De-congregation)

The findings capture a turning point that took place once the staff were exposed to the person as an individual:

“I’ve known this lady for 30 years and I’ve learnt more in the last six months than I ever knew about her...I’ve known her as a patient or a client or whatever, but I had no idea who she was or what she was capable of.”
(Disability, De-congregation).

Strategically using transformative stories:
“Here it is actually now working...There’s evidence now.”

These transformative stories were considered ‘proof of concept’ and evidence of the effectiveness of such new ways of working. They were felt to contribute to a momentum and movement towards new ways of working. Across the programme, success stories were

used strategically to address these fears and anxieties amongst staff. Such stories were also felt to bring staff along towards new ways of working.

“We had staff going out there as part of a transition, as part of the individual’s transition, linking up with people who had done it before. Just to share their experiences with the individuals, the residents themselves and also with the staff. So, that has been good as well, to share success stories.”
(Disability, De-congregation)

Success with working in person-centred ways were further perceived to have the potential to positively reinforce these successes:

“When you sit with someone and you map out their journey, and how well they’ve done and Housing First being a part of that...it gives people, it heightens their self-esteem, their confidence...it gives great tools in terms of positive reinforcement for service users...it gives me something to positively reinforce with people.”
(Housing First, HSE)

The impact of seeing people do well was said to “give everyone a huge lift” and build momentum for change. The momentum of change towards person-centred ways of working grew and gained energy, as the people who they supported continued to succeed – a nearly virtuous cycle and positive feedback loop. The transformations witnessed through person-centred ways of working were felt to be energising and inspiring for staff.

Simply put, staff felt good working in person-centred ways. Describing feeling “proud” (Housing First, HSE) of the people they support, “rewarded” in their roles (Housing First, HSE, NGO), “lucky to be in a position to be implementing this type of work” (Housing First, NGO) and how “it’s actually really lovely to see it [service user success in employment] happening” (Mental Health). The Housing First model, for instance, was seen to allow for an alignment between the needs of the people supported and staff skillsets. It allowed teams the capacity to meaningfully engage with the people they support in a new way. This helped staff feel good about being able to provide “meaningful supports” for the first time.

Across the programmes, staff shared stories of their perceptions of the transformation for the people who engaged with person-centred programmes. Such stories were described as “motivating for everyone” (Mental Health), “giving everyone a huge lift” (Housing First, HSE), and a “‘good news story’ at a time when not many good news stories” (Mental Health). The success of people gave staff hope about working in a person-centred way.

“So many people said at least two or three of them would be dead by now, they wouldn’t last a year and they’re there three years now and their health has improved, their quality of life... That’s a rewarding part of it.”
(Disability, De-congregation)

Within disability, it was people’s personal stories that drove this staff member to

“make me want to come to work each day” (Disability, De-congregation), describing how:

“For a lot of the people who have spent the majority of their lives in institutional care, the opportunity to support them to have an improved quality of life, to expand their opportunities to have a good life and to experience the good things in life. It is really the little things that add up to the major changes that we can make in the lives of the people we support.”
(Disability, De-congregation)

**“You can’t change the culture for the service user without changing culture for the staff”:
Sustaining new ways of person-centred working**

Across the datasets, there was a sense that these individual changes needed to be sustained to lead to a true culture change throughout the system, one that would embrace and embed person-centred ways of working. These systemic cultural changes were considered a crucial component of sustainable reform.

“[Service user involvement is] totally brand new to the service... ‘Well, we can’t do that...’, you couldn’t have somebody who had that lived experience coming or, you know, it wouldn’t be safe or it would be so risky, but now it’s saying actually this works really well and this is a really positive thing... this is the kind of bread and butter of how we should be doing it now.”
(Mental Health)

Without the shifting of such ingrained beliefs and practices, there was a sense the reform could not be sustained:

“You can’t change the culture for the service user without changing culture for the staff...and maybe broaden our very, kind of, narrow hierarchy at the top in terms of the medical view at times or the ‘The way things have always been’ view...and you’re trying to dilute that or change that.”
(Mental Health)

Getting staff “on board” with SRF-related efforts were considered crucial in making SRF-related reforms, with a lack of such buy-in being described as likely to lead to failure of the SRF.

SECTION 4.

Discussing the Findings

>> The SRF provides robust insights into how service reforms in homelessness, mental health, and disability sectors caught the attention of stakeholders across a system that prioritises emergencies.

The €45 million fund required applicants to meet funding criteria and had a monitoring element attached. The study of pressurised, crisis situations provides an opportunity to analyse decision-making and offers lessons for future reform [2, 3, 15, 16]. This allocation of funding against agreed outcomes achieved buy-in from key decision-makers at the local implementation level across homeless, mental health, and disability sectors *“strengthening commitment at precisely the time that flexibility and improvisation are required”* [4].

>> The SRF created a space for stakeholders to work through the initial fear, confusion, and anger arising from the uncertainty and unpredictability of the reform.

The negative emotions expressed in the earlier interviews eventually led to acceptance that the reform was an evolving process and was more controllable than initially thought [5]. The evolving process gave rise to greater creativity, dynamism, and adaptability across the programmes, leading to stronger outcomes than a straightforward linear process.

The SRF provided an opportunity for collaboration, planning, action, and reflection, providing a platform for stakeholders to meaningfully engage with the change process and to feel ownership over the reform programme. As stakeholders occupied this space, they began to think through the process and reflect on the lessons learned.

>> While the SRF did not provide a blueprint, it did offer tools for stakeholders to navigate the complexity of the reform process.

The monitoring element helped to keep the reform programme on the agenda and provided a pathway amidst the uncertainty and ambiguity. The availability of an empirical evidence-base and fidelity measures helped to alleviate the fears, frustration, and uncertainty of implementing change in challenging circumstances [1]. The Action Research aspect of the SRF offered a tool for those tasked with its implementation to make order amid uncertainty and to make real-time sense of what was happening [3, 17].

>> Those responsible for implementing the SRF found ways to navigate the system and act based on what they had learned to transform seemingly complex problems into more manageable ones [4, 7, 5].

They began to *“bring events and structures into existence and set them in motion”* (5, p.306).

>> The SRF was the impetus for the development of meaningful partnership developing between a range of bodies including the recently formed CHOs, local authorities, diverse service providers, NGOs, clinicians, senior management in the HSE, and frontline staff.

The development of meaningful partnerships was indicative of a more transformative change, which requires *“transforming the relationships between people who make up the system...far too often, organisations, groups, and individuals working on the exact same social problems work in isolation from each other. Simply bringing people into a relationship can create a huge impact.”* [6, p.7].

>> To truly achieve transformative change, a system needs to allow actors to break free of deeply embedded, institutionalised practices [6].

The SRF required system actors to work in new ways that were often counterintuitive to their training and deeply ingrained beliefs about the capacities and capabilities of the people they support [9]. The findings suggest that staff at the frontline level were *“unlearning of what has been ingrained over history and embedded into structures, policies, metrics, rhetoric, and practice”* [18, 19].

This “unlearning” was not an organic process. Staff had to feel comfortable with working in new ways. Staff also had to have the

opportunity to put training and capacity building into practice. Once afforded this opportunity, many staff went on a *“journey of discovery”* whereby their expectations and views about the people they support were challenged.

>> Change champions and passionate believers in the reform programme purposefully and strategically convinced other staff to abandon deeply held beliefs and assumptions about the people they support [20, 21, 22].

Hence, as new ways of working evolved, the impetus for change came from within the services. In some cases, the change came from people who were embedded in the organisation, including those with clinical roles [23]. These embedded actors were well-positioned: they knew the inner workings of the organisation, had built up relationships with other actors and had legitimacy among other workers. However, despite their efforts, the fact remained that there was resistance to change and the continued privileging of the professional voice over that of the people they support.

Conclusion: Lessons from the SRF

The lessons from the SRF highlighted in this report illustrate how non-traditional approaches to reform at the systemic level can pave the way for new ways of working which enable frontline staff to appreciate the capacities of the people they support. Funding against criteria which promoted the scaling of these approaches, in line with national policy, was a critical factor in the mainstreaming of these models.

The SRF provided reflective spaces and tools for stakeholders to navigate the reform process. This was not a top-down or a linear process. The application of principles in practice exposed many policy-implementation gaps. Confusion and challenges often increased as implementation challenges emerged.

For example, the translation of service-user engagement principles into practice raised more questions than answers and forced stakeholders to confront challenges including tokenism and the exclusion of the most marginalised perspectives. Indeed, these are considerations that should be taken into account prior to embarking on a reform programme. Which voices are represented and how? What mechanisms and resources are in place to facilitate meaningful consultation with the people using the services?

While the current report focuses on the homeless, mental health and disability sectors, the lessons learned from the SRF could be applied across a wide range of complex social systems which may require a change in deeply ingrained ways of delivering services, particularly for underserved populations who face stigma and assumptions about their capabilities and capacities.

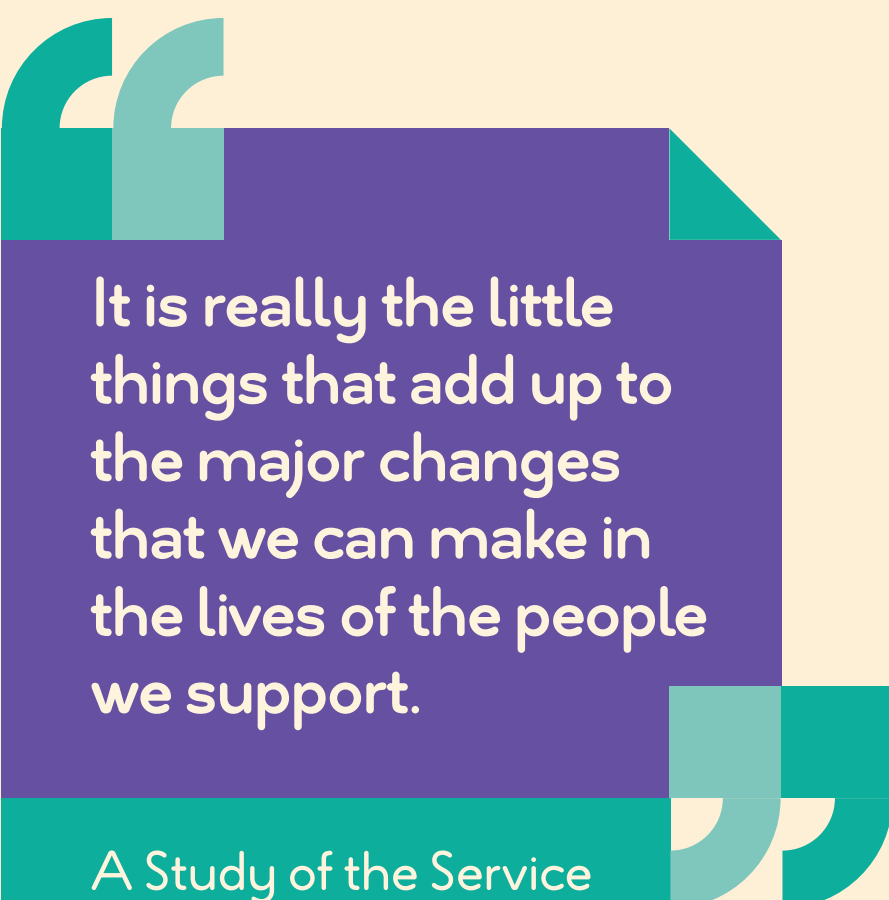
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It is really the little things that add up to the major changes that we can make in the lives of the people we support.

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