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Understanding the Processes that Shape Cross Sector Service Provision in the Towards Flourishing Mental health Promotion Strategy: A Secondary Analysis Utilizing Constructivist Grounded Theory Methodology

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A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Health and Rehabilitation Sciences

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Abstract

In Canada, many national, provincial, and regional policies indicate that working together within and across sectors in health and social care is necessary and expected but evidence to support this call is lacking. This dissertation explored the concept of cross sector service provision (CSSP), defined as: independent, yet interconnected sectors working together to better meet the needs of service users and improve the quality and effectiveness of service provision. The intent was to advance our understanding of processes involved in shaping service provision offered by two or more sectors. The thesis contains three studies. A Scoping Review that explored collaboration in mental health crisis response services uncovered findings pointing to the need to consider crisis services as occurring within a system of providers, including those from sectors outside of mental health. An Umbrella Review explored CSSP more generally, focusing broadly on health and social care sectors where the findings point to a lack of evaluation outcomes and theoretical underpinnings of CSSP. Finally, a secondary analysis utilizing existing data collected during an evaluation of the Towards Flourishing Mental Health Promotion Strategy (TF-the original study) was undertaken to generate a theory of processes that shape CSSP at the boundary between the two sectors - mental health and public health. Secondary analysis methodology was paired with constructivist grounded theory methods. Five processes emerged that together shape cross sector service provision in the TF strategy. These include: Establishing and growing the project around needs, priorities, and evidence; encouraging meaningful and enduring engagement from both sectors; aligning with what already exists; preparing and supporting stakeholders; and adapting to challenging contextual landscapes (social, historical, political) of both sectors. The findings from the three studies contribute to the fields of Education, Practice, Policy and Research.

Keywords: Cross Sector Service Provision, Mental Health, Public Health, Education, Practice, Theory

Co-Authorship

I, Shannon Winters acknowledge that the three manuscripts (Chapters 2, 3 and 4) included in this dissertation resulted from collaborations with coauthors. In all three articles the primary intellectual contributions were from the first author, Shannon Winters who conducted literature reviews, developed the ethics approval application, developed the research methodologies, collected data, extraction and analyses. Members of thesis advisory committee: Dr. Lilian Magalhaes (Supervisor), Dr. Anne Kinsella, Dr. Anita Kothari and Dr. Jennifer Volk met regularly to provide guidance and support as well as editing for publication.

Chapter 2: Dr. Magalhaes and Dr. Kinsella advised S. Winters on study design and methods for a Scoping Review. S. Winters performed all database searches, data extraction, data analysis and initial write up independently. Drs. Magalhaes and Kinsella reviewed and assisted with revisions and approved the final published version of the article.

Chapter 3: Dr. Magalhaes, Dr. Kinsella, and Dr. Kothari advised S. Winters on study design and methods for an Umbrella Review. S. Winters performed all database searches, data extraction, data analysis and initial write up independently. Drs. Magalhaes, Kinsella and Kothari reviewed and assisted with revisions and approved the final published version of the article.

Chapter 4: Dr. Magalhaes, Dr. Kinsella, Dr. Kothari and Dr. Volk advised S. Winters on study design and methods for a secondary analysis of existing data utilizing constructivist grounded theory methods. S. Winters performed all data analysis and initial write up independently. Drs. Magalhaes, Kinsella, Kothari and Volk reviewed the emerged theory components and advised on revisions. All members of the advisory committee will assist with revisions for the final published version of the article following the defense of the thesis.

Dedication

To my parents

Craig and Ezzy Winters

Who have given me a lifetime of support

for all of my wild ideas.

Acknowledgments

First and foremost I must acknowledge the unwavering support that I received from Dr. Lilian Magalhaes over the course of our eight years working together. I am sure I would not have made it through to the end without you by my side, encouraging me to keep walking. I was incredibly fortunate to have you as an advisor.

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To the original Towards Flourishing team, I am enormously grateful for the opportunity to delve deeper into the rich data that we collected.

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Chapter One

Introduction

The push to work together to provide more coordinated, integrated and collaborative health and social care is strong the world over (Kernaghan, 1993), but the evidence to support this call is lacking (Winters, Magalhaes, Kinsella, & Kothari, 2016). In Canada, many national, provincial and regional policies are increasingly indicating that working together within and across sectors in health and social care is necessary and expected (IPAC, 2013; Province of Manitoba, 2012; The Mental Health Commission of Canada, 2012). Known components of interprofessional collaboration include role clarity and communicating effectively (Suter et al 2009; Regan, Orchard, Khalili, Brunton, and Leslie 2015). However, it is taken for granted that we have a shared understanding of contributing factors that shape *how* cross sector work is done (Winters et al., 2016). Previous literature suggests that if we do not increase our understanding, we risk continuing to provide disjointed services and people may continue to fall through the cracks (Glasby & Dickinson, 2008; Kodner & Spreeuwenberg, 2002).

Winters et al. (2016) conducted an umbrella review¹ of cross sector service provision (CSSP) and perhaps the most notable finding was that there was an immense pool of literature in the area yet all but one of the authors wrote about the troubling lack of evaluation and outcomes of CSSP (Collet, De Vugt, Verhey, & Schols, 2010; Davies et al., 2011; Donald, Dower, & Kavanagh, 2005; Dowling, Powell, & Glendinning, 2004; Fisher & Elnitsky, 2012; Fleury, 2006; Grenfell et al., 2013; Hillier, Civetta, & Pridham, 2010; Howarth, Holland, & Grant, 2006;

¹ An Umbrella Review, or sometimes called an overview of reviews, is a systematic review of previously conducted systematic reviews. See chapter three for more details.

Hussain & Seitz, 2014; Lee, Crowther, Keating, & Kulkarni, 2013; Soto, Bell, Pillen, & For The Hiv/aids Treatment Adherence, 2004; Winters, Magalhaes, & Kinsella, 2015). As Hillier et al. (2010) note, models of teamwork are well described but not well evaluated. Moreover, CSSP has not been analytically explored to systematically identify processes involved in these types of arrangements. Making firm recommendations about CSSP is challenging without adequate evidence (Collet, De Vugt, Verhey, & Schols, 2010; Davies et al., 2011; Donald, Dower, & Kavanagh, 2005; Dowling, Powell, & Glendinning, 2004; Fisher & Elnitsky, 2012; Fleury, 2006; Grenfell et al., 2013; Hillier et al., 2010; Howarth, Holland, & Grant, 2006; Hussain & Seitz, 2014; Lee, Crowther, Keating, & Kulkarni, 2013; Soto, Bell, Pillen, & For The Hiv/aids Treatment Adherenc, 2004; Winters, Magalhaes, & Kinsella, 2015). Theoretical underpinnings of CSSP are largely absent from the existing literature (Winters et al., 2015, 2016) with only two articles putting forth suggestions for potentially relevant extant theories, by name only, with no elaboration on goodness of fit (Fisher & Elnitsky, 2012; Howarth et al., 2006). Interestingly, the findings of Winters et al. (2016) strongly aligned with those found 10 years earlier by Sloper (2004) indicating that little movement in the way of evaluation and outcome measurement has occurred in the last decade. Despite an enormous body of literature to draw on, much remains unknown about *how* care providers work together across independent yet interconnected sectors of the health and social care system. Taking it further, the vantage point of work to date has primarily been at the micro/provider level (Reeves, 2011; Suter 2009) with the boundary between the independent sectors left largely unexplored (Winters et al., 2016) Research was needed to determine what occurs at the boundary between sectors, where tensions and synergies emerge beyond the individual level. Professionals working within and across sectors not only need to navigate interprofessional boundaries within their home sector but must also grapple with the

social, philosophical, political, and cultural differences that exist at the boundary between sectors. More awareness of how different organizational and strategic governance structures are involved in shaping CSSP was needed to advance our understanding of the phenomenon.

This dissertation is the compilation of a research project exploring CSSP and the work that led up to completion of the full dissertation. Two of the chapters in this thesis have already been published and others will be published in the near future, hopefully. For that reason, the integrated article format was adopted to display the work to date. Repetition of introductory content will be noted throughout the various chapters because they are intended to stand-alone as independent publications.

In the next section I will provide the reader with insight into how I came to construct the current study by walking them through the rationale for the various components. This thesis was the culmination of numerous professional and academic experiences over the last 10 years. Reflecting back it is clear that the facets of this work were forming and taking shape gradually as I proceeded through moments of tension, uncertainty, and triumph. In what follows, I will share the seminal instances which paved the way to this piece of work.

Situating the Researcher

I align with the belief that we are part of the world we study and the data we collect. Assuming the position that there are multiple interpretations of phenomena (Ponterotto, 2005) and that all of our experiences shape our interpretations. Charmaz (2014) suggests that researchers must reflect on the impact that our past and present beliefs, values, and positions in society have on the research process. Researchers must to be transparent about examining our assumptions (Finlay, 2002).

Reflexivity

I view meaning as negotiated between the researcher and the researched. Reflexivity, defined by Finlay (2002 p. 533) as immediate, continuing, dynamic, and subjective self-awareness, played an integral role in ensuring the quality and rigour of the current study. As Finlay (2002) stresses, reflexivity can offer a tool to analyze how we come to make sense of the social world and our place in it. As I moved through the process of completing my dissertation project I not only maintained memos related to the emerging theory, but also maintained a reflexive journal, see appendix 4 for examples. I was intentional about locating myself within the research process by examining my subjective interpretations of the data and deeply considering how my experiences, beliefs and values were shaping my interpretation of the data (Finlay, 2002). I endeavored to be transparent about the analysis process and remained close to the data, while acknowledging elements that may be shaping the generation of the theory (Charmaz, 2014). I do not intend to report facts or truth related to cross sector service provision, but rather a situated account of my interpretation of the processes involved (Finlay, 2002). Throughout the research process I strived for coherence by examining the match between the aim of the research, epistemological location and the methodology adopted (Finlay & Ballinger, 2006).

In the next section I situate myself as a researcher in an effort to be transparent about my worldview and how I came to the topic of CSSP.

My work in the health and social care field began just over 10 years ago when I started working as an addictions counsellor. I would describe myself as naïve and green to all things related to service delivery. I held a narrow view of what my job entailed; providing counseling for individuals seeking support for their addiction. I did not consider myself to be working within a system of any sort, but simply within one sector responsible for providing services directly to

an individual. Frustrations grew over time as I began to notice the hurdles and roadblocks that service users faced while trying to get the care they needed. Those hurdles were not caused by me or my organization... or so I thought. I felt they were the result of the individuals working in *other* parts of the system. One example of a major hurdle that comes to mind involved a service user who had just entered a 60 days treatment program but was unable to stay because this person was living in social housing at the time and *that* agency would not agree to pay for their housing after finding out they would not be residing on the premises for almost two months. It came as a huge surprise to both the service user and me. I remember thinking that it was such a travesty for the person. Rather than lose their home and have to make arrangements for all of their contents this person chose to leave treatment. I put the blame fully on the housing system. I was operating according to my policies and procedures that stressed that service users needed to be fully committed to working on their recovery, attend all classes and sessions, on time, and to minimize distractions in their lives. I could not allow the individual to leave a session to make arrangements for their home and contents because then they would be missing out on content and fall behind. It never occurred to me that our service was part of the problem. These policies and procedures made sense. Service users needed to be 100% committed to their recovery from addiction. If the individuals were distracted their chances of recovering would be diminished. I remember thinking, "how could the housing sector NOT see the importance of this person attending treatment?" I hope the incongruous nature of the situation is evident? It is not hard to imagine the person at housing services having those exact thoughts but replace housing sector with addictions sector. Likely they were just following their policies and procedures and doing what they had to do under the conditions of their service.

One other example of a hurdle that we saw time and time again was the conflict that arose when individuals were experiencing more than one issue or concern, could be health or social. If we deemed the other issue to be a distraction while they were in treatment we would often suggested that they “take care of that issue first and then come back.” These concerns could be other general health, or mental health problems, family hurdles like obtaining child care, transportation issues etc. Interestingly, when we would send individuals away it was common for them to come back a short while later saying that their other provider, for example say their eating disorder counselor, felt that their addiction was the main concern and that needed to be addressed first. The individual was told that after the addiction was addressed then they could work on the eating disorder. We on the other hand felt that until they got their eating disorder under control they could not possibly focus on their addiction. It was a game of ping pong that only ended when the ball fell off the table and moved out of sight².

The concept of Collaboration was just starting to emerge as an appropriate approach to service provision when I was leaving the addictions field to begin my masters. The notion of collaboration made sense to me in terms of working within my sector (for example, the addictions counselor, methadone nurse, and in house physician collaborating regarding care). Working together was better than working alone. It had not occurred to me at that time to consider working collaboratively across sectors. *This* was my job and *that* was theirs. I would provide the best service possible to service users within the bounds of what my policies and procedures dictated and they would do the same. As my career progressed and I became more familiar with systems

² It is important to note that attending to co-occurring disorders is now regularly a part of addictions work. At the time, it was far less common.

thinking I began to feel shame for not seeing the issue for what it really was: conflicting policies. The hardest hit victim was an individual with complex needs desperately trying to get help in a fragmented, complex and ever changing system.

I began working for the Winnipeg Regional Health Authority (WRHA) shortly after completing my masters. I held two positions simultaneously; I was an Embedded Researcher with the Crisis Response Centre (CRC) and the George and Fay Yee Centre for Healthcare Innovation evaluation platform (CHI). Both were departments within the WRHA.

By the time I began working as an embedded researcher the notions of collaboration, integration and partnership had spread like wild fire! The terms seemed to be everywhere. Our regional strategic plan, job postings, region wide training programs all pointed to the need for working together. This was quite unsettling to me because I felt like the expectation was so strong yet I was unsure about the benefit or what the process of working together really entailed. It seemed to be assumed that everyone (except me) knew *how* to collaborate, and that collaboration would lead to positive service user outcomes.

The need for understanding what shapes how sectors work together to offer appropriate care crystalized when I began working at the Crisis Response Centre (CRC). It was evident that service users and service providers had become accustomed to the emergency department and/or police being the first points of contact when individuals experienced a mental health crisis. However, now that a new service was introduced I noticed the struggle service users and service providers had as they attempted to make sense of everyone's role and determine the best route for clients to take.

Around the same time, I began working on my PhD and the opportunity presented itself for me to conduct the scoping review of the literature looking at what was known about

collaborative service provision for people experiencing a mental health crisis. I will not go into great detail about the findings from this review here; the second chapter in this dissertation provides an in-depth overview of a scoping review that was conducted by Winters et al. (2015). The findings from the scoping review pointed to the need to look at mental health crisis service provision in terms of a system of services, rather than a service that can adequately be provided by one sector alone. With that in mind, I thought it was appropriate to further explore the literature from a higher vantage point, conceptually and methodologically. I wanted to look more generally at what the literature could tell us about cross sector service provision in health and social care. I share this paper with you in chapter three of the dissertation so will not elaborate on the details in this section. I will say that the findings from this umbrella review pointed to a paucity of outcomes related to CSSP as well as any clear indication of what shapes how different sectors work together.

After looking to the literature, I was both relieved and frightened. Relieved because it was clear that other people were questioning whether the push to collaborate was justified by the known outcomes of collaboration. Frightened because despite the findings indicating that little was known about outcomes of working together, the ferocity and consistency of the message to collaborate relentlessly pushed down on what seemed like every part of service provision. The notion of collaboration in general and cross sector service provision specifically greatly interested me and I knew that I wanted to explore CSSP further to better understand *how* sectors work together to provide services.

Through the CHI position I was consulted to inform and undertake the qualitative component of the Towards Flourishing Mental Health Promotion Strategy (TF) evaluation. Mariette Chartier at the University of Manitoba was the Principle Investigator of the original

project³. Below I provide an overview of the original project, the reader can refer to that section for details. The overall evaluation was large in scope but one of the elements built into the evaluation plan was to evaluate the effectiveness of collaboration between individuals in the mental health and public health sectors when offering TF to families. The focus was on collaboration at the individual level. What resulted was an immense pool of data that could not be fully analyzed given the large scope of the project.

It was at that time that I began considering the feasibility of doing a secondary analysis of the existing data and marrying that methodology with grounded theory methodology to deeply explore cross sector service provision with the TF data. Chapter four provides insight into how I combined these two methodologies. Given that I was already familiar with the data that were collected I was confident that there would be sufficient data to begin forming a theory of what processes shape cross sector service provision in health and social care. Utilizing secondary data was advantageous for three specific reasons. It would allow me the time and space to isolate and fully analyze data specifically relating to processes involved in working *across* sectors. Secondly, considering that the original TF project was intentionally set up to be a partnership between two independent yet interconnected sectors of the health care system that had produced positive outcomes (see Chartier et al., 2015) it seemed like the ideal project to use to better understand cross sector service provision. Thirdly, and most transformative for me as a service provider and

³ When referring to the study led by Mariette Chartier I will use the term “original study” and will use “the current study” when referring to the work of this dissertation.

researcher it would allow me the opportunity to explore service provision from a positive mental health perspective⁴.

Mental health promotion and positive mental health are a key underpinning of TF. It might sound surprising considering my tenure in the field of mental health, but I had never considered these concepts in theory or in practice up until I was introduced to them during my work with the TF project. I truly paused for what seemed like an exceptionally long time when I finally made the connection between viewing mental health as being mentally healthy, not just being free from a mental illness. Despite having worked in mental health for many years, I had never made that connection. It was like I had taken a corner and was reconsidering all of the work that I had done up to that point.

To tie it all together, the topic for this dissertation did not result from a superficial consideration of content areas but rather was derived from reflecting critically on both my professional and academic experiences over the past ten years. To help situate the research further, I will provide an overview of the health care context in Canada and then move to a description of mental health in Canada and Manitoba in the following section.

⁴Westerhof and Keyes (2010) describe positive mental health as being informed by three core components: feelings of happiness and satisfaction with life (emotional well-being), positive individual functioning in terms of self-realization (psychological well-being), and positive societal functioning in terms of being of social value (social well-being).

Background

Healthcare Context in Manitoba

Regionalization and Changing Landscapes

Each province in Canada operates slightly differently in terms of health care delivery. Primarily services are offered through a combination of public and private services, to varying degrees from province to province (IPAC, 2013). Manitoba is comprised of a population of just over 1,300,000 total residents, roughly half male and half female (Province of Manitoba, 2015) with nearly 30% of residents living in rural settings (IPAC, 2013). Almost 100,000 Manitoban's self-identified as first nations in 2014 (Province of Manitoba, 2015). Manitoba sees roughly 16,200 births annually (16,207 in 2013 and 16,292 in 2014) (Province of Manitoba, 2014, 2015). Health services are managed locally by regional health authorities (IPAC, 2013; Province of Manitoba, 2015) with provincial oversight in Manitoba from the Manitoba Health, Seniors and Active Living department of the Provincial Government (Province of Manitoba, 2015). Further, the Mental Health and Spiritual Health Care Branch is housed under the Manitoba Health, Seniors and Active Living department.

Fiscal constraints are a common theme in healthcare across the country, with growing financial pressures to deliver high quality services efficiently with low costs (IPAC, 2013). In response to these pressures, most provinces have adopted regionalization and have begun changing their governance structures. Manitoba is no exception. In 1997 healthcare services in Manitoba were starting to become regionalized and by 2002 the province was comprised of 11 Regional Health Authorities (RHAs) (IPAC, 2013). Ten years later the province shuffled its resources and moved from an 11 region model down to a five region model (IPAC, 2013; Province of Manitoba, 2015). According to IPIC (2013) the amalgamation of the RHAs intended

to better integrate services, promote greater collaboration and coordination among service providers, and reduce costs. Additionally, the amalgamation intended to save \$10 million over 3 years.

In the next section I will provide an overview of the prevalence of mental health concerns in the Canadian context while attending to the Manitoban context specifically. I will then discuss the history of Mental Health Policy, highlighting key periods of change. Following that, I will describe the intent and rationale of the current study.

Mental Health in Canada

Prevalence of Mental Health Concerns

The Mental Health Commission of Canada Mental Health Strategy report (2012) states that in any given year, one in five (20%) individuals in Canada experiences a mental health problem or illness, and this costs the economy more than \$50 billion annually. Between 2010-2015 approximately 25% of Manitobans (278,060) age 10 and older received medical care for at least one of the following mental illnesses: depression, anxiety, substance abuse, personality disorder, or schizophrenia (Province of Manitoba, 2015). The Canadian Mental Health Association states that suicide accounts for 24% of all deaths among 15-24 year olds and 16% among 25-44 year olds (Canadian Mental Health Association, 2016). In 2014/2015 there were approximately 570 hospitalizations related to self-inflicted injury for Manitoba residents and on average, there were 192 suicides per year for the period of 2009 to 2014 (Province of Manitoba, 2015). Furthermore, the Canadian Mental Health Association (Canadian Mental Health Association, 2016) states that almost one half (49%) of those who feel they have suffered from depression or anxiety have never gone to see a doctor about this problem. Between 2010 and 2015 the prevalence of mental illness was higher for females than males for all age groups

(Province of Manitoba, 2015). In the following section I will further explore maternal mental health specifically.

Maternal Mental Health

The World Health Organization (2008) reported that 1 in 3 to 1 in 5 women in developing countries, and about 1 in 10 in developed countries, have a significant mental health problem during pregnancy and after childbirth. Vesga-Lopez et al. (2008) found the prevalence of psychiatric disorders to range from 15% to 29% in their review. Findings show that women from all social backgrounds can experience poor maternal mental health but socio-demographic factors such as poverty, stress, family violence or abuse, history of depression, and low social support can play a role in increasing the risk (Healthy Child Manitoba, 2012; Vesga-Lopez et al., 2008; World Health Organization, 2008). Additionally, Indigenous women, newcomer women, and Francophone women were reported to be more likely to experience maternal depression (Healthy Child Manitoba, 2012). Depression following childbirth can have a detrimental impact on the mother and her children (O'Hara & McCabe, 2013; Robertson, Grace, Wallington, & Stewart, 2004; Vesga-Lopez et al., 2008). However, promoting the mental health of women in the post-partum period can play an important role in the wellbeing of mothers and their families (Chartier et al., 2015; Keyes, 2002; McDaid & Park, 2011). The perception of mental health has shifted over the years and in the next section I will provide an overview of the historically relevant events that have shaped how mental health and mental health services are offered.

Timeline of Key Periods in History for Mental Health Policy

Key historical events have shaped the perception of mental health and how mental health services are offered (Davis, 2006; Kirby & Keon, 2004). Figure 1 provides an overview of events. In 2012 national and provincial mental health strategies were introduced with strong threads of

endorsement toward promotion and prevention (The Mental health Commission of Canada, 2012; Manitoba Government MH strategy 2012). The priorities outlined in the mental health strategies stem from the Declaration on Prevention and Promotion from Canada’s Ministers of Health and Health Promotion/Healthy Living titled *Creating a Healthier Canada: Making Prevention a Priority* (2010). Among other areas of health, the declaration specifically recognizes the importance of promoting positive mental health and mental fitness throughout the lifespan as contributing to a foundation for optimal overall health and wellbeing.

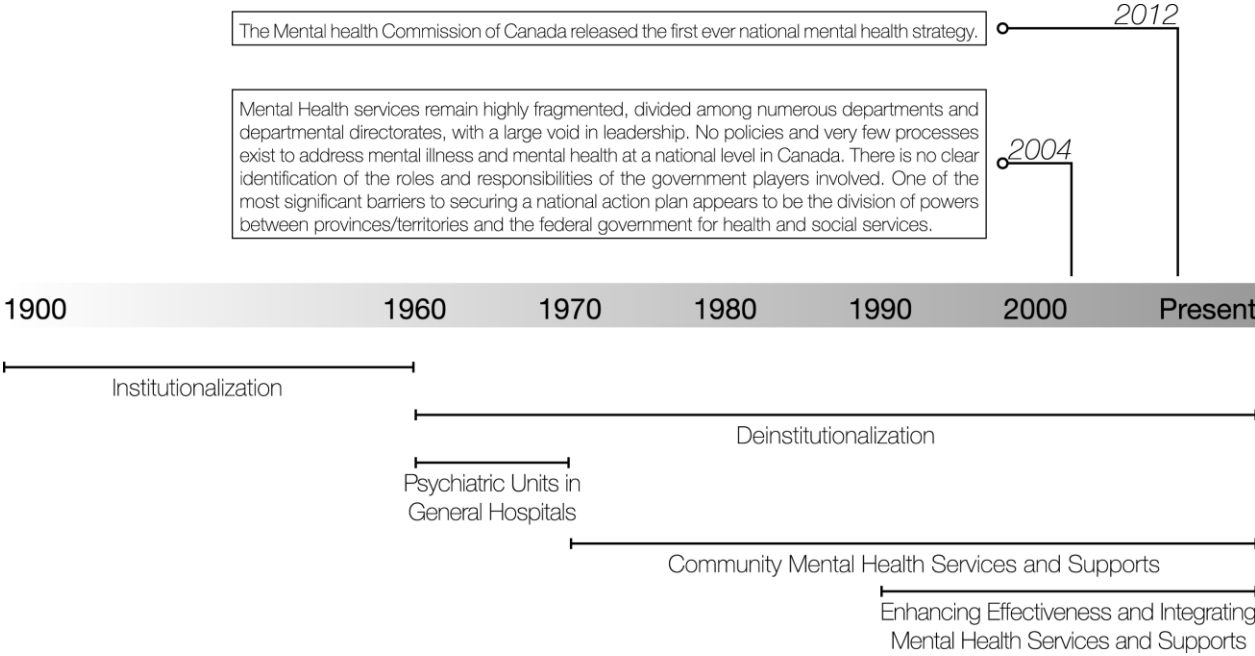


Figure 1 Chapter 1 Timeline of historical events in mental health care in Canada⁵.

⁵ Content derived from Kirby and Keon (2004) and Davis (2006), designed by Shannon Winters and graphic created by Emil-Peter Sosnowski.

The first ever mental health strategy for Canada was presented by The Mental Health Commission of Canada (2012) . The strategy was titled *Changing Directions, Changing Lives* and was comprised of six strategic directions and 26 priorities necessary to improve mental health and wellbeing and create a mental health system that better meets the needs of all Canadians. The strategy calls on all levels of government, providers and service users to work together to put the recommendations into practice. The six strategic directions outlined in the national strategy include: Promotion and prevention, recovery and rights, access to services, disparities and diversity, and a focus on First Nations, Inuit and Métis.

Just prior and through collaboration with the Mental Health Commission of Canada the Manitoba Government put out a provincial Mental Health Strategy titled *Rising to the Challenge*. The provincial strategy is a 5-year plan that addresses 6 strategic areas: mental health and wellbeing; access to services; innovation and research; social inclusion; family participation and; workforce development.

Mental Health Promotion

Historically mental health has been viewed as the absence of illness (Westerhof & Keyes, 2010; World Health Organization, 2004) rather than being viewed as an individual's state of mental well-being. Mental health refers to an individual realizing his or her own abilities, having the ability to cope with the normal stresses of life, working productively and fruitfully, and being able to make contributions to his or her community (World Health Organization 2001). Further, mental health is the capacity for each of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face (Public Health Agency of Canada 2016). Mental Health Promotion (MHP) is the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health, by collaborating

with many sectors of society (Province of Manitoba, 2012; Public Health Agency of Canada, 2016) . MHP involves the population as a whole and applies equally to all people, sick or well (The Province of Manitoba 2012)

The Towards Flourishing Mental Health Promotion Strategy (TF) which will be presented below is based on the dual continua model introduced by Keyes (2002) and stresses that regardless of whether an individual is experiencing a mental illness or not, there is capacity within every individual to improve their mental health (Westerhof & Keyes, 2010). The presence of mental health is described as flourishing and the absence of mental health as languishing (Keyes, 2002). Flourishing individuals are said to be full of positive emotion and to be functioning well both psychologically and socially, whereas languishing individuals are said to be experiencing low well-being. TF aims to promote the mental health and well-being of families and children connected to the Families First Home Visiting Program (FF). How the current study relates to the original TF study will be discussed further in Chapter four.

In the following sections I will offer an overview of both the Families First Home visitor (FF-HV) Program and the original Towards Flourishing Mental Health Promotion Strategy (TF) project. I will then describe how I came to conceptualize the current study and conclude with an overview of ethical considerations of the study.

Families First Home Visiting Program

The FF-HV program provides services to families with children (from prenatal to five years old) who are living in what are considered at-risk conditions (Healthy Child Manitoba, 2010). Risk factors can include, being a teenage parent, parents experiencing financial difficulties, or parents with mental health problems. In Manitoba, Public Health staff screen all new mothers shortly after giving birth to assess for risk factors related to healthy child

development. If a sufficient level of risk is identified, families are provided with the opportunity to receive additional support, on a voluntary basis. If the family agrees, they are connected with Families First (FF) Home Visiting program. A home visitor (FF-HV) meets with the family regularly for up to three years to offer a range of supports.

Towards Flourishing as a Concept

Healthy Child Manitoba conducted an evaluation of the Families First program and identified a gap related to mental health supports offered to families in the FF program (Healthy Child Manitoba, 2010). The Winnipeg Regional Health Authority, the University of Manitoba and Healthy Child Manitoba joined forces to create a demonstration project called the Towards Flourishing Mental Health Promotion Strategy that intended to fill this gap. In 2011 TF was embedded into the existing FF program as a multifaceted approach to promoting mental health for Manitoban families with newborns (Chartier et al., 2015). TF supports include: adding a mental health promotion Facilitator (Facilitator) to support the home visitors and public health nurses, a mental health screening package, mental health promotion educational materials for new parents and training for the Families First Home Visitors (HVs) and Public Health Nurses (PHNs) (Chartier et al., 2015).

Study Purpose

Few authors have theoretically explored CSSP in any depth. Extensive research exists that informs how people work together on an individual/provider (Micro) level but findings are scarce when it comes to understanding how organizational/regional (Meso), and policy/strategic governance (Macro) level arrangements impact the ability of sectors to work effectively together (Winters et al., 2016). The current study uses existing data collected from the evaluation of TF (the original study) to explore CSSP at the boundary between the two sectors (mental health and

public health), focusing on individual provider (micro) organizational (meso) and policy/strategic governance (macro) levels. The original TF study focused on all components of the implementation of the project and was large in scope. Collaboration was one component of the original study but given the magnitude of the overall evaluation, this concept was only minimally explored.

Extensive research has been done in the area of CSSP, however, numerous gaps still exist in understanding what processes shape these arrangements. I argue that we must systematically identify the processes involved in CSSP to generate a theory that is situated in the local context, historically, temporally, and socially. In the current study I adopted grounded theory methods (Charmaz, 2014) to undertake a secondary analysis of the original study data to generate a mid-level theory that increases our understanding of the processes involved in CSSP.

Research Question

The following research question guided the current study: *What processes shape cross sector service provision at the boundary between mental health and public health sectors in the Towards Flourishing Mental Health Promotion Strategy?*

Ethical Considerations

The Western University Health Research Ethics Board approved the current study and the University of Manitoba Health Research Ethics board approved the original study. The original study data were de-identified and kept in a secure locked location. Electronic data were stored on a password-protected computer, which was stored in a secure location. Any hard copy data were stored in a locked cabinet behind a locked door. Only those individuals immediately involved in the current study had access to the data. Data sent electronically between study stakeholders

(advisory committee members, original study team, participants), were housed in a password-protected document.

The materials for the current study will be destroyed 7 years following the completion of the study. Findings from the current study may be reported in peer-reviewed journals and presented at conferences; however no identifying information will be reported. Every effort was made to sanitize information so as not to reveal the participant's identity.

There were no known risks to participating in this study. There may or may not be benefits to the participants who participated in either the original or current study, however it is hoped that through gathering information related to cross sector service provision, service delivery and care that service users receive will be improved.

Overview of Thesis

This dissertation presents the findings from a secondary analysis utilizing Grounded Theory methodology to explore processes that shape cross sector service provision. To begin setting the stage for this project I provided the reader with a vignette of how I came to be interested in studying the concept of CSSP. Following my story I provided a brief overview of the Canadian health care context and then moved into a fuller description of the Manitoban context, the location where the dissertation project took place. A historical account of Mental Health Care in Canada was depicted prior to moving to a discussion about Mental Health Promotion specifically. In the following chapters I will present the findings from a scoping review that explored the literature regarding collaboration in mental health crisis response systems (Winters et al., 2015) and will then move on to describe CSSP more generally by presenting the umbrella review mentioned above that explored CSSP in health and social care (Winters et al., 2016). A more in depth description of the methodology adopted for this study and

the findings that resulted will be described in chapter four. I will conclude this dissertation with a chapter that highlights the contribution of this work to the field of Health Professional Education, implications to practice, research, and policy. In closing I will discuss methodological considerations and my transformation as a researcher and the impact that this work had on me as I engaged with the process of understanding more fully how people engage across sectors.

This concludes the introductory chapter of this dissertation. The call to provide more effective services is strong and improving coordination of care is often suggested to be the solution to fixing the fragmented health and social care system (Kernaghan, 1993). However, it appears to be taken for granted that we have a shared understanding of *how* to do this. At this juncture, this is simply not the case and more research is needed to ensure that care is being provided in the best possible way across independent, yet interconnected sectors. If we do not begin conceptualizing *how* this is done we will continue providing disjointed services and people may continue to fall through the cracks (Glasby & Dickinson, 2008; Kodner & Spreeuwenberg, 2002). The current study used secondary data from the TF study to explore cross sector service provision and begin shedding light on the processes involved in providing care in a coordinated or joint manner. The findings from this inquiry will be presented in the following chapters.

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Chapter Two; Paper One⁶: Interprofessional Collaboration in Mental Health Crisis Response Systems: A Scoping Review

In this chapter I present the findings of a scoping review that informed the early development of the current study. Although the current study does not focus on mental health crisis exclusively, elements of responding to a mental health crisis are salient features that shape CSSP in TF. The article is included to provide a deep overview of mental health crisis response systems, but also because it strongly informed the Umbrella Review that will be discussed in the following chapter.

Abstract

Post deinstitutionalization saw the rise of mental health crisis response in Canada. First points of contact for individuals in a mental health crisis (MHC) are often police services or emergency departments. Professionals in these areas may report feeling unprepared, ill equipped, and a lack of confidence to work with clients in crisis. Police indicate that this work is time consuming, demanding, and “not their job”. Entry points can exacerbate the crisis given the chaotic, over-stimulating and frightening environment of emergency departments and the perceived threat of police officers. Despite the outcry of support for working more collaboratively, little is known about the impact Interprofessional Collaborative Practice (IPC) has in mental health crisis response systems (MHCRS). Purpose: Given this challenge, the aim of

⁶ A version of this paper was published by Taylor & Francis Group in *Disability & Rehabilitation* on January 14, 2015, available online: <http://www.tandfonline.com/article/DOI/10.3109/09638288.2014.1002576>. Winters, S., Magalhaes, L., & Kinsella, E. A. (2015). Interprofessional collaboration in mental health crisis response systems: a scoping review. *Disability & Rehabilitation*, 00, 1–13. <http://doi.org/10.3109/09638288.2014.1002576>.

this scoping review is to contribute to understanding the current state of knowledge related to IPC in MHCRS. Methods: A scoping reviews was conducted to address the research topic. Results: Review of the literature identified 18 articles for inclusion, 5 experimental or exploratory papers, 7 models of care, and 6 discussion papers. Analysis identified the following themes: Support for interprofessional collaboration, quest for improved care delivery system, merging distinct visions of care, and challenges to interprofessional collaboration. Implications for practice, policy, and research are discussed, as well as issues in the literature related to: Lack of conceptual clarity, absent client perspectives, unequal representation across sectors, and a young and emergent body of literature. Conclusion: Key concepts need better conceptualization, and further empirical research is needed.

Introduction

The rise of mental health crisis response services emerged from a considerable change in the mental health care delivery system, deinstitutionalization. Deinstitutionalization focused on an alternative to long term hospitalization for individuals with mental health concerns. It was initiated in the 1960s, and argued for shorter durations of stay in institutions, and for more community level interventions (Davis, 2006). This shift was based on the understanding that community based care could better meet the needs of individuals experiencing mental health concerns (Bachrach, 1994; Davis, 2006). During this transition, many institutions were downsized or closed (Davis, 2006). Simultaneously, this considerable shift in service delivery brought the need for a different approach to mental health services, in particular, mental health crisis (MHC) services (Fourie, McDonald, Connor, & Bartlett, 2005; Fry, O’Riordan, & Geanellos, 2002). Davis (2006) and Torrey (2010) take particularly critical viewpoints of deinstitutionalization, noting many challenges that resulted from this shift, such as homelessness,

alcohol and substance abuse, poor nutrition, and social isolation. Other authors argue that the issue was not with deinstitutionalization per se, which is still the more favorable approach, but rather lies in the limited resources that individuals with mental health concerns have to draw on (Clarke, Brown, Hughes, & Motluk, 2006; Fry et al., 2002).

The first points of contact for individuals experiencing a MHC are often through police services (Fry et al., 2002) or emergency departments (Clarke et al., 2006; Clarke, Dusome, & Hughes, 2007) because clients may feel they “have nowhere else to go” (Clarke et al., 2007 p. 139). Other points of entry for crisis response services include clergy (Burns, Jhazbhay, Kidd, & Emsley, 2011; Farrell & Goebert, 2008), college and university campus personnel (Drum & Denmark, 2012; Pinder-Amaker, 2012), social services (Laing, Irwin, & Toivonen, 2012) and traditional healers (Maar et al., 2009).

Crisis response points of entry are staffed with professionals who may report feeling unprepared (Fry et al., 2002), ill-equipped (Laing et al., 2012) or who report a lack of confidence (Broadbent, Jarman, & Berk, 2002; Clarke et al., 2006; Fry et al., 2002) when working with individuals experiencing a MHC. Moreover, Clarke et al. (2007) reported that clients felt as though they were not viewed as a priority when they accessed care in emergency departments, particularly when escorted by police. Fry et al., (Fry et al., 2002 p. 281) reported that from police officers’ perspectives working with individuals experiencing a MHC was: time consuming, increased the demand on them, and was “not their job”. Other studies highlight that these entry points may not only be unsupportive of individuals in crisis but could exacerbate the crisis given the chaotic environment of emergency departments (Ordonez et al., 2007), their over-stimulating and frightening nature (Clarke et al., 2007) and the perceived threat of police officers (Fry et al., 2002).

Numerous studies support the adoption of a collaborative approach to crisis response. Rossen, Bartlett, and Herrick (2008) stress the necessity of developing interdisciplinary teams of care providers for individuals with acute and chronic mental illnesses, while acknowledging that achieving this can be difficult. Similarly, research conducted in emergency (Bergmans et al., 2009; Clarke et al., 2006; Simakhodskaya, Haddad, Quintero, & Malavade, 2009) and police departments (Fry et al., 2002; Hanafi, Bahora, Demir, & Compton, 2008; Mclean & Marshall, 2010; Oliva & Compton, 2008; Ordonez et al., 2007; Silver & Goldstein, 1992; Watson & Fulambarker, 2012) call for interprofessional collaboration when care providers work with individuals who are experiencing a MHC. Despite the outcry of support for interprofessional collaboration, little is known about the impact it has in the mental health crisis response systems (MHCRS).

Interprofessional Collaboration in Mental Health Crisis Response

Rigorous reviews have been conducted that focus broadly on interprofessional collaboration (IPC) in healthcare (Reeves et al., 2011; Zwarenstein, Goldman, & Reeves, 2009) and specifically on IPC in mental health (Craven & Bland, 2006). To the best of our knowledge, a review of interprofessional collaborative practice focusing on the area of mental health crisis response systems (MHCRS) has not yet been conducted.

The chosen methodology for the current review was a scoping review. Scoping reviews, as delineated by Arksey and O'Malley (2005), are typically used to address broad research topics where the literature may include different study designs. The intent is to rapidly map key contributions to knowledge, especially in areas that are complex or have not yet been reviewed comprehensively. The intent of the current scoping review is to summarize and disseminate research findings, and to identify gaps in the existing literature related to IPC in MHCRS.

Definition of Key Concepts

Although there is a lack of consistency in the existing literature regarding definitions and conceptualization of key terms, working definitions of ‘Crisis’ ‘Systems’ and ‘Interprofessional Collaborative Practice’ are presented, with the aim of being transparent regarding our interpretations.

Crisis

The notion of crisis is often credited to Gerald Caplan, a British born psychiatrist who served as the director of the Harvard University School of Public Health and who Cutler and Huffine (2004) refer to as a hero of community psychiatry. Caplan extended the work of colleague Erich Lindemann regarding Crisis Theory, in what remains today as the preferred theory of crisis (Ball, Links, Strike, & Boydell, 2005). Ball et al. (2005) further drew on Caplan’s conception of crisis - that people typically exist in emotional homeostasis until they encounter an event or precipitant that disrupts this state - to generate a theoretical model of crisis that applies specifically to individuals with severe and persistent mental illness.

Ball et al. (2005) theory claims that individuals with severe and persistent mental illness experience an underlying vulnerability leading to the crisis, where they begin to feel overwhelmed and a lack of control, from there they exhibit signs of agitation, anger, aggression; being low; feeling anxious; and euphoria, which leads to either an immediate response of getting help or of managing alone. Ball et al. (2005) go on to state that the experience usually culminates in crisis resolution and prevention whereby crises are resolved when the individual regains a sense of control and no longer feels overwhelmed.

Subsequently, Brennaman (2012) extended Ball’s theory to include a distinction between a crisis and a mental health emergency. Crisis, as stated by Brennaman (2012) is manifested by

an increase in anxiety, tension, or depression that precludes the individual from functioning at his or her typical level in everyday life. A mental health emergency is where a situation presents that requires an immediate response in order to avoid possible harm. A mental health emergency as Brennaman describes it, includes potential suicide, potential danger to others, and confusion or functional decline that places the client at imminent risk for injury. The purpose of Brennaman's theory was to provide nurses and emergency department staff with a situation specific theory given the large and growing presence of clients with severe and persistent mental health concerns presenting in crisis to emergency departments. Fourie et al. (2005) suggest that mental health nurses in emergency departments adopt a crisis oriented model of care that focuses on the here and now, symptom stabilization, with a focus on triage, assessment, stabilization, and the containment of risk. The above mentioned definitions of crisis inform the scope of the current review, next we present our working definitions of interprofessional collaborative practice and mental health crisis response systems.

Interprofessional Collaborative Practice

For the purpose of this article we adopt the term Interprofessional collaborative practice (IPC), and operationalize our understanding below. Reviews conducted by Zwarenstein et al. (2009) and Craven and Bland (2006) inform the conceptualization of IPC adopted in the current review. Zwarenstein et al. (2009) distinguish between three forms of interprofessional interventions: interprofessional education (IPE), interprofessional organization (IPO), and interprofessional collaborative practice (IPP) (for more information regarding IPE and IPO see Zwarenstein et al. (2009). Zwarenstein et al. (2009) describe IPC as an intervention that involves more than one health and/or social care profession interacting together with the explicit purpose of improving their practices. Craven and Bland (2006 p. 9S) undertook an analysis of the

evidence base intended to inform better practices in collaborative mental health care. Drawing on this work, they define collaborative care as “involving providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support, to ensure that individuals receive the most appropriate service from the most appropriate provider in the most suitable location, as quickly as necessary, and with minimal obstacles.” For the remainder of this article we will use the term interprofessional collaboration (IPC) to include members from the various sectors involved in MHCRSs.

Mental Health Crisis Response ‘System’

Based on the existing literature, responding to crisis involves various sectors. These cross sector collaborations with mental health professionals occur within the healthcare system (Clarke et al., 2006; Tummey, 2001), and police services (Fry et al., 2002; Hanafi et al., 2008), clergy (Burns et al., 2011; Farrell & Goebert, 2008), college and university campus personnel (Drum & Denmark, 2012; Pinder-Amaker, 2012), social services (Laing et al., 2012) and traditional healers (Maar et al., 2009). For this reason, it is important to note that we will use the term ‘system’ as opposed to ‘service’ when referring to IPC given that the literature suggests that no one service can independently provide everything that an individual experiencing a MHC requires. The relationship between the different sectors will be discussed further in the following sections.

Methodology

The aim of this scoping review is to map the current state of knowledge regarding IPC in MHCRS and to identify trends that might prove helpful to service providers who work with individuals experiencing a MHC. The process for narrowing down the scope of this literature review was iterative and not predetermined at the outset (Arksey & O’Malley, 2005). The initial search was broad in nature; the intent was to systematically retrieve all literature in the area of

‘healthcare and interprofessional collaboration’ and to subsequently narrow the scope to focus on mental health crisis as we became more familiar with the content.

Inclusion Criteria

The above mentioned descriptions of key terms helped to define the scope of the current study. The broad initial scope of this review sought out experimental and exploratory studies that included an intervention or routine for the specific purpose of improving, measuring or exploring ‘Interprofessional Collaborative Practice’ (IPC). Included studies had reported findings, or were models of interprofessional collaboration interventions or routines. The scope was then narrowed to focus on the specific area of ‘adult mental health crisis response systems’ (MHCRSs). We placed no restriction on geography, time period of publication, or type of source for review (books, peer reviewed articles, grey literature).

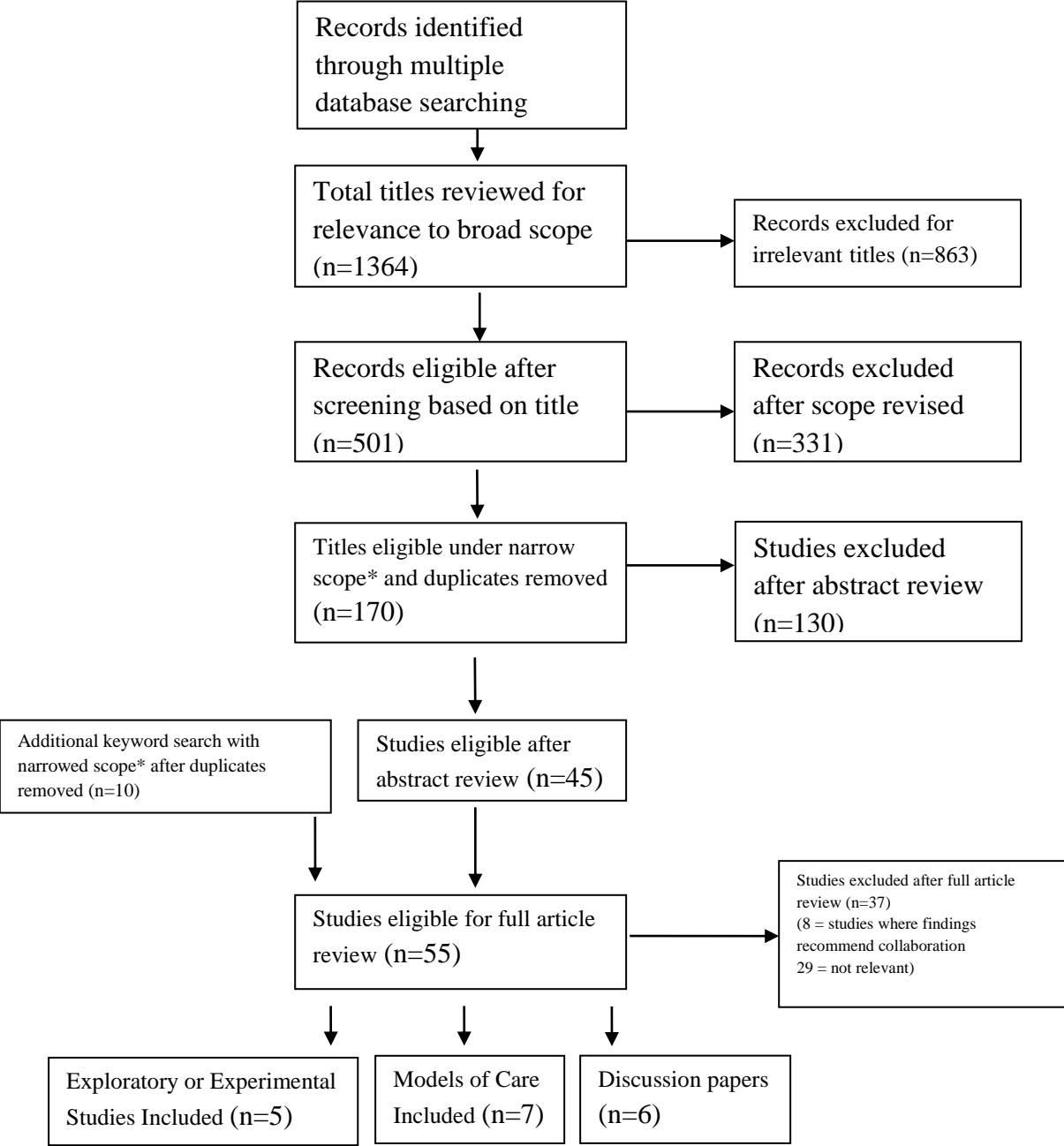
Exclusion Criteria

- Studies not published in English
- Studies focused on Interprofessional collaborative education
- Participant groups under 18 years of age because of the considerable differences between the child and adult mental health systems
- Studies that recommend collaborative practice but did not directly study Interprofessional collaborative practice

Figure 2 presents a flow diagram of article selection and exclusion. Table 1 provides a complete list of keywords searched in PubMed, Scopus and CINHAL databases. The initial broad search yielded (n=1364) studies. Titles were reviewed and articles immediately identified as irrelevant were discarded and all other titles (n=501) were brought forward. Arksey and O’Malley (2005) recommend maintaining a wide approach in order to generate breadth of coverage. Once a

sense of the volume and general scope of the field was gained additional parameters were set to further narrow the scope. Studies fitting with the narrowed scope (Interprofessional Collaborative Practice in adult mental health crisis response) were brought forward and duplicates eliminated (n=170). Abstracts were reviewed and 45 articles were sent forward. As a quality measure, a second search of the literature was employed using specific keywords to ensure that all relevant literature regarding this specific area were obtained. Multiple studies were identified. After cross referencing with the original list to rule out duplication, 10 new articles were added to the 45 original articles sent forward for further review. The 55 full articles were reviewed for appropriateness against the narrowed scope and resulted in the inclusion of 18 articles. The remaining papers were excluded because they were irrelevant (n=20).

Figure 2 Chapter 2 MHCRS Study Selection and Exclusion Flow Diagram.



* Scope of review was narrowed from Collaboration in Healthcare to Interprofessional Collaboration in Mental Health Crisis Response Environments.

Table 1. Chapter 2 Keyword Search by Database.

| Database | Key Words Searched | Number of Articles Found |
|----------|---|--------------------------|
| CINHAL | Crisis and Mental and Health and Urgent and Collaboration | 2 |
| CINHAL | “Mental Health Crisis” and Collaboration | 23 |
| PubMed | “Mental health Crisis” and Collaboration | 26 |
| Scopus | “Mental Health” and Police and Collaborative | 21 |
| Scopus | “Mobile Crisis” and Collaborative | 6 |
| Scopus | “Crisis Intervention Teams” and Collaborative | 29 |
| Scopus | “Mental Health” and Collaborative and Crisis | 76 |
| Scopus | “Mental Health” and Crisis and Collaborative and “Emergency Department” | 4 |
| Scopus | “Mental Health” and Collaborative and “Emergency Department” | 32 |
| Scopus | Interdisciplinary and Collaborative and Mental and Health | 130 |
| Scopus | Healthcare and Collaboration | 1015 |

Reference lists of the included articles, as well as three review papers (Craven & Bland, 2006; Reeves et al., 2011; Zwarenstein et al., 2009) were searched to identify potentially relevant studies. No articles were brought forward from these searches. All articles identified in this step were either irrelevant to the study scope or duplications of included articles.

Data Abstraction and Charting the Data

The next step involved abstracting data from included studies utilizing a narrative review approach as suggested by Arksey and O’Malley (2005) whereby information is presented in a way that is contextualized and more understandable to readers. A consistent analytical framework was applied to all primary research reports when gathering information on each study. Charted information included: authors, title, year of publication, participant groups, number of participants, method, setting, purpose, intervention, findings.

Summarizing Results

Given that a scoping review does not seek to aggregate findings from different studies (Arksey & O'Malley, 2005), a formal quality appraisal was not applied to articles included in this review. Data were analyzed to identify themes within and across included studies, as well as gaps identified in the review. These are reported below in a descriptive manner.

Findings

A total of 18 studies are included in this scoping review. See Table 2 for an overview of included experimental or exploratory studies and Table 3 for a description of models of care included in this study. Four categories of literature emerged. Five exploratory studies were conducted between 2000 and 2012. Of these, two were action research studies (Laing et al., 2012; Maar et al., 2009), two were general qualitative studies (Carvalhana & Flak, 2009; Skubby, Bonfine, Novisky, Munetz, & Ritter, 2013), and one was a retrospective document review study (Steadman, Deane, Borum, & Morrissey, 2000). In addition, seven papers discussed IPC care models that support individuals experiencing a mental health crisis (Drum & Denmark, 2012; Farrell & Goebert, 2008; Oliva & Compton, 2008; Silver & Goldstein, 1992; Simakhodskaya et al., 2009; Tummey, 2001; Watson & Fulambarker, 2012). These papers were included because they provide insight into how agencies and or individuals have suggested or attempted to offer a MHC service with an IPC approach. Five of the seven studies of models were descriptions of actual models in use from different sectors and the remaining two studies were discussion papers on hypothetical models, one in the area of campus suicide prevention (Drum & Denmark, 2012) and one regarding Crisis Intervention Teams (CIT) (Watson & Fulambarker, 2012). Six discussion papers were also included to inform the background of this study (Brennaman, 2012; Clarke et al., 2006, 2007; Marynowski-Traczyk & Broadbent, 2011; Marynowski-Traczyk,

Moxham, & Broadbent, 2013; Rossen et al., 2008). Finally, eight articles that argued for the *need* for IPC in MHCRS were retained because they informed the background section of the current study (Bergmans et al., 2009; Burns et al., 2011; Farrell & Goebert, 2008; Fourie et al., 2005; Fry et al., 2002; Hanafi et al., 2008; Mclean & Marshall, 2010; Ordonez et al., 2007).

Table 2. Chapter 2 Characteristics of Included Studies of Interprofessional Collaborative Practice in Mental Health Crisis Environments.

| Reference | Study Design | Participants | # Participants | Methods | Country/ Setting | Purpose | Intervention | Interprofessional Collaboration Outcomes |
|--|-----------------|--|--|---|---|---|--|---|
| Carvalhana & Flak, Role of a Pharmacist on a multidisciplinary psychiatry team: Impact on medication adherence in a community setting 2009 | Case study | Pharmacists and psychiatrists | 3 case studies reported | Not specified | Canada/ Pharmacies – not specified further | To report a series of cases of interprofessional collaboration between community pharmacists and the treating psychiatrist and the successful management of patients at otherwise high risk of decompensating or readmission to hospital. | Daily communication between Pharmacist and Psychiatrist Shift in dispensing practices – daily as opposed to weekly Follow-up if change in behavior noted by pharmacist | Increased medication compliance. Reduced overdose. Economic - fewer hospital admissions. |
| Laing, Irwin & Tiovonon Across the divide: Using research to enhance collaboration between mental | Action Research | Domestic violence workers—including welfare and community workers, social workers, psychologist s, and | Time 1 (6 month mark): 16 =9 MH professional and 7 DV professional | Part of a larger study. Current study: Participants attended 12 working group | Australia/ Community based domestic abuse services for women who also have mental | To generate initiatives aimed at developing and improving collaboration between the domestic violence and mental health sectors. This | Working group formed with the purpose of generating initiatives aimed at developing and improving collaboration between the two sectors – met monthly for one | Coordinated care - providers from both services developed an increased understanding of what the other service can provide to women experiencing abuse, mental health professionals shifted their practice to include screening women about experiencing abuse – which increases the chances of intervening earlier. Number of cases where screen occurred rose from 52% to 85% of cases after exposure to intervention, whereas no change was noted by professionals not exposed to intervention (not to be inferred as causal). Increased coordination of referrals from one service to the other – now use a formal service agreement developed collaboratively |

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|---|-------------------------------|--|--|--|---|---|---|--|
| health and domestic violence services 2012 | | women's health practitioner. And mental health practitioners –including nurses, occupational therapists, social workers, and psychologists. | onal) Time 2 (12 month mark): 11 = 6 MH professional and 5 DV professionals Total = 27 | meetings 27 telephone interviews Observations Document review | health concerns | included trialing these initiatives, reflecting on and evaluating the outcomes, and based on this, refining the initiatives and re-trialing them as part of the action research cycle. | year. Cross training Developing shared service agreement | between the two services. “Institutional empathy” each service learned about the other which shaped more realistic expectations and reduced mutual blame. Developed a level of trust and shared purpose, personal relationships formed. Successfully lobbied for funding for a new specialist role to improve coordination of service across sectors. |
| Maar, Erskine, McGregor, Larose, Sutherland, Graham, Shawande, & Gordon Innovations on a shoestring: a study of a collaborative community based Aboriginal mental health service model in rural Canada | Participatory Action Research | The local mental health team, visiting mental-health consultants, therapists, social workers, tribal police. Aboriginal clients who received service in the last two years | 31 Service providers 23 Aboriginal clients | Ethnographic interviews and Focus Groups with two groups: Service Providers and Aboriginal clients | Canada/ Northern Ontario Aboriginal communities | Study was designed to go beyond the anecdotal evidence to identify critical components and outcomes of a collaborative care model. Focused on how collaborative mental health care is provided in this northern Aboriginal context. Strategies that support interdisciplinary collaboration | Co-location- centrally located shared home office Weekly intake meetings with core multidisciplinary team Common intake Multidisciplinary teams that include traditional healers as well as health professionals Traditional health practices explicitly respected and healing protocols developed Specialized coordinator role Peer Supervision and informal case consultation Cultural training | Increased understanding of clinical and traditional approaches led to significant progression toward successful integration of the typically separate sectors. Shared understanding of culture whereby client beliefs, religions, backgrounds and history were accepted by providers and the focus was on building the strength of Aboriginal people. Reduced professional isolation. More positive work environment. Increased sense of support from interdisciplinary team members New team members were able to work at full capacity sooner as a result of mentorship that occurs between team members. Increased cultural safety. Improved quality of illness management – reduced acute care admissions to psychiatric hospitals. Increased privacy when accessing mental health services – not typically found in rural communities. Higher levels of satisfaction with care received. Well managed wait times. Commitment from all sectors to continue working together. |

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|--|--|---|---|-----------------|----------------------------------|---|--|---|
| 2009 | | | | | | and service integration. Identify the strengths and challenges related to this model | | |
| Skubby, Bonfire, Novisky, Munetz, & Ritter Crisis Intervention Team (CIT) Programs in Rural Communities: A focus group study 2012 | General Qualitative Study | Mental health professionals, criminal justice personnel, mental health service users, and advocates | 36 MH professionals 29 Criminal Justice personnel 4 service user advocates Total n = 70 | Focus groups | USA Ohio/rural police department | better understand the collaborative process of program development in rural, urban and suburban communities that are working towards jail diversion programs. | Development of a community jail diversion initiative for individuals with mental illness Cross training criminal justice personnel with mental health personnel. Created opportunities for increased communication across sectors. | Increased understanding by both sectors. Police officers approach to clients changed, appeared to be more kind and understanding of the clients situation. More able to de-escalate the situation. Increased sense of support from both sectors. More equipped to respond to different calls. Responses are more coordinated, as opposed to before where they are haphazard. Providers feel there is a plan of action. Police officers take a less threatening approach with clients and often this leads to clients going willingly to hospital rather than resisting. Community's relationship with police improved. Improved cooperation across sectors. |
| Steadman, Williams Dean, Borum, & Morrissey Comparing models of major models of police responses to mental health emergencies | Cross-site descriptive design of three sites | Police and mental health care providers | 297 documents reviewed Retrospective document analysis (record review) Police dispatch call reports | Document review | USA Tennessee and Alabama | Compare three different models of police based specialized responses to calls that police dispatchers categorize as calls for "emotionally disturbed persons." All three | Compare three sites where police officers were trained and work in collaboration with the mental health system | The specially trained officers were able to resolve almost two-thirds of the mental disturbance calls on the scene without the necessity of further transportation or use of coercive procedures to facilitate treatment. For the entire sample, only 7 percent of the incidents resulted in arrest. In Knoxville the collaboration between the police and the mobile crisis unit allowed people with mental illness to be linked to treatment resources. Immediately places the person in crisis within the purview of the mental health system as opposed to the criminal justice system. Mobile unit lengthy response time and having limited number of specially trained police officers made wait times long and frustrated the officers. The delayed response led officers not to use the unit's services as often as they otherwise might have and forced them to consider alternative dispositions. |

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|------|--|--|----------------------------|--|--|--|--|--|
| 2000 | | | and incident reports | | | programs were designed to divert persons suspected of having mental illness from jail to mental health services whenever possible | | Data strongly suggest that collaborations between the criminal justice system, the mental health system, and the advocacy community, when they are combined with essential elements in the organization of services such as a centralized crisis triage center specifically for police referrals, may reduce the inappropriate use of U.S. jails to house persons with acute symptoms of mental illness. |
|------|--|--|----------------------------|--|--|--|--|--|

*IPC - Interprofessional Collaborative Practice

*CIT - Community Intervention Team

*Outcome categories derived from Reeve et al

Learner (changed in knowledge and behavior from the health professionals)

System (Sustainability, cost savings)

Provider (Recruitment, retention, morale, satisfaction)

Client (access, quality, safety, disease, specific disease related outcomes)

Table 3. Chapter 2 Overview of Interprofessional Collaboration Models of Care in Mental Health Crisis Environments.

| Reference | Year | Status of Model | Setting | Main Elements/Abstracts |
|-----------------------|------|---------------------|---|--|
| Drum & Burton | 2012 | Ideal | Campus not specified | After reviewing findings that support the need to adopt a broader, problem-focused paradigm, this article provides a framework for bridging this paradigm with the clinical-intervention approach and for conceptualizing a full continuum of preventive interventions. For each level of intervention (ranging from the individual to the ecological), we describe the goals and methods used, and provide examples to illustrate the role of psychiatrists and other campus mental health providers in the collaborative partnerships that must form to support a comprehensive, campus-wide suicide-prevention strategy. |
| Olivia & Compton | 2008 | Actual model in use | Police USA- Georgia | This overview provides a description of the evolution of the Georgia Crisis Intervention Team (CIT) program to train a portion of its law enforcement officers to respond safely and effectively to individuals with mental illnesses who are in crisis, including discussions of the historical context in which the program developed; the program's vision, mission, and objectives; the importance of the multidisciplinary Georgia CIT Advisory Board; the training curriculum; the role played by state and local coordinators; the value of stakeholders' meetings; practical operations of the program; the importance of considering the adequacy of community-based and hospital-based psychiatric services; costs and funding; the program's expansion plan; and evaluation, research, and academic collaborations. |
| Pinder-Amaker & Bell | 2012 | Actual model in use | Campus USA-Maryland | McLean Hospital's College Mental Health Program was established four years ago as an institutional response to escalating, national college mental health concerns. McLean Hospital is the first psychiatric hospital to develop a comprehensive college student program that bridges the gap between a psychiatric hospital and multiple campus settings as an attempt to address the specific needs of college student-patients across levels of psychiatric care and diagnostic areas/programs. Using a bioecological systems framework, this review examines (1) the strategic clinical, education/outreach, and research efforts that collectively represent a paradigm shift to extend responsibility for addressing serious college mental health challenges beyond college and university campuses, (2) the challenges and benefits of creating stronger multi-campus/hospital collaborations in order to improve our understanding of college students with serious mental illness, and (3) the progress in addressing these needs more effectively and in establishing documented best practices and policies through effective and innovative partnerships. |
| Silver & Goldstein | 1992 | Actual model in use | Police USA- Ohio | A model is introduced for the classification of crisis intervention and disaster services as being clinic-based, ad hoc, school-oriented, disaster service based and integrative. An example is presented of an integrative- collaborative model that was developed in Lake County, Ohio to cope with situations of suicide, accidental death or natural disaster when they occur in rural areas and small towns. The Community Crisis Intervention Team (CCIT) was developed with characteristics specific to a collaborative model. The distinctive qualities of the CCIT are identified and discussed within the context of a case study of a postvention in a school setting following adolescent suicide. |
| Simakhodskaya et al., | 2009 | Actual model in use | Emergency Departments USA – New York | Research has shown that follow-up rates with aftercare recommendations upon discharge from psychiatric emergency services are low. These patients are in need of additional wrap-around support services. This article illustrates how an innovative program has been effective in utilizing crisis intervention services and mobile crisis outreach within an emergency room (ER) setting and how these unique services can be integral in preventing psychiatric decompensation and repeated presentations to the ER. In addition, implementing these services helps ensure better compliance with follow-up recommendations, allowing for the resolution of the crisis, enhanced diagnostic clarification, and identification of barriers to continued care in the community. Essential elements of successful application of this model include providing an immediate appointment, having close follow up, and ensuring a collaborative and interdisciplinary approach that addresses the biopsychosocial needs |

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|----------------------|------|---------------------|-------------------------|--|
| | | | | of patients. |
| Watson & Fulambarker | 2012 | Ideal | Police Not specified | As persons with mental illnesses and law enforcement become increasingly entangled, the collaboration of police and mental health service providers has become critical to appropriately serving the needs of individuals experiencing mental health crises. This article introduces the Crisis Intervention Team (CIT) Model as a collaborative approach to safely and effectively address the needs of persons with mental illnesses, link them to appropriate services, and divert them from the criminal justice system if appropriate. We discuss the key elements of the CIT model, implementation and its related challenges, as well as variations of the model. While this model has not undergone enough research to be deemed an Evidence-Based Practice, it has been successfully utilized in many law enforcement agencies worldwide and is considered a "Best Practice" model in law enforcement. This primer for mental health practitioners serves as an introduction to a model that may already be utilized in their community or serve as a springboard for the development CIT programs where they do not currently exist. |
| Tummey | 2001 | Actual model in use | Primary Care England | The National Service Framework for Mental Health was launched in October 1999 and detailed the standards required for an effective and robust service. Within North Solihull, a quick response initiative for urgent referrals to the mental health team has been in operation for the past five years. It is a nurse-led service that appears to meet some of the standards set, including collaboration with primary care and suicide prevention. This article identifies the benefits of a nurse-led service to combat the growing need for urgent assessment. It also discusses the need for specific mental health practitioner involvement at the point of referral. Particular reference is made to clients in crisis and with suicidal ideation. Important liaison at the interface between primary and secondary care is presented, for the benefit of this client group and effective alleviation of referrer anxiety. |

Thematic Analysis

Major themes in the literature were identified in the analysis and are presented below.

Support for Interprofessional Collaboration

In general, the included literature is very supportive of efforts to deliver care in a collaborative manner (Carvalhana & Flak, 2009; Drum & Denmark, 2012; Laing et al., 2012; Maar et al., 2009; Oliva & Compton, 2008; Pinder-Amaker, 2012; Silver & Goldstein, 1992; Simakhodskaya et al., 2009; Skubby et al., 2013; Steadman et al., 2000; Tummey, 2001; Watson & Fulambarker, 2012). Carvalhana and Flak (2009) point out that pharmacists are integral, yet often overlooked, members of multidisciplinary teams and can enhance the levels of care provided to mental health patients. Laing et al. (2012) whose action research study explored collaboration between the mental health and domestic violence sectors in Australia, and Maar et al. (2009), whose participatory action research study explored collaboration across care providers in Aboriginal communities in Canada, pointed out that although the call has gone out to make

collaboration stronger, little evidence exists to guide the different sectors on how to proceed collaboratively. All authors of included studies indicated that taking the time to engage collaboratively across sectors was a worthwhile use of their time (Carvalhana & Flak, 2009; Laing et al., 2012; Maar et al., 2009; Steadman et al., 2000). Many of the studies indicated positive interactions between the diverse parties (Laing et al., 2012; Maar et al., 2009; Skubby et al., 2013; Steadman et al., 2000) and positive client outcomes from the perspective of care providers (Carvalhana & Flak, 2009; Laing et al., 2012; Maar et al., 2009; Steadman et al., 2000) and clients themselves (Maar et al., 2009).

Improved Care Delivery Systems

All authors suggested that given the complexity of mental health crisis, no one profession or sector alone can adequately meet the needs of the clients (Carvalhana & Flak, 2009; Drum & Denmark, 2012; Laing et al., 2012; Maar et al., 2009; Oliva & Compton, 2008; Pinder-Amaker, 2012; Silver & Goldstein, 1992; Simakhodskaya et al., 2009; Skubby et al., 2013; Steadman et al., 2000; Tummey, 2001; Watson & Fulambarker, 2012). Many acknowledged that working collaboratively can produce positive outcomes for clients and professionals, and can therefore improve care delivery (Carvalhana & Flak, 2009; Laing et al., 2012; Maar et al., 2009; Skubby et al., 2013; Steadman et al., 2000). Nonetheless, some authors are more optimistic than others regarding the potential of adopting interprofessional collaboration initiatives. Carvalhana & Flak (2009) for example, concluded that pharmacists working on collaborative teams with prescribing psychiatrists saw increased medication adherence, lower levels of overdose, and fewer hospital admissions. Laing et al. (2012) reported that following the collaborative training, rates of screening for domestic abuse increased, which resulted in an increase in identifying need and providing appropriate support to clients. Other authors are cautiously optimistic with more

tempered views of the benefits of interprofessional collaboration such as Maar et al. (2009) who notes that the complexity of service delivery for mental healthcare in aboriginal communities in Ontario Canada must be acknowledged. Maar and colleagues' study revealed positive client outcomes such as improved illness care and cultural safety, improved management of wait times, as well as positive outcomes such as a reduction in professional isolation. However, they also draw attention to the need for purposefully built in mechanisms to sustain collaboration across team members. Crisis Intervention Team (CIT) models have been studied extensively in the literature (Compton, Bahora, Watson, & Oliva, 2008; Hanafi et al., 2008; Watson & Fulambarker, 2012) and have been found to result in positive client outcomes, but to our knowledge Skubby et al. (2013) were the first to specifically explore collaboration among professionals using a CIT model. Although Skubby et al. (2013) revealed positive outcomes from police services and mental health professionals working collaboratively together, they also noted the importance of considering the sustainability of the model. The general consensus in the literature is that care providers in MHCRS are focused on improving service delivery through IPC, but that attention to the sustainability of IPC in complex environments is also crucial.

Merging Distinct Visions of Care

Included articles in this scoping review encompass studies conducted across diverse sectors. These sectors might fall within the healthcare system (primary, emergency, or community care departments) or across sectors that fall outside of the healthcare system (police services, campus services, domestic violence services). The different sectors espouse different models of care, which guide their specific practices, and can at times be conflicting (Laing et al., 2012; Maar et al., 2009; Skubby et al., 2013). Laing et al. (2012) specifically mentioned how different histories, knowledge bases and organizational cultures can make cross-sector collaboration challenging.

Specifically, the biomedical model that often guides mental healthcare is very different than the social justice philosophy that informs the domestic violence sector (Laing et al., 2012 p. 123). Laing and colleagues further state that they found diagnosis of illness to be at the forefront of the mental health sector which conflicts with the domestic violence sector given that a diagnosis can negatively impact a person involved in a domestic court case. Maar et al. (2009) point out the dichotomy between clinical and traditional healing methods, which are based on very different therapeutic approaches with different values and philosophies. Skubby et al. (2013 p. 4) noted that there was often antagonism and animosity across sectors and that even the language used to discuss the same situation highlighted the different viewpoints related to mental illness. For example ‘wacko’ was used early on in their study by police personnel and the perceived orientation toward individuals with mental health from the ‘other’ sector was often negative. Merging these differing approaches required deliberate effort (Laing et al., 2012; Maar et al., 2009; Skubby et al., 2013), but the authors noted that as their study proceeded, the different sectors began to recognize a shared commitment to merging the divergent interests. Importantly, Maar et al. (2009) noted that extensive consultation occurred when conceptualizing the service and on-going capacity building related to increased understanding of traditional healing. The ability to work through these differences does not immediately present itself, with some authors indicating that it was an on-going iterative process to get to a place where all sectors involved aligned with a shared vision of care (Craven & Bland, 2006; Laing et al., 2012; Maar et al., 2009; Skubby et al., 2013).

Challenges to Interprofessional Collaboration

Although study conclusions regarding IPC in MHCRS are very positive, as described above, authors do note that it is important to acknowledge the challenges that come with embarking on a

collaborative endeavour (Carvalhana & Flak, 2009; Laing et al., 2012; Maar et al., 2009; Skubby et al., 2013; Steadman et al., 2000). Overlooking the challenges can impede progress, as mentioned by Laing et al. (2012) in regard to negotiating and acknowledging power difference among team members. Carvalhana and Flak (2009) note that lack of resources, time constraints, communication difficulties (with clients), lack of sufficient training, and stigma can make collaboration challenging. Maar et al. (2009), Skubby et al. (2013), and Steadman et al. (2000) also noted how a lack of resources can thwart collaborative efforts. Maar and colleagues gave the example of not being able to expand the important role of the case manager due to challenges recruiting qualified candidates and limited financial resources. Skubby et al. (2013) discussed the financial and human resources needed to start a CIT initially; a factor which could impede getting it off the ground. Steadman et al. (2000) discussed how the lack of available human resources of Mobile Crisis units changed the way police officers in their study were able to practice, the long wait times led police officers to avoid calling for the mobile team's assistance. Given that most studies included in this scoping review described minor to substantial challenges, professionals embarking on interprofessional collaborative projects should anticipate challenges and be prepared to work through them as a team.

Discussion

The findings of this review identified prevalent themes in the literature, including: support for interprofessional collaboration, quest for improved care delivery system, merging distinct visions of care, and challenges to interprofessional collaboration. It is clear that scholarship in this area is in the early stages, and that it is a complex and emergent body of literature. The findings of this study point to implications for practice, policy, and future research. Each will be discussed in what follows.

Collaboration Occurs Across Multiple Sectors

As discussed in the background, an interesting finding of this scoping review is that it appears that given the complex setup of crisis response services, care providers are often required to collaborate across different sectors (healthcare system in collaboration with police departments, social services, university campuses, and traditional healers). This finding runs contrary to those in Reeves et al. (2011), where the authors found that most studies were of interdisciplinary teams within one facility. The typical way that IPC has been conceptualized in regard to other practices will not overlay completely with MHCRS. Perhaps, given that police and emergency departments were traditionally the first entry points to accessing help for a mental health crisis; collaborative practice in this domain needs to include sectors outside of the health sector.

Sufficient Resource Allocation Crucial

For effective collaboration to occur and be sustained, dedicated resources are needed. Public funding allocated to general mental health in Canada is low, at only 6% of total health funding (Jacobs et al., 2008) and falls below that of other developed countries, Australia at 6.8%, USA at 7.5%, and the highest being the UK at 12.1% (Institute of Health Economics, 2007). This translates to stretching scarce dollars to meet the needs of individuals experiencing mental health concerns. Skubby et al. (2013) note that the two services (mental health and police) were required to share their limited monetary resources allocated to mental health crisis, limiting the sustainability of their IPC attempt. Maar et al. (2009) and Laing et al. (2012) both credit the addition of a case manager/coordinator role with greatly enhancing collaborative efforts but stress that sustaining these positions directly relies on sufficient resources allocated to IPC. Without dedicated resources to sustain collaboration, many of the efforts fall to the wayside, despite being

highly valued by frontline staff and clients (Carvalhana & Flak, 2009; Laing et al., 2012; Maar et al., 2009; Skubby et al., 2013; Steadman et al., 2000).

From the existing literature in the area we can see that IPC in MHCRS may need to view IPC as occurring in a broader sense by including sectors outside of healthcare. Similar to previous reviews, the findings of the current review indicate that IPC may produce favorable client outcomes but more research is needed to explore the challenges and beneficial aspects from the client perspective and devoted resources are key to the sustainability of IPC endeavours. Furthermore, this scoping review identified numerous implications to research that require attention when implementing future IPC initiatives in MHCRS. Lack of conceptual clarity, absent client perspectives, and unequal representation across sectors must be attended to in future research. The implication of each will be discussed below.

Future Research Implications

Conceptual Clarity Needed

As it currently stands, the body of literature in MHCRS appears fragmented and inconsistent in its conceptualization of IPC, similar to the findings of Reeves et al. (2011) from a scoping review of interprofessional collaborative practice, where the authors found that there was a lack of conceptual clarity in the IPC literature. Both Laing et al. (2012) and Maar et al. (2009) discussed their philosophical underpinning related to their specific sectors (domestic violence and Aboriginal mental health respectively), however none of the articles included in this scoping review clearly discussed how they conceptualized their work from an IPC perspective.

Researchers initiating future projects should take time to understand what collaboration means to them and how their understandings relate to the knowledge claims that result from their study

(Davidson et al., 2010). Similar to findings by Reeves et al. (2011), conceptual clarity remains an issue in IPC literature relating to mental health crisis response.

Absent Client Perspectives

Despite all five of the included studies reporting favorable client outcomes from the perspective of the care providers (Carvalhana & Flak, 2009; Laing et al., 2012; Maar et al., 2009; Skubby et al., 2013; Steadman et al., 2000) only one of the included studies presented the clients' experiences (Maar et al., 2009) with IPC. For the most part, this important perspective was absent. Including the perspectives of recipients of service is crucial because it provides essential information for evaluating whether services are adequately meeting needs, and for informing corrections to designs of such services. As Davidson et al. (2010) assert, clients need to be included in research and collaboration undertakings to ensure relevance, to and influence from, individuals who the service is created for.

Unequal Representation Across Sectors

At times the perspective of one sector involved in a study was stronger than others, with the onus for change being placed on the less represented sector. For example, in Laing et al. (2012 p. 124) the perspective of the domestic violence sector appeared dominant throughout the article and expectations for mental health sector changes were explicitly stated, such as “the working group decided that an important aspect of achieving institutional change was improving mental health staff implementation of the domestic violence screening tool.” There appeared to be a marked divide between who the knowers were and who the benefactors or recipients of that knowledge were in their study. In the same article the authors discuss the importance of negotiating power differences in achieving trusting and respectful collaborative partnerships.

When embarking on a collaborative practice endeavor, attention should be paid to ensuring equal representation across sectors.

A Young and Emergent Body of Literature

IPC is often described as a necessary component of service delivery in healthcare, yet consistent with the current scoping review, both of the IPC reviews previously conducted, identified a very small pool of eligible literature (Craven & Bland, 2006; Zwarenstein et al., 2009). Craven and Bland (2006 p. 17S) noted a shift in existing research in collaborative mental health care, where in recent years research has moved from “purely descriptive accounts of collaborative models and enthusiastic reports of early program evaluation findings to more rigorous experimental studies.” The current scoping review focused on Interprofessional Collaborative Practice in mental health crisis response systems and it appears that the literature in crisis response is consistent with the general mental health related works reviewed by Craven and Bland (2006). All exploratory studies identified in this review were published after the year 2000 suggesting the evidence base is relatively young, but growing. Seven of the included studies were descriptions of models, some currently in use, while others were depictions of what an ideal model might look like.

The pool of literature exploring mental health crisis is relatively small when compared to the pool of literature for other mental health concerns such as chronic mental health, for example. Two studies included in this review contained crisis components but were not solely exploring crisis. More research in the area of crisis specifically is needed as this domain has been narrowly explored to date.

Limitations

This study is not without limitations. The scope of the study was narrowed to focus on interprofessional collaborative *practice* however future studies will want to scope the literature on IPE and IPO studies to develop a more robust picture of the potential for interprofessional collaboration in the area of mental health crisis response. Studies that were published in languages other than English were not included however could provide insight into IPC that was not obtained in the current review. Furthermore, given the paucity of studies specifically exploring crisis with reported outcomes, meta-analyses of findings are not yet possible. Finally, we did not incorporate stakeholder consultations into the published scoping review as this is suggested as an optional step (Levac, Colquhoun, & O'Brien, 2010). However as a knowledge translation element we did present the findings to leaders in the area of Mental health Crisis Response in Winnipeg, following publication. The individuals stated that the findings were meaningful to their specific context, and additionally that the review puts into words what they had often observed in their work.

Conclusion

Overall, literature in the area of collaborative practice in mental health crisis response environments is relatively young. More attention is needed to define key concepts, and to develop coherent theoretical underpinnings of interprofessional collaboration. Furthermore, studies should continue to move from simply describing models of care to actual exploratory and experimental studies that include reported outcomes. Future research in this area should adopt participatory designs, or at a minimum, include client perspectives. Furthermore cost-benefit, efficacy and effectiveness studies could contribute to our understanding of the benefits of IPC. Unique

elements of crisis response as they related to IPC were identified through this scoping review and may prove useful to sectors intending to develop IPC approaches to MHCRS.

This concludes the chapter that explored mental health crisis response systems specifically. In the next chapter I will discuss a second systematic review that was conducted, focusing on cross sector service provision in health and social care more generally. The review was an Umbrella review, which is sometimes referred to as an overview of reviews because it systematically explores and synthesizes data from existing systematic reviews.

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Chapter Three; Paper Two: Cross-Sector Service Provision in Health and Social Care: An Umbrella Review⁷

This chapter introduces the reader to the concepts of cross sector service provision. I provide an overview and discussion related to what the literature says about service provision offered by one or more sectors. The findings from this Umbrella review informed the conceptualization of the current study and will be carried forward to subsequent chapters.

Abstract

Intro: Meeting the complex health needs of people often requires interaction among numerous different sectors. No one service can adequately respond to the diverse care needs of service users. Having providers work more effectively together is frequently touted as the solution. Cross-sector service provision (CSSP) is defined as: independent, yet interconnected sectors working together to better meet the needs of service users and improve the quality and effectiveness of service provision. CSSP is expected, yet much remains unknown about how CSSP is conceptualized, or its impact on health status. This umbrella review aims to clarify the critical attributes that shape CSSP by presenting the current state of the literature and building on the findings of the 2004 review by Sloper (2004). Methods: Literature related to CSSP is immense which poses a challenge for decision makers wishing to make evidence informed decisions. An Umbrella Review (Aromataris et al., 2015; The Joanna Briggs Institute, 2014) was conducted to articulate the overall state of CSSP literature and examine the evidence to allow for the discovery of consistencies and discrepancies across the published knowledge base. Findings:

⁷ A version of this chapter has been published: Winters, S., Magalhaes, L., Kinsella, E., & Kothari, A. (2016). Cross-sector Service Provision in Health and Social Care: An Umbrella Review. *International Journal of Integrated Care*, 16(1), 1–19. <http://doi.org/10.5334/ijic.2460>

16 reviews met the inclusion criteria. Four themes emerged: focusing on the service user, developing a shared vision of care, enhancing and supporting service provision across sectors and navigating power differentials. Future research from a cross-organizational, rather than individual provider, perspective is needed to better understand what shapes CSSP at the boundaries.

Conclusion: Findings aligned closely with the work done by Sloper (2004) and raises red flags related to reinventing what is already known. Future researchers should look to explore novel areas rather than looking into areas that have been explored at length. Evaluations of outcomes related to CSSP are still needed before any claims about effectiveness can be made.

Introduction

Meeting the complex health needs of people often requires interaction among numerous different sectors (Glasby & Dickinson, 2008; Kodner & Spreeuwenberg, 2002). The need for various sectors to work together to offer continuous, coordinated and effective care has been depicted as critical (Ansari, Phillips, & Hammick, 2001; Glasby & Dickinson, 2008; Kodner & Spreeuwenberg, 2002). If sectors are unable, unwilling or precluded from working together, the service user may not receive the care they require, potentially resulting in dire consequences (Glasby & Dickinson, 2008; Kodner & Spreeuwenberg, 2002). It has been repeatedly said in the literature that no one service can adequately respond to the diverse needs of the health care service user (Glasby & Dickinson, 2008; Winters, Magalhaes, & Kinsella, 2015). Enhancing the ability for providers to work together is frequently touted as the solution to this problem (Kernaghan, 1993). As Kodner (2002) states, performance suffers if integration is absent at various levels; furthermore, services are delayed and quality and patient satisfaction decline (Glasby & Dickinson, 2008; Kodner & Spreeuwenberg, 2002). As Glasby and Dickinson (2008) emphasize, a lack of partnership and co-ordination can literally be a matter of life and death, with

fatal outcomes resulting from sectors not working together to meet the complex needs of service users.

When sectors within the health and social care industries work together to provide a service it is said to enhance the quality of service provision by providing more consistent, coordinated, appropriate care in a more timely (timelier??) fashion (Kodner & Spreeuwenberg, 2002). Additionally, as (Kernaghan, 1993) notes, cross sector service provision (CSSP) has evolved from impromptu responses to more concerted and planned approaches to increasing efficiency, effectiveness and responsiveness of organizations. Moreover, Kodner (2002) indicated that CSSP can facilitate less duplication and waste, more flexible service provision, and better coordination and continuity.

The call for CSSP, as found in many high-level international, national, and local policies (Glasby & Dickinson, 2008; Kernaghan, 1993) mandates that sectors will work together to provide better care. Numerous assumptions exist within these policies, the most striking being that CSSP does in fact improve the care that gets delivered (Babiak & Thibault, 2009; Glasby & Dickinson, 2008). CSSP is now seen as the expectation rather than the exception (Glasby & Dickinson, 2008) and is becoming increasingly more common (Kernaghan, 1993). However, based on the previous literature in the area, much remains unknown about how cross sector service provision is conceptualized, let alone it's presumed positive impact (Babiak & Thibault, 2009; Scott & Hofmeyer, 2007). The push to deliver more strongly coordinated services across sectors claims to be based on evidence, however these claims may be hollow given that what the existing evidence states is that very little is known about the impact of CSSP (Ansari et al., 2001; Babiak & Thibault, 2009; Varda, Shoup, & Miller, 2012; Zwarenstein, Goldman, & Reeves, 2009). In fact Babiak and Thibault (2009) found that there were an increasing number of studies

pointing to challenges, rather than benefits related to cross-sector partnerships and that more work was needed to determine how these challenges could be overcome. Pronouncements to minimize the boundaries between sectors within the health and social care industries have advanced more rapidly than the available evidence supports. Considering the issues mentioned above, more research is warranted to establish the benefits of CSSP prior to introducing major changes. The current umbrella review aims to clarify the essential attributes that shape CSSP by critically examining the current state of the literature and building on the findings of the 2004 review of ‘coordinated multi-agency working’ conducted by Sloper (2004).

In this paper the authors generated the term Cross Sector Service Provision (CSSP) to refer to independent, yet interconnected sectors⁸ working together to better meet the needs of service users and improve the quality and effectiveness of service provision. We will consistently use CSSP with the understanding that numerous substantial and independent bodies of research inform the concept. Our focus is on what many refer to as integration, collaboration, partnership, and coordination across the health and social care industries, or what are sometimes referred to as the human services. We are interested in uncovering what shapes cross sector interactions between the health and social care industries, specifically related to the provision of services. In addition, we will use the overarching umbrella term service user⁹ to refer to the recipient of the

⁸ We use the term ‘sector’ to refer to divisions of the health and social care industries that are distinct from one another with regard to structure.

⁹ Consumer was used in the published version of this article however, we use service user in the remaining sections of the dissertation so for consistency we will use service user in this chapter.

cross sector service provision with the understanding that numerous terms are used by different sectors, such as patient, client, suspect, student, etc.

The aim of this review is to provide a comprehensive overview of the existing body of evidence related to cross sector service provision (CSSP). The overarching research question guiding this umbrella review was: What shapes CSSP among independent yet interconnected sectors in health and social care? The intent is to uncover what is known about the following:

How is CSSP conceptualized in the existing literature?

What impacts related to CSSP and service delivery have been reported?

What barriers and facilitators to CSSP have been identified?

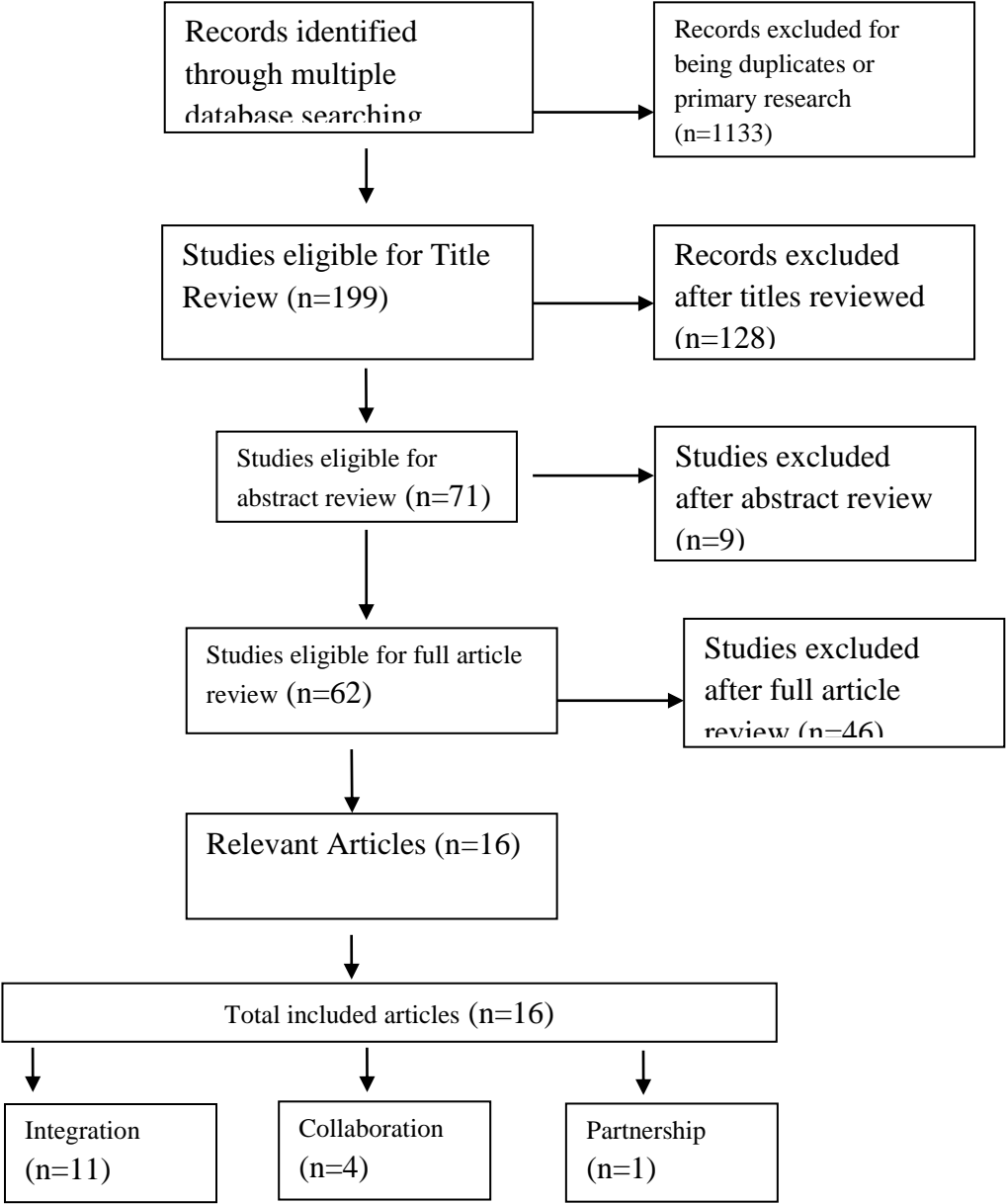
What remains to be known about CSSP?

Methodology

Initially the current authors intended to conduct a systematic review of the literature related to cross sector service provision. At the outset, the search criteria were broad, intended to capture all existing literature in the area. However, in gauging the scope of the literature, it became clear that the pool of evidence was massive and growing rapidly (see figure 3). Given the extent of the existing literature, it was decided that an overview of reviews would be a more efficient and useful approach. Consequently, the inclusion criteria were narrowed to include only previously conducted systematic reviews. When a plethora of existing literature exists, those who make decisions in health and social care (clinicians, leadership, informed service users, and policy makers) may be overwhelmed trying to determine what evidence to consider when making their decisions (Higgins & Green, 2011; The Joanna Briggs Institute, 2014). Overarching reviews are becoming a welcomed alternative to traditional reviews as they provide a means of showcasing a wide picture, articulating an overall state of a particular content area (Aromataris et

al., 2015; Grant & Booth, 2009; Higgins & Green, 2011; The Joanna Briggs Institute, 2014) or a “Friendly Front End” to massive pools of evidence (Higgins & Green, 2011, p. 608). They also enable a more comprehensive overview of the gaps and inconsistencies that exist and provide direction for future research and practice (Higgins & Green, 2011). The current review aligns with the parameters outlined by the Joanna Briggs Institute (Aromataris et al., 2015; The Joanna Briggs Institute, 2014) for conducting *Umbrella Reviews*, more so than the parameters outlined by the Cochrane Collaboration for an *Overview of Reviews* in that we aim to incorporate all types of syntheses (systematic reviews, meta-analyses, narrative reviews, critical reviews, scoping reviews) as opposed to only including previously conducted Cochrane reviews.

Figure 3 Chapter 3 Study selection and exclusion flow diagram.



Search Methods and Scope

Scopus, PubMed, PsychInfo databases were searched; see Table 4 for a list of search terms. The following inclusion criteria were adopted to frame the scope of this review of reviews: Review methodology must be explicitly stated, focus on cross sector service provision or delivery among the health and/or social industries, and be published from 2004 onward. The date range

was restricted to focus on a current view of literature and because a review of reviews by Sloper (2004) had been previously conducted in a similar area (coordination). Given that we were looking to obtain a comprehensive account of reviews exploring CSSP, no restrictions were placed on geographical location, intervention type, or typology of published reviews.

Table 4. Chapter 3 Search Terms.

| |
|--|
| health OR social care, AND partnership, OR collaboration, OR integration, OR joint working, OR coalition, OR alliance, OR interprofessional, AND cross sector, OR bridging, OR multisite, OR inter-sectorial, OR across, AND service provision OR delivery |
|--|

**Original search conducted November 11, 2014 and replicated September 6, 2015. One new article was obtained in September search through PubMed (Green et al., 2014).

Reasons for excluding articles: studies were primary research papers, discussion or position papers, not related to direct service provision/delivery; focused on one site; focused on disciplines rather than sectors, related to one professional group only; fell outside of the health and social care fields; methodology was not explicitly stated; reviews of tools to measure partnership but not actual studies of service provision. Only those studies published in English were included. The search was limited to include only review papers that had been peer-reviewed.

Initial search results were restricted to review papers and duplicates were removed. Titles of each article were reviewed against the eligibility criteria and all potentially relevant articles were sent forward. Article abstracts as well as ostensibly relevant full articles were reviewed against the eligibility criteria by authors SW and LM. SW and LM were in agreement in regard to including all 16 articles but initially diverged on whether to include Sloper (2004) in the reviewed articles. The authors later agreed not to include Sloper (2004) in the reviewed articles but as a comparison paper to see how the literature has changed over the last 10 years.

A quality appraisal was conducted for all articles using the Joanna Briggs Critical Appraisal checklist, with higher scores indicating that more quality measures were met (The Joanna Briggs Institute, 2014), see Table 5. The Joanna Briggs Critical Appraisal checklist does not provide a cutoff rule for determining when to keep or remove studies based on the score they receive, but does indicate that at the outset of the study reviewers must agree on what they deem to be an acceptable score for inclusion (The Joanna Briggs Institute, 2014). Reviewers for the umbrella review decided to retain reviews such as Dowling et al. (2004), Loader and Keeble (2008), and Soto et al. (2004), despite being rated on the low side on the Joanna Briggs Quality Appraisal Checklist because we felt that they provided information that was relevant to the research question (The Joanna Briggs Institute, 2014). Certain data elements were extracted and stored in tabular form (see tables 6, 7, 8, & 9) using the Joanna Briggs data extraction form (The Joanna Briggs Institute, 2014). Included articles were analyzed thematically to depict what the literature says about how cross sector service provision has been conceptualized, what impacts have been reported, what facilitates and precludes CSSP, and future directions for research, policy and practice.

Table 5. Chapter 3 Quality Appraisal Checklist Scores.

| Author | Score | Reject or Retain |
|-----------------|--------------|-------------------------|
| Butler (2011) | 10/11 | Retain |
| Collet (2010) | 10/11 | Retain |
| Davies (2011) | 10/11 | Retain |
| Donald (2005) | 8/11 | Retain |
| Dowling (2004) | 5/11 | Retain |
| Fisher (2012) | 7/11 | Retain |
| Fleury (2006) | 6/11 | Retain |
| Green (2014) | 11/11 | Retain |
| Grenfell (2013) | 8/11 | Retain |
| Hillier (2010) | 8/11 | Retain |
| Howarth (2006) | 9/11 | Retain |
| Hussain (2014) | 10/11 | Retain |
| Lee (2013) | 6/11 | Retain |
| Loader (2008) | 1/11 | Retain |
| Soto (2004) | 5/11 | Retain |
| Winters (2015) | 8/11 | Retain |

Table 6. Chapter 3 Characteristics of Included Studies of Cross-Sector Service Provision.

| Author | Title | Service user Group | Sectors | Intervention | Primary Term | Year Range of included studies | Location of Authors | Included Articles |
|----------------|---|--|--|---|--------------|--------------------------------|---------------------|-------------------|
| Butler (2011) | Does Integrated Care Improve Treatment for Depression? | Individuals with depression | Mental health and primary care | Integrated care planning | Integration | 1995-2006 | USA | 49 |
| Collet (2010) | Efficacy of integrated interventions combining psychiatric care and nursing home care for nursing home residents: A review of the literature | Nursing home clients with mental health concerns | Psychiatric care and nursing homes | Integrated interventions combining both psychiatric care and nursing home care in nursing home residents | Integration | 1996-2003 | Europe | 8 |
| Davies (2011) | A systematic review of integrated working between care homes and health care services | Nursing home patients with primary care needs | Health care services and care homes | Interventions designed to develop, promote or facilitate integrated working between care home or nursing home staff and health care practitioners | Integration | 1998-2008 | UK | 17 |
| Donald (2005) | Integrated versus non-integrated management and care for clients with co-occurring mental health and substance use disorders: A qualitative systematic review of randomized controlled trials | Mental health and substance abuse | Mental health and Substance use disorder | Integrated approaches are compared with non-integrated approaches to treatment of adults with co-occurring mental health and substance use disorder | Integration | 1993-2001 | Australia | 10 |
| Dowling (2004) | Conceptualizing successful partnerships | General health and social care | Not described | Not described | Partnership | 1999-2003 | UK | 36 |

| | | | | | | | | |
|-----------------|---|-------------------------------------|--|--|---------------|-----------|-----------|-----|
| Fisher (2012) | Health and social services integration: A review of concepts and models | Veterans | Veterans health and social care-general | Different approaches to services integration for the needs of veterans | Integration | 1993-2008 | USA | 76 |
| Fleury (2006) | Integrated service networks: The Quebec case | General – not specified | General – not specified | Not mentioned | Integration | 1961-2005 | Canada | 46* |
| Green (2014) | Cross Sector collaboration in Aboriginal and Torres Strait Islander childhood obesity: a systematic integrative review and theory-based synthesis | Indigenous children with disability | Health, education and social services | inter- and intra-sector collaboration in Aboriginal and Torres Strait Islander childhood disability | Collaboration | 2001-2014 | Australia | 18 |
| Grenfell (2013) | Tuberculosis, injecting drug use and integrated HIV-TB care: A review of the literature | HIV, IDU with potential for TB | Health, Substance Abuse, Social services | Governmental or non-governmental health or community-based services providing testing, prevention, treatment or other care for TB or HIV and TB, either directly or by referral. | Integration | 1995-2011 | UK | 87 |
| Hillier (2010) | A systematic review of collaborative models for health and education professionals working in school settings and implications for training | School Aged children | Education and health sectors related to children of school-age | Interdisciplinary or multidisciplinary teams and any conclusions drawn about the knowledge or skills required by the professionals to promote these models. | Collaboration | 1980-2005 | Australia | 34 |
| Howarth (2006) | Education needs for integrated care: A literature review | Primary care | Primary care with social care | Education and training initiatives | Integration | 1995-2002 | UK | 25 |
| Hussain (2014) | Integrated Models of Care for Medical | Medicine inpatients | Health and Mental | Integrated models of care (IMC) where | Integration | 1997-2010 | Canada | 4 |

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|---------------|---|---|---|---|---------------|-----------|-----------|-----|
| | Inpatients With Psychiatric Disorders: A Systematic Review | with psychiatric concerns | health | psychiatrists and general medical physicians, either in isolation or in combination with other allied health staff, were integrated within a single team to provide care to an entire inpatient population. | | | | |
| Lee (2013) | What is needed to deliver collaborative care to address comorbidity more effectively for adults with a severe mental illness? | Mental health - Adults with comorbid concerns | Mental health, employment, forensic, homelessness, housing, physical health and substance abuse | Models that have addressed comorbidities to Severe Mental Illness (SMI), to demonstrate key principles needed to promote collaborative care. | Collaboration | 1995-2012 | Australia | 76* |
| Loader (2008) | Health informatics for older people: A review of ICT facilitated integrated care for older people | Older people with health conditions needing welfare support | Information technology, Computer science and health care (hospitals, clinics, laboratories, surgeries) and social and community agents (housing, voluntary and community groups, social services, carers, community nurses) | Dimensions of care as they were seen to relate to the modernizing of adult social care objectives. | Integration | 1981-2005 | UK | 35* |
| Soto (2004) | Literature on integrated HIV care: | HIV and SUD | Social services, | Integrated HIV care models HIV-infected | Integration | 1990-2003 | USA | 47 |

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|----------------|--|----------------------------|---|---|---------------|-----------|--------|----|
| | A review | | mental health, and substance abuse | clients and their use of ancillary services, and integrated mental health and substance abuse treatment, | | | | |
| Winters (2015) | Interprofessional Collaboration in mental health crisis response systems: a scoping review | Adult Mental health crisis | Mental health, emergency department, police, pharmacy, traditional healers, university campus support | Studies that included an intervention or routine for the specific purpose of improving, measuring or exploring Interprofessional Collaborative Practice | Collaboration | 2000-2012 | Canada | 18 |

Table 7. Chapter 3 Purpose and Main Findings of Included Review Papers.

| Author | Title | Purpose | Main Findings |
|----------------|---|--|--|
| Butler (2011) | Does Integrated Care Improve Treatment for Depression? | To assess whether the level of integration of provider roles or care process affects clinical outcomes. | Although most trials showed positive effects, the degree of integration was not significantly related to depression outcomes. Integrated care appears to improve depression management in primary care patients, but questions remain about its specific form and implementation. |
| Collet (2010) | Efficacy of integrated interventions combining psychiatric care and nursing home care for nursing home residents: A review of the literature | Not stated | N=8 (4RCT). 7 studies showed beneficial effects of a comprehensive, integrated multidisciplinary approach combining medical, psychiatric and nursing interventions on severe behavioural problems in nursing home patients. Important elements include a thorough assessment of psychiatric, medical and environmental causes as well as programs for teaching behavioural management skills to nurses. DCD nursing home patients were found to benefit from short-term mental hospital admission. |
| Davies (2011) | A systematic review of integrated working between care homes and health care services | To evaluate the different integrated approaches to health care services supporting older people in care homes, and identify barriers and Facilitators to integrated working. | Most quantitative studies reported limited effects of the intervention; there was insufficient information to evaluate cost. Facilitators to integrated working included care home managers' support and protected time for staff training. Studies with the potential for integrated working were longer in duration. Limited evidence about what the outcomes of different approaches to integrated care between health service and care homes might be. The majority of studies only achieved integrated working at the patient level of care and the focus on health service defined problems and outcome measures did not incorporate the priorities of residents or acknowledge the skills of care home staff. |
| Donald (2005) | Integrated versus non-integrated management and care for clients with co-occurring mental health and substance use disorders: A qualitative systematic review of randomized controlled trials | To examine integrated treatment approaches versus nonintegrated treatment approaches for people with co-occurring Mental Health/Substance Use Disorders in order to investigate whether integrated treatment approaches produce significantly better outcomes on measures of psychiatric symptomatology and/or reduction in substance use. | The findings are equivocal with regard to the superior efficacy of integrated approaches to treatment. Clearly, this is an extremely challenging client group to engage and maintain in intervention research, and the complexity and variability of the problems render control particularly difficult. The lack of available evidence to support the superiority of integration is discussed in relation to these challenges. |
| Dowling (2004) | Conceptualizing successful partnerships | To review literature published in the UK since 1997 to examine the success of partnerships in the health and social care fields. To discuss the definitional and methodological problems of evaluating success in the context of partnerships before proposing approaches to conceptualizing successful partnerships. | Research into partnerships has centered heavily on process issues, while much less emphasis has been given to outcome success. If social welfare policy is to be more concerned with improving service delivery and user outcomes than with the internal mechanics of administrative structures and decision-making, this is a knowledge gap that urgently needs to be filled. |
| Fisher (2012) | Health and social services integration: A review of concepts and models | The immediate goal of this review of literature is to (a) trace the various definitions and uses of the concept; (b) explain the rationales for services integration; (c) describe how the | Veterans' services integration models along with interorganizational relationship (e.g., network) models are common in the literature. Models range from centralized government agency initiatives to less formalized community-based networks of care. |

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| | | concept has been utilized theoretically and in practice and provide examples of services integration models; (d) discuss factors that have been found to facilitate or challenge services integration as learned from these applications; and (e) inform future development or improvement of policy and related programs coordinating services and providing outreach to populations in need. | Findings from this review of literature may be particularly important to organizations that work with Veterans, homeless, chronically ill, and aging populations, whose needs often span a number of service areas and who often face multiple delivery systems that heretofore may not have effectively coordinated their services with others. |
| Fleury (2006) | Integrated service networks: The Quebec case | On the basis of a review of publications on services integration and inter-organizational relations and on the Quebec context of healthcare reform, this article aims at generating a greater understanding of the concept of integration and certain underlying issues such as the effectiveness of models. | Integrated service networks -form of system structuring- is one of the main solutions for enhancing efficiency, especially for clientele with complex or chronic health problems. Nevertheless, integrated service networks have lately been highly criticized for their inability to promote better system efficiency, which might be explained by a lack of knowledge in defining models and implementation difficulties. Parameters for organizing integrated service networks, either virtual or vertical, have been strongly articulated in response to the lack of knowledge on that notion. The importance of integration strategies and of the density of inter-organizational exchange in the network as well as the critical role of governance have been particularly outlined. Finally, information is still lacking on the following topics: effective models and strategies for developing integrated service networks; levels of density and centrality required in a network to achieve better results; clientele's needs assessment in terms of services and levels of continuity and their influence on network modeling; impact of integrated service network models on system effectiveness, and clientele health and wellbeing. Impact assessment on integrated services network is central, but the level of reform implementation needs to be evaluated before measuring that impact (the black box effect.) The literature on network implementation and change stresses the importance of investing time and energy in developing tangible strategies to support a reform. |
| Green (2014) | Cross Sector collaboration in Aboriginal and Torres Strait Islander childhood obesity: a systematic integrative review and theory-based synthesis | To identify important components involved in inter- and intra-sector collaboration in Aboriginal and Torres Strait Islander childhood disability | Structure of government departments and agencies The siloed structure of health, education and social service departments and agencies was found to impede service integration and the ability of providers to work collaboratively. Policies Collaboration at the level of policy making can address the barriers generated by existing structures of government departments and agencies. Formalized agreements like memoranda of understanding (MoU) and collaborative frameworks between government sectors can facilitate collaboration at the level of service provision. Communication – Awareness Lack of awareness can lead to duplication of resources. Raising awareness of collaborative partnerships through the distribution of educational resources across agencies and services facilitates collaboration. Lack of role clarity and responsibility Ambiguity and lack of role clarity and responsibilities of different providers, |

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|-----------------|---|--|---|
| | | | <p>agencies and organizations is a key barrier to collaboration. Financial and human resources providing service when resources are limited is a barrier and often are done so “on sheer good will” with staff often working beyond their normal hours. Service delivery setting The effectiveness of a collaborative program is influenced by the setting in which it is delivered. Relationships A key Facilitator to collaboration at this level is the coordinator or linking role. The appointment of a person external to the services or agencies involved whose role is to link the different players and act as a trainer, motivator and sustainer can be important to a collaborative interdisciplinary approach. Inter- and intra-professional learning The modeling of inter- and intra-professional collaboration by clinical educators from different disciplines for university students on placement has been reported to facilitate a well-coordinated and holistic approach to learning</p> |
| Grenfell (2013) | Tuberculosis, injecting drug use and integrated HIV-TB care: A review of the literature | This paper builds on a recent review of TB among people who use drugs (Deiss et al., 2009) but focuses specifically on Persons Who Inject Drugs (PWID), a socially marginalized group with complex treatment needs. Specifically, to (1) describe the prevalence, incidence and risk factors for TB, MDR-TB, and HIVTB and HCV-HIV-TB co-infections among PWID and (2) identify models of TB and HIV-TB care for PWID. | Latent TB infection prevalence was high and active disease more common among HIV-positive PWID. Data on multidrug-resistant TB and co-infections among PWID were scarce. Models of TB care fell into six categories: screening and prevention within HIV-risk studies; prevention at TB clinics; screening and prevention within needle-and-syringe-exchange (NSP) and drug treatment programs; pharmacy based TB treatment; TB service-led care with harm reduction/drug treatment programs; and TB treatment within drug treatment programs. Co-location with NSP and opioid substitution therapy (OST), combined with incentives, consistently improved screening and prevention uptake. Small-scale combined TB treatment and OST achieved good adherence in diverse settings. Successful interventions involved collaboration across services; a client-centered approach; and provision of social care. Grey literature highlighted key components: co-located services, provision of drug treatment, multidisciplinary staff training; and remaining barriers: staffing inefficiencies, inadequate funding, police interference, and limited OST availability. Integration with drug treatment improves PWID engagement in TB services but there is a need to document approaches to HIV-TB care, improve surveillance of TB and co-infections among PWID, and advocate for improved OST availability. |
| Hillier (2010) | A systematic review of collaborative models for health and education professionals working in school settings and implications for training | Search of the literature to reveal the rudimentary state of the art in conceptualizing, measuring and demonstrating the success of partnerships. | Models of interaction and teamwork are well-described, but not necessarily well evaluated, in the intersection between schools and health agencies. They include a spectrum from consultative to collaborative and interactive teaming. It is suggested that professionals may not be adequately skilled in, or knowledgeable about, teamwork processes or the unique roles each group can play in collaborations around the health needs of school children. |
| Howarth (2006) | Education needs for integrated care: A literature review | To identify and critically appraise the evidence base in relation to education needed to support future workforce development within primary care and to promote the effective delivery of | Six themes were identified which indicate essential elements needed for integrated care. The need for effective communication between professional groups within teams and an emphasis on role awareness are central to the success of integrated |

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| | | integrated health and social care services. | services. In addition, education about the importance of partnership working and the need for professionals to develop skills in relation to practice development and leadership through professional and personal development is needed to support integrated working. Education which embeds essential attributes to integrated working is needed to advance nursing practice for interprofessional working |
| Hussain (2014) | Integrated Models of Care for Medical Inpatients With Psychiatric Disorders: A Systematic Review | To review the different models of Integrated Models of Care (IMC) for Medical Inpatients with Psychiatric Disorders (MIPD) and to examine the effects of IMCs on mental health, medical, and health service outcomes when compared with standard models of care. | In 2 studies, IMCs improved psychiatric symptoms compared with those admitted to a general medical service. Two studies demonstrated reductions in length of stay with IMCs compared with usual care. One study reported an improvement in functional outcomes and a decreased likelihood of long-term care admission associated with IMCs when compared with usual care. There is preliminary evidence that IMCs may improve a number of outcomes for medical inpatients with psychiatric disorders. |
| Lee (2013) | What is needed to deliver collaborative care to address comorbidity more effectively for adults with a severe mental illness? | To identify Australian collaborative care models for adults with a Severe Mental Illness (SMI), with a particular emphasis on models that have addressed comorbidities to SMI, to demonstrate key principles needed to promote collaborative care. | A number of nationally implemented and local examples of collaborative care models were identified that have successfully delivered enhanced integration of care between clinical and non-clinical services. Several key principles for effective collaboration were also identified. Governmental and organizational promotion of and incentives for cross-sector collaboration is needed along with education for staff about comorbidity and the capacity of cross-sector agencies to work in collaboration to support shared clients. Enhanced communication has been achieved through mechanisms such as the co-location of staff from different agencies to enhance sharing of expertise and interagency continuity of care, shared treatment plans and client records, and shared case review meetings. Promoting a 'housing first approach' with cross-sector services collaborating to stabilize housing as the basis for sustained clinical engagement has also been successful. |
| Loader (2008) | Health informatics for older people: A review of ICT facilitated integrated care for older people | To find examples of good practice and any evidence to support the high expectations and confidence in Information and Communications Technology (ICT) to effectively address the challenges of health and social care of older people. | The aspiration of ICTs to reconcile competing models of care also foregrounds the importance of recognizing that ICTs are designed and diffused within a particular social context that can either stimulate its adoption or make it redundant. The fastest broadband network connection will be of little use if health and social care professionals are not prepared to share information with each other, let alone allow access to older people wishing to participate in decisions about their care. Similarly, the most accessible website will be seldom used by older people if its information content is not perceived as relevant to the life experiences of the user. Thus, while ICTs may be regarded as important tools for enabling the 'modernization' objectives to be achieved, their effectiveness is crucially shaped by the outcome of debates about those objectives themselves. ICTs cannot be viewed as a means to reconcile such policy contradictions. Such confused rhetoric is only likely to produce expensive and ineffective health informatics outcomes. The contradictions will merely be encoded into the |

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| | | | system. Despite the repeated policy claims for health informatics to facilitate integrated person-centered health and social care, there is little evidence in the literature review considered here that it has been realized. |
| Soto (2004) | Literature on integrated HIV care: A review | To present the findings related to integrated HIV care models, the needs of HIV-infected clients and their use of ancillary services, and integrated mental health and substance abuse treatment, as well as descriptions of innovative integrated HIV care programs. With the goal of providing useful information to HIV service providers, program managers, and policy makers, these findings are discussed, and directions for future research are offered. | The few evaluations of integrated models tended to focus on measurements of engagement and retention in medical care, and their findings indicated an association between integrated HIV care and increased service utilization. The majority of reviewed articles described integrated models operating in the field and various aspects of implementation and sustainability. Overall, they supported use of a wide range of primary and ancillary services delivered by a multidisciplinary team that employs a 'biopsychosocial' approach. Despite the lack of scientific knowledge regarding the effects of integrated HIV care, those wanting to optimize treatment for patients with multiple interacting disorders can gain useful and practical knowledge from this literature. |
| Winters (2015) | Interprofessional Collaboration in mental health crisis response systems: a scoping review | To rapidly map key contributions to knowledge, especially in areas that are complex or have not yet been reviewed comprehensively. To summarize and disseminate research findings, and to identify gaps in the existing literature related to Interprofessional collaboration in Mental Health Crisis Response Systems. | Support for interprofessional collaboration, quest for improved care delivery system, merging distinct visions of care, and challenges to interprofessional collaboration. Lack of conceptual clarity, absent client perspectives, unequal representation across sectors, and a young and emergent body of literature were found. Key concepts need better conceptualization, and further empirical research is needed. |

Table 8. Chapter 3 Frequency of terms used interchangeably by authors of included studies.

| | Butler | Collet | Davies | Donald | Dowling | Fisher | Fleury | Green | Grenfell | Hillier | Howarth | Lee | Loader | Hussain | Soto | Winters | # terms used |
|--|----------|----------|----------|----------|----------|-----------|-----------|----------|----------|-----------|-----------|-----------|----------|----------|----------|----------|--------------|
| Alliance | | | | | | ■ | ■ | | | | | | | | | | 2 |
| Client centered | | | | | | | | | ■ | ■ | | | | | ■ | | 3 |
| Collaborating/ion | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ * | ■ | ■ * | ■ | ■ * | | ■ | ■ | ■ * | 15 |
| Consolidating/ion | | | | ■ | | ■ | ■ | | | | | | | | | | 3 |
| Coordinating/ion | ■ | | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | | ■ | 11 |
| Integrating/ion | ■ * | ■ * | ■ * | ■ * | ■ | ■ * | ■ * | ■ | ■ * | ■ | ■ * | ■ | ■ * | ■ * | ■ * | ■ * | 16 |
| Interdisciplinary | | | | | | ■ | ■ | ■ | | ■ | ■ | | | | | ■ | 6 |
| Inter-organizational | | | | | | ■ | ■ | ■ | | | | | | | | | 3 |
| inter-agency | | | | | ■ | ■ | ■ | ■ | | | | ■ | | | | | 4 |
| Inter-sectorial | | | | | | ■ | ■ | | | | | | | | | | 2 |
| Interprofessional | | | | | | | | ■ | | ■ | ■ | | | | | ■ | 4 |
| Joint- ventures/ working /initiative /care | | | ■ | | ■ | ■ | | | | ■ | ■ | ■ | ■ | ■ | | | 8 |
| Multi-agency | | | | | | | | | | ■ | | | ■ | | | | 2 |
| Multidisciplinary | | ■ | ■ | | | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | 12 |
| multi- Organizational | | | | | | ■ | ■ | | | | | | | | | | 2 |
| Multi-professional | | | | ■ | | | ■ | | | | ■ | | | | | | 3 |
| Partnership | | | ■ | | ■ * | ■ | ■ | ■ | ■ | | ■ | ■ | ■ | | | ■ | 10 |
| Spoke/ Case Management /coordination | ■ | ■ | | ■ | | ■ | ■ | | ■ | ■ | | ■ | | ■ | ■ | ■ | 11 |
| Team | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | ■ | ■ | ■ | | | ■ | ■ | 12 |
| Teamwork | | | ■ | | | | | | | ■ | ■ | ■ | | ■ | | | 5 |
| Transdisciplinary | | | | | | | | | | ■ | | | | | | | 1 |
| Transorganizational | | | | | | ■ | | | | | | | | | | | 1 |
| Vertical integration | | | | | | | ■ | | | | | | | | ■ | | 2 |
| Virtual Integration | | | | | ■ | | ■ | | | | | | | | | | 2 |
| Terms used Per Article | 5 | 5 | 7 | 7 | 7 | 15 | 16 | 9 | 7 | 13 | 11 | 10 | 6 | 6 | 7 | 9 | 140 |

*Indicates the primary term adopted by the authors

Table 9. Chapter 3 Definitions of Primary Concept used by authors of Included Studies.

| Author | Primary Term | Definition provided |
|-----------------|---------------|---|
| Butler (2011) | Integration | At the simplest level, integrated mental and physical health care occurs when mental health specialty and general medical care clinicians work together to address both the physical and mental health needs of their patients. Models of integrated care, sometimes called collaborative care, vary widely, but most include more than merely enhanced coordination of or communication between the clinicians responsible for the mental and physical health needs of their patients. Indeed, attempts to integrate provider roles emphasize parity and mutual respect for the 2 health components. At the same time, they include efforts to improve the process of care using evidence-based standards of care. |
| Collet (2010) | Integration | Not defined |
| Davies (2011) | Integration | Integration of service provision can be defined as ‘a single system of needs assessment, commissioning and/or service provision that aims to promote alignment and collaboration between the cure and care sectors (Rosen & Ham, 2008). There are different levels of integration between health care services (Kodner & Spreeuwenberg, 2002). In the context of integrated working with care homes, these can be summarized as: Patient/Micro level Close collaboration between different health care professionals and care home staff e.g. for the benefit of individual patients. Organizational/Meso level Organizational or clinical structures and processes designed to enable teams and/or organizations to work collaboratively towards common goals (e.g. integrated health and social care teams). Strategic/Macro level Integration of structures and processes that link organizations and support shared strategic planning and development for example, when health care services jointly fund initiatives in care homes (Bond, Gregson, & Atkinson, 1989 and The British Geriatrics Society, 1999). |
| Donald (2005) | Integration | There is considerable diversity concerning the definition of integration, and the extent of integration varies enormously across different studies and settings. For example, it is used to refer to treatment provided both by multi-professional teams and by individual providers. In general, integrated approaches refer to those where both the mental health disorder and the addictive disorder are treated simultaneously. Typically this is regarded as requiring the treatment to take place within the same service by the same clinician. The nature of the integrated treatment should also be considered. If integration merely involves augmentation through the addition of either a standard mental health treatment component or a standard drug and alcohol treatment component then it may be argued that this is not truly integrated. Rather it may be that an integrated treatment would directly acknowledge and address the presence of the comorbidity in terms of the tailoring of the treatment to the current status of the person and would treat the co-occurring nature of the disorders, which may involve making adjustment in one treatment to take account of the other. |
| Dowling (2004) | Partnership | For the purposes of the present paper, the authors adopted the Audit Commission’s (1998) definition of partnership as a joint working arrangement where partners are otherwise independent bodies cooperating to achieve a common goal; this may involve the creation of new organizational structures or processes to plan and implement a joint program, as well as sharing relevant information, risks and rewards. This definition is compatible with a wider range of terms than ‘partnership’, including similar terms such as ‘cooperation’ and ‘collaboration’. |
| Fisher (2012) | Integration | Not defined |
| Fleury (2006) | Integration | To paraphrase Leutz (1999) the term integration has put forward a large number of models concerning the organization of services or types of intervention. All refer to ‘anything from the closer coordination of clinical care for individuals to the formation of managed care organizations that either own or contract for a wide range of medical and social support services’. |
| Green (2014) | Collaboration | Not defined |
| Grenfell (2013) | Integration | Not defined |

| | | |
|----------------|---------------|--|
| Hillier (2010) | Collaboration | Not defined |
| Howarth (2006) | Integration | Not defined |
| Hussain (2014) | Integration | Collaborative or integrated mental health care has been defined as care delivered by general medical physicians working with psychiatrists and other allied health professionals to provide complementary services, patient education, and management to improve mental health outcomes (Katon, Von Korff, & Lin, 1995). Integrated models of care (IMCs) are patient-centered, and they not only involve the psychiatrist as a consultant with co-location of psychiatric and medical services, but also involve a shared responsibility for the care of all patients within a service. |
| Lee (2013) | Collaboration | Not defined |
| Loader (2008) | Integration | Not defined |
| Soto (2004) | Integration | For the purpose of this review, we offer the following working definition: Integrated HIV care combines HIV primary care with mental health and substance abuse services into a single coordinated treatment program that simultaneously, rather than in parallel or sequential fashion, addresses the clinical complexities associated with having multiple needs and conditions. |
| Winters (2015) | Collaboration | Craven and Bland (2006) “involving providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support, to ensure that individuals receive the most appropriate service from the most appropriate provider in the most suitable location, as quickly as necessary, and with minimal obstacles” |

(Audit Commission, 1998; Bond & Bond, 1990; Craven & Bland, 2006; Ham, 2013; Katon et al., 1995; Kodner & Spreuwenberg, 2002; Leutz, 1999)

Findings

The included reviews were heterogeneous and a meta-analysis of quantitative findings was not possible, therefore the available findings are presented in narrative form. Sixteen articles were reviewed (See Figure 3 for the Study Selection and Exclusion Flow Diagram and Table 6 for the Characteristics of Included Studies).

The included review articles were published between 2004 and 2015, and the time period of the individual primary articles represented in the reviews spans 1961-2012. Authors were from Europe (n= 6), Australia (n= 4), Canada (n=3) and The United States (n= 3). Analysis of where the individual studies were conducted could not be determined because many authors did not report this information. Service user groups included: school aged children with health concerns, adults with co-morbidity concerns (mental health with various other sectors), adults living with a disability, veterans, nursing/care home patients, persons living with HIV, and persons accessing primary care in general. Service type provided in the included reviews spanned acute, primary, and community care. The number of articles included in each review ranged from 4-87.

Authors used various terms to describe cross sector service provision, which will be discussed further in the following section, however the primary terms¹⁰ used by authors in the included reviews are: Integration (n= 11), Collaboration (n=4), and Partnership (n=1). Type of primary research study included in the reviews could not be determined because the authors did not consistently report this information. Of the papers that did describe study type, there was a broad range. Six reviews included findings from randomized control trials (Butler et al., 2011; Collet, De Vugt, Verhey, & Schols, 2010; Davies et al., 2011; Donald, Dower, & Kavanagh, 2005; Grenfell et al., 2013; Hussain & Seitz, 2014) while others reported on a mix of quasi-experimental design studies, qualitative studies, basic descriptions of models (either in use, or hypothetical) and evaluation outcomes. Overall, a number of the authors of the review papers commented on the lack of reported outcomes and evaluations of CSSP arrangements (Dowling et al., 2004; Fisher & Elnitsky, 2012; Hillier, Civetta, & Pridham, 2010; Lee, Crowther, Keating, & Kulkarni, 2013; Loader et al., 2008). Lack of evaluation will be discussed later in this paper. See Table 7 for an overview of the purpose and main findings of the included studies.

The previously conducted review of reviews by Sloper (2004) published in 2004 will be referenced in this article as baseline knowledge to see how the field has evolved over the last 10 years. Sloper (2004) explored what they refer to as coordinated multi agency working (which the author also calls Joint Working and Collaboration). In a sense our review is both offering an overview of the massive body of evidence related to CSSP, but also updating the findings since

¹⁰ The authors of the current paper will use the “primary term” when referring to the terms specified by the authors of the included review papers. They include: Integration, Collaboration, or Partnership and articles will be categorized this way for the remainder of the current article. It is important to note that often the authors adopted a primary term, but also used numerous different terms interchangeably throughout the individual articles.

Sloper's (2004) review was conducted. Throughout this paper we will refer to similarities and differences and indicate gaps that still remain, as well as highlight novel areas to consider in moving the field of research forward.

How is CSSP Conceptualized in the Existing Literature?

In this section, we discuss the emergent terminology that appears to inform the overarching concept of CSSP. Determining how the authors conceptualized CSSP was challenging. Numerous terms are used interchangeably and with great frequency in the included articles (see table 8 for the frequency breakdown). Cross sector service provision appears to be informed by a number of separate bodies of literature. The current findings suggest that three concepts primarily inform the conception of CSSP included in the studies: Integration, Collaboration, and Partnership. Integration is the most commonly used term and is used in each of the 16 included articles. Collaboration is the second most used term, found in all but one of the included articles. Interestingly, multidiscipline/ary is used in 12 of the 16 articles despite none of the authors adopting it as a primary term. Authors in the included studies also frequently use team and teamwork, as well as case management.

Only half (n=8) of the authors of the included papers articulate their interpretation of the primary terms they adopt. Authors who do include a definition use a number of different terms as though they are synonymous with the primary term. The range of different terms used ranges from 5-16 terms, with the average being 9, and midpoint being 7 terms used per article. On average authors use 9 different terms, often synonymously, when referring to CSSP, yet it can be argued that each of those terms are not synonymous with one another. There is also variation in how the authors define the same primary term. (See table 9 for a breakdown of definitions articulated by the authors). Even when the same primary term is used across different papers,

rarely do the authors define the terms in the same way. In addition, elements of the definitions overlap regardless of the primary term. Common elements from the various definitions include: independent sectors working together to improve care, focusing on the service user, and understanding that service user needs are complex (Butler et al., 2011; Davies et al., 2011; Donald et al., 2005; Dowling et al., 2004; Fleury, 2006; Green et al., 2014; Hussain & Seitz, 2014; Soto et al., 2004; Winters et al., 2015).

Integration and collaboration literatures have begun to discuss cross sector service provision as occurring at different levels but differences exist in how these levels are conceptualized. As Davies et al.(2011), Fisher and Elnitsky (2012) and Green et al. (2014) outline, CSSP can occur at three levels. Davies et al. (2011) and Fisher and Elnitsky (2012) label the levels as: Micro/Patient, Meso/Organizational, or Macro/Strategic. With slight variation, Green et al. (2014) uses the following distinctions for levels: Macro/government, Exo/organizational and Meso/provider levels. Although similarly discussed there are variations in how the terms are used in the literature. Other authors that adopt different primary terms (Integration, Collaboration, and Partnership) do not formally make the distinction between the levels, but do speak to elements required for effective CSSP that are similar to the levels outlined above.

Although not all of the included reviews specify a theoretical framework, some authors name theories that might be helpful in working toward bringing greater conceptual clarity to CSSP. Some of the theories mentioned include: federalism theory, governance theory, interorganizational theory, intersectoral theory, institutional change theory, innovation theory, public choice theory, humanistic theory, boundary theory (Fisher & Elnitsky, 2012) and

professional socialization theory (Howarth, Holland, & Grant, 2006). However, how these theories specifically align with the included articles was not specified.

The findings above indicate the need to clearly identify what is meant by CSSP and to pay particular attention to the differences between some of the more commonly used terms such as integration, collaboration, partnership, and coordination. As described above, these terms have different meanings and should not be used synonymously. Kodner and Spreeuwenberg (2002, p. 4) state, “as is often the case with nascent fields, especially those with a strongly multidimensional character, the defining concepts and boundaries lack specificity and clarity. Thus, the definitions that are commonly used tend to be vague and confusing. This makes it difficult to develop the knowledge base essential to refine and move the field ahead.” More consideration of terminology is needed.

What Impacts Related to CSSP and Service Delivery have been Reported?

The authors of the included reviews strongly support the need to collaborate across sectors to provide more comprehensive, faster, and more appropriate care to service users (Butler et al., 2011; Collet et al., 2010; Davies et al., 2011; Donald et al., 2005; Dowling et al., 2004; Fisher & Elnitsky, 2012; Fleury, 2006; Grenfell et al., 2013; Hillier et al., 2010; Howarth et al., 2006; Hussain & Seitz, 2014; Lee et al., 2013; Loader et al., 2008). Despite the strong support for CSSP and many papers reporting positive impacts related to processes, only four papers included reviews report positive outcomes related to CSSP. Seven papers in Collett et al.(2010) indicate the beneficial effect of CSSP combining medical, psychiatric and nursing interventions for severe behavioral problems in nursing home patients needing both psychiatric and nursing care. Hussain, & Seitz (2014) found that integrated models of care (IMC- provided by general medical physicians, psychiatrists, and other allied health professionals) are associated with improvements

in psychiatric care and that length of stay, and re-admission rates of long-term placements may be reduced by IMCs. The authors conclude that there is some preliminary evidence to suggest that IMCs are helpful in improving care for this complex population. Dowling et al. (2004) found CSSP leads to improvements in the accessibility of services to users; more equitable distribution of services; the efficiency, effectiveness or quality of services delivered through partnerships; improved experiences of staff and informal care givers; improved health status, quality of life or well-being experienced by people using services; and reductions in otherwise likely deteriorations in their health. The majority of the studies reviewed by Butler et al. (2011) show significant benefit with regard to treatment response and remission, but only 1 model shows consistent benefits in terms of improvements in symptom severity. All other included reviews conclude that before any claims to positive outcomes related to CSSP are possible, further research is needed.

What Barriers and Facilitators to CSSP have been Identified?

Evolving Best Practices - Service User Centred

Almost half of the included studies stress the importance of placing the service user at the center of the CSSP arrangement (Fleury, 2006; Grenfell et al., 2013; Howarth et al., 2006; Lee et al., 2013; Soto et al., 2004; Winters et al., 2015). This variously involves making sure that: service users are centrally involved in care provision and that their voice is present during decision making (Grenfell et al., 2013; Lee et al., 2013); establishing trust and ensuring that the service user's goals are met (Lee et al., 2013); establishing mechanisms for communication across sectors in the event that the service user's needs rapidly change (Lee et al., 2013), and to improve continuity of care (Lee et al., 2013). Notably, almost all authors discuss the glaring gap of the missing service user perspective in all levels of service provision: planning, delivery,

policy and research. This will be discussed further in the next section. The consensus is that taking a service user centered approach facilitates CSSP.

Toward a Shared Vision of Care – Perceived Need, Commitment, and Involvement

Striving for a shared vision of care across sectors is mentioned as integral to the success of CSSP by a number of authors (Dowling et al., 2004; Fisher & Elnitsky, 2012; Howarth et al., 2006; Lee et al., 2013; Winters et al., 2015). A number of authors suggest that for CSSP arrangements to be successful there must first be a perceived need for the arrangement (Dowling et al., 2004; Hillier et al., 2010; Howarth et al., 2006; Lee et al., 2013), and commitment from all sectors (Hillier et al., 2010; Howarth et al., 2006; Lee et al., 2013). Authors stress the importance of involving staff early on in the conceptualization phase (Winters et al., 2015) and in an on-going and iterative manner for the duration of the CSSP arrangement (Hillier et al., 2010; Winters et al., 2015). Clarity of goals and purpose are seen as important by a number of authors (Dowling et al., 2004; Fisher & Elnitsky, 2012; Howarth et al., 2006). Furthermore, a number of authors suggest that goals of the CSSP are best developed in a cooperative and coordinated manner (Hillier et al., 2010; Howarth et al., 2006; Lee et al., 2013). Decision making that occurs in a collaborative and shared manner is also reported to facilitate CSSP (Hillier et al., 2010; Lee et al., 2013). Winters et al. (2015) suggest that devoting time to work through differences as they emerge between sectors is important for ensuring that all parties align with a shared vision for the CSSP arrangement. Sloper (2004) highlights similar findings and notes that if the reverse (lack of perceived need and shared vision) is found to be the case, it acts as a barrier to the success of CSSP.

Many authors mention that equality across sectors involved in CSSP plays an important role in providing better care (Davies et al., 2011; Hillier et al., 2010; Howarth et al., 2006; Soto et

al., 2004; Winters et al., 2015). In particular, Soto et al. (2004) highlight that arranging the team members in a non-hierarchical way facilitates a high level of collaboration (Soto et al., 2004). Winters et al, (2015) report that at times, included studies would regard one sector as the knower and one as the learner, which could create tension between two sectors. Similarly, Davies et al. (2011) report that in all of the studies included in their review, health care staff, rather than home care staff, led or conducted the programs. Many home care staff in their studies reported feeling like their knowledge and views were not valued. Equal participation across sectors is therefore viewed to be important for achieving success related to CSSP.

Leadership

Effective leadership is considered to be an integral element of CSSP (Davies et al., 2011; Dowling et al., 2004; Fisher & Elnitsky, 2012; Fleury, 2006; Lee et al., 2013; Soto et al., 2004). Sloper (2004) indicates that appropriate leadership, if present, is a Facilitator to CSSP and if lacking, is a barrier in many of the articles they reviewed. Buy-in, on-going support and consistent involvement by leadership are viewed as mechanisms to challenge ways of thinking that preclude CSSP facilitation (Davies et al., 2011; Fisher & Elnitsky, 2012; Lee et al., 2013; Soto et al., 2004). Moreover, suitable leadership is reported to promote the inclusion of approaches that facilitate CSSP into everyday practice (Lee et al., 2013). Fleury (2006) indicates that collective leadership, meaning the involvement of all levels of governance - structural, tactical and operational, is necessary to support coherent and integrated support for CSSP.

Service Provision Across the Boundaries

Given that sectors involved in CSSP are rarely governed under the same body, or are socialized differently based on the cultures of their workplaces, providing a service across boundaries can be challenging. Communication (or its absence) is frequently identified as a

facilitator or barrier to providing effective CSSP (Green et al., 2014; Hillier et al., 2010; Lee et al., 2013; Soto et al., 2004; Winters et al., 2015). Many sectors have their own language or jargon (Hillier et al., 2010; Winters et al., 2015) and as Hillier et al. (2010) state, attention is needed to ensure that sectors are not disempowering one another with their use of jargon. Hillier et al. stress that open communication among team members should be fostered and encouraged (Hillier et al., 2010). Other scholars recommend the implementation of mechanisms to enhance regular and direct communication across sectors such as developing shared or agreed upon protocols, procedures, service agreements or memoranda of understanding (Fisher & Elnitsky, 2012; Green et al., 2014; Lee et al., 2013; Soto et al., 2004). Lee et al. (2013), Soto et al. (2004) and Green et al. (2014) state that introducing specific and well-defined protocols and partnership agreements related to performing the intervention of interest are important for clarifying expectations of those involved and for ensuring accountability. Lee et al. (2013) also highlight joint or shared treatment planning across sectors as a means of underpinning a model's success.

Sharing information across sectors is a complex issue requiring deliberate attention from all sectors involved. A number of authors point to the challenges experienced when sectors have different rules related to service user confidentiality or sharing service user information (Hillier et al., 2010; Lee et al., 2013; Soto et al., 2004). Lee et al. (2013) found that some partners were able to share information freely and that the sharing of information improved over time for those who originally experienced challenges.

On a similar vein, nine reviews speak to the value of having someone in an expert/specialized role, or taking on a coordinating function (Butler et al., 2011; Davies et al., 2011; Fisher & Elnitsky, 2012; Fleury, 2006; Green et al., 2014; Hillier et al., 2010; Lee et al., 2013; Winters et al., 2015). Hillier et al. (2010) mention that viewing all team members as equal

but assigning a leadership role to the individual with the greatest expertise results in greater team functioning and cohesion, as well as promotes an equal distribution of leadership responsibilities. A number of authors note the benefits of having someone in a coordinator, linking, case manager, transition support worker, or boundary spanner role (Butler et al., 2011; Fleury, 2006; Green et al., 2014; Lee et al., 2013; Soto et al., 2004; Winters et al., 2015). Lee et al. (2013) state that these roles improve client engagement and satisfaction rates. Issues of language use, jargon, confidentiality, agreed upon documents and coordinator roles are reported to enhance the success of CSSP.

Adequately Resourcing CSSP

Committing adequate resources across sectors that are attempting to offer CSSP is a critical feature frequently identified in the included review (Davies et al., 2011; Fisher & Elnitsky, 2012; Green et al., 2014; Grenfell et al., 2013; Lee et al., 2013; Winters et al., 2015). Funding can be challenging to navigate when sectors retain most or all of their independence from one another (Davies et al., 2011; Fisher & Elnitsky, 2012; Lee et al., 2013; Winters et al., 2015). In CSSP arrangements where the program is jointly funded this issue appears to be reduced (Davies et al., 2011). However, a number of reviews noted that when there are hard divides between sectors, ensuring that the service provision is funded equally by all involved can be difficult (Fisher & Elnitsky, 2012; Lee et al., 2013; Winters et al., 2015). Fisher and Elnitsky (2012) discuss creative ways of sharing costs when categorical (sector specific) funding is provided. The authors highlight blended funding and the ‘medical home’ approach as a means of navigating categorical funding arrangements. The medical home approach provides patients with a range of services and blended funding often occurs through fund matching from different sources. Fisher and Elnitsky (2012) go on to warn that adopting this approach must be done

flexibly given the changing needs of service users. Lee et al. (2013) discuss a funding arrangement where one government department oversaw funding for two sectors with the expectation that care be provided in partnership. Green et al, (2014, p. 10) found that often service provision occurred “on sheer good will” where staff worked beyond their normal hours to provide the service. Dedicated time (Green et al., 2014; Grenfell et al., 2013), appropriate infrastructure, space (Soto et al., 2004; Winters et al., 2015), and adequate staffing (Green et al., 2014; Grenfell et al., 2013; Winters et al., 2015) are also viewed as critical to the sustainment of CSSP.

Resources allocated to evaluation and monitoring are noted as critical to ensuring that CSSP produces the desired effect (Dowling et al., 2004). The elements of evaluation, particularly in regard to outcomes, are reported as largely missing from most of the included studies in the review papers. This will be discussed further later on in this section.

Developing Novel Arrangements or Fostering Existing Relationships

For CSSP to be implemented, slight to significant changes to standard practice are needed (Davies et al., 2011; Fleury, 2006; Howarth et al., 2006; Lee et al., 2013). However, two reviews (Lee et al., 2013) mention that often when CSSP arrangements parallel a pre-existing relationship with a history of shared service provision between two or more sectors, they are more successful, rather than when novel partnerships are established. Others stress that the introduction of any model requires that it be molded to the context in which it will be delivered (Fleury, 2006; Grenfell et al., 2013), taking into account the unique needs of the service user group (Grenfell, 2013). In Fleury’s (2006 p. 162) extensive review of the conceptualization of integrated service networks, the authors indicate that “the networks that have reached a higher level of density, meaning a better integration between organizations, have developed the most formalized ties

between organizations through various integration strategies at the structural, functional/ administrative, and clinical levels”. Davies et al. (2011) similarly state that formal structures may need to be in place for CSSP to be successful. Consideration must be given to attempting to align the CSSP with an existing relationship, or devoting time to align novel CSSP arrangements with the context in which they will be delivered.

Strengthening Connections Among Sectors

As Hillier et al. (2010) conclude that team building work is one of the biggest predictors of success. This notion was shared by Howarth et al. (2006), who stress that the need for team working skills is necessary for strong CSSP. The stronger the linkages are between the sectors involved, the more successful the CSSP arrangements are thought to be (Green et al., 2014; Soto et al., 2004). Cross training, learning together, or increasing knowledge about the other sector is mentioned by a number of authors as a means to strengthen the connection between sectors (Davies et al., 2011; Howarth et al., 2006; Lee et al., 2013; Winters et al., 2015). But again, Davies et al. (2011) note that being able to access training requires dedicated resources (time and funding) for such activities and that all levels of staff need to be encouraged to participate in the training.

Role clarification is another area that is mentioned profusely in bodies of literature related to integration, collaboration, partnership, and coordination. Findings from this umbrella review further support the notion that clarification of roles is critical to the success of CSSP (Green et al., 2014; Hillier et al., 2010; Howarth et al., 2006; Lee et al., 2013; Winters et al., 2015). Hillier et al. (2010) mention that clarifying roles through observing each other’s work contributes to the success of the service delivery. Howarth et al. (2006) find that negotiating roles removed professional tribalism and turf war issues. These findings are in line with Sloper’s (2004) review

where the authors conclude that clearly defined roles ensure that everyone knows what was expected of them. Similar to Sloper's (2004) findings, the degree to which members from each sector respect and trust the members of the other sector shape the success of the CSSP (Dowling et al., 2004; Howarth et al., 2006; Lee et al., 2013) and can be promoted by joint training.

Opportunities to meet regularly (Fisher & Elnitsky, 2012; Green et al., 2014; Howarth et al., 2006; Lee et al., 2013; Winters et al., 2015), face to face or by phone, or being co-located (Green et al., 2014; Lee et al., 2013; Winters et al., 2015) are identified as helping to build stronger connections between sectors involved in CSSP. Reasons for coming together include: consulting on a case (Lee et al., 2013; Winters et al., 2015) having regular steering committee meetings (Lee et al., 2013) or to participating in a community of practice (Fisher & Elnitsky, 2012). A number of authors of included reviews state that having opportunities to engage with members from other sectors is necessary for success and parallel the findings in Sloper (2004).

Contrarily, the constant mutation of services and/or the expansion of roles (Howarth et al., 2006), high staff turnover (Green et al., 2014; Lee et al., 2013), different professional ideologies (Winters et al., 2015) and turf wars (Howarth et al., 2006; Soto et al., 2004) are identified as posing challenges to increasing connections across sectors. Green et al. (2014) mentioned the negative impact racism and historical trauma has on CSSP which is similar to the discussion in Sloper (2004) related to negative stereotypes and how they impact on staff building strong connections with one another. However, other authors did not mention these notions. Future research should explore these concepts in more depth.

What Remains to be Known About CSSP?

Absent Service User Voice Notable

The main reason for engaging in CSSP is to improve the care provided to service users, but what is strikingly absent from much of the included literature is the voice of the service user (Davies et al., 2011; Fleury, 2006; Hillier et al., 2010; Loader et al., 2008; Winters et al., 2015). Hillier et al. (2010) indicate that the bulk of the literature included in their review is from the perspective of the expert opinion, with the values and preferences of the service user left unreported. Winters et al. (2015) similarly state that the service user perspective is relatively absent and that service user related outcomes were reported from the perspective of the caregivers. Only one study in their review reported outcomes from the service user's perspective (Winters et al., 2015). Numerous authors are strongly calling for more research related to service user outcomes (Davies et al., 2011; Fleury, 2006; Hillier et al., 2010; Loader et al., 2008; Winters et al., 2015). Including this perspective is critical to ensuring that CSSPs are provided in a way that meets the needs of the service user (Winters et. al, 2015).

Lack of Published Evaluation Findings and Outcomes

Perhaps most notable, all but one of the authors of the included reviews writes about the lack of evaluation and outcomes (Butler et al., 2011; Collet et al., 2010; Davies et al., 2011; Donald et al., 2005; Dowling et al., 2004; Fisher & Elnitsky, 2012; Fleury, 2006; Grenfell et al., 2013; Hillier et al., 2010; Howarth et al., 2006; Hussain & Seitz, 2014; Lee et al., 2013; Soto et al., 2004). As Hillier et al. (2010) note, models of teamwork are well described but not well evaluated. Making firm recommendations about CSSP is challenging without evidence (Collet et al., 2010; Davies et al., 2011; Donald et al., 2005; Dowling et al., 2004; Fisher & Elnitsky, 2012; Fleury, 2006; Grenfell et al., 2013; Hillier et al., 2010; Howarth et al., 2006; Hussain & Seitz,

2014; Lee et al., 2013; Soto et al., 2004; Winters et al., 2015). Unfortunately, the findings from the current review strongly align with those found 10 years previously by Sloper (2004) indicating that little movement in the way of evaluation and outcome measurement has occurred. Almost all authors in this review implore future researchers to include evaluative components in future research related to CSSP in order to demonstrate effectiveness (Collet et al., 2010; Davies et al., 2011; Donald et al., 2005; Dowling et al., 2004; Fisher & Elnitsky, 2012; Fleury, 2006; Grenfell et al., 2013; Hillier et al., 2010; Howarth et al., 2006; Hussain & Seitz, 2014; Lee et al., 2013; Soto et al., 2004; Winters et al., 2015). Fisher and Elnitsky (2012) suggest that evaluations occur early on, and Lee et al., (2013) suggest that they occur alongside service innovation to measure services integration success. Dowling et al. (2004) posit that perhaps this paucity is related to the extended time frames and complexity of measuring outcomes. The authors also stress that evaluating processes, although more straightforward to measure, may only be relevant for the duration of the partnership (Dowling et al., 2004). They conclude that these difficulties may contribute to placing misleading evidence in our grasp. More attention to evaluating CSSP and determining outcomes is necessary.

Discussion

The findings from this umbrella review parallel in many ways those found by the 2004 review of reviews conducted by Sloper (2004). A more disappointing similarity between the current review, and that of Sloper (2004), was that even though authors have long-concluded their studies with a plea for more research on outcomes related to the effectiveness of CSSP, to date very few studies report effectiveness outcomes. Even if reported, the outcomes related to effectiveness were rarely positive. Again, many reviews found that the bulk of the evidence is

still related to descriptions or findings related to the process of CSSP, but at present there is minimal evidence related to the outcomes of CSSP.

There is much overlap between the supposedly distinct bodies of literature drawn on to inform the current view of CSSP. The first issue at hand is the lack of conceptual clarity in the literature related to CSSP. Immediate work is needed to ensure that the emerging body of literature facilitates a dialogue among researchers, policy makers, service providers and service users regarding what cross sector service provision entails, and its possible benefits and drawbacks. The current authors proposed a working definition of CSSP - as independent, yet interconnected sectors working together to better meet the needs of service users and improve the quality and effectiveness of service provision - in the hopes that it will spur dialogue and debate needed to progress the field and to ensure coherence in service delivery planning, provision and sustainment.

The terms used interchangeably carry similar but not identical meanings; therefore care must be taken to ensure that researchers and decision makers understand the nuanced differences in the terms they are using. Moreover, attention is required to exploring CSSP at intersection of care transition points, as opposed to at the individual provider level. Much remains to be known about what shapes cross sector service provision and the outcomes that result from these arrangements. The current authors could not easily discern from the included literature why any of the included reviews adopted one central term over another. Of the authors who did delineate how they conceptualized the central term, there was substantial overlap between their definition and that of other authors' definition of different central terms.

Future Research Implications

Significant time and attention must be given to conceptualizing how all sectors involved in the provision of services make sense of the arrangement. This includes things like developing a shared vision, how to facilitate communication, and what to do about power differentials. Moreover, additional work is needed to determine what occurs at the boundary between sectors, where tensions and synergies emerge beyond the individual level. More awareness of how different organizational structures are involved in shaping CSSP is needed. Differing payment structures and their impact on cross sector working should be explored further. The focus has largely been at the micro/provider level but the interface between policies related to the independent sectors has not been explored. How these policies shape CSSP is unknown. Future research could explore what it is like for the leaders to lead their own teams while needing to consider other sectors in how they provide service to service users. In addition, what is known about the difference between CSSP for chronic, as opposed to acute and short-lived conditions, is missing from the literature. There is likely variation in how the acuity of the concern shapes service provision across sectors, but little to nothing is reported about this in the literature.

Limitations

The focus of this umbrella review was on service provision between two or more interconnected, yet *independent* sectors. Integration has come to be understood as existing on a continuum ranging from loose coordination to more overlap with a shared governance structure (Fleury, 2006). All appropriate studies related to integration were included in this umbrella review; however it is worth mentioning that it was difficult to discern the extent of integration of all papers included in the existing reviews and this may have skewed the result of the current umbrella review slightly. However, excluding integration studies based on this concern would

have posed a bigger threat to the overall integrity of the review. Despite lacking certain information, we felt it was important to include studies that might have been deemed lower quality because they still provided useful information regarding CSSP. Given the year range of articles included in the existing systematic reviews, it is possible that studies were included in more than one review, which could potentially influence the findings of the current umbrella review. The current authors could not do a comparison of included papers because authors of the included reviews did not always provide this information. Finally, only studies conducted in English were included in this umbrella review, therefore we likely missed important studies conducted in other languages. As an example, we could not include a German review by Schmid, Steinert, and Borbe (2013).

Conclusion

The literature shows that the focus is still at the individual provider level, more so than the sector level. Further investigation is needed into what is involved in developing a shared vision of care across diverse sectors. This will undoubtedly include the service user, front line staff, and leadership of each sector but should take a higher level look at what organizational facilitators and challenges exist at the boundary between sectors in regard to CSSP. The findings from the vast amount of literature in the area has aligned with the following: taking a client centered approach, developing a shared vision of care, enhancing and supporting communication across sectors involved with CSSP and navigating power differentials. The findings from this umbrella review provide much needed insight into the role that individuals involved with CSSP play in the success and failure of the arrangements. However, future research from a cross-organizational perspective is needed to better understand what shapes cross sector service provision. Highlighting substantial similarities to the work done a decade prior by Sloper (2004) is not

meant to imply that no progress has been made in the years since that review was conducted, but it does raise some concerns related to duplicating approaches that have previously been explored at length. Future researchers should focus on novel aspects that advance our understanding of cross sector service provision.

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Chapter Four: Processes that Shape Cross Sector Service Provision in the Towards Flourishing Mental Health Promotion Strategy: A Secondary Analysis Utilizing Constructivist Grounded Theory Methods

This chapter provides an overview of a secondary analysis utilizing constructivist grounded theory methods to identify processes that shape Cross Sector Service Provision in the Towards Flourishing Mental Health Promotion Strategy. A much shorter version of this paper will be submitted for publication but for the purpose of depth, the entire paper (material, content) will be presented here in this dissertation.

The requirement to work together to provide more coordinated, integrated and collaborative health and social care is strong the world over (Kernaghan, 1993), but the evidence to support this call is lacking (Winters, Magalhaes, Kinsella, & Kothari, 2016). It appears to be taken for granted that we have a shared understanding of *how* this work is done (Winters et al., 2016). I argue that gaining a deeper understanding of *what processes shape* cross sector work is needed. Previous literature suggests that if we do not increase our understanding, we risk continuing to provide disjointed services and people may continue to fall through the cracks (Glasby & Dickinson, 2008; Kodner & Spreeuwenberg, 2002).

Conceptualization of Cross Sector Service Provision

I will use the term *Cross Sector Service Provision (CSSP)* generated by (Winters, Magalhaes, Kinsella, & Kothari, 2016) throughout this paper to refer to independent, yet interconnected sectors working together to better meet the needs of service users and improve the quality and effectiveness of service provision. Further, I use the term ‘sector’ to refer to divisions of the health and social care system that are distinct from one another with regard to structure, but not necessarily function. I will consistently use CSSP with the understanding that numerous substantial and independent bodies of research inform the concept. CSSP focuses on what many

refer to as collaboration, integration, partnership, and coordination across the health and social care system. In addition, I use the umbrella term *service user* to refer to the recipient of the cross sector service provision with the understanding that numerous terms are used by different sectors, such as patient, client, service user, suspect, student, etc.

Winters et al. (2016) conducted an umbrella review looking at Cross Sector Service Provision (CSSP) in health and social care and found that there was an immense pool of literature in the area but a troubling lack of evaluation and outcomes related to CSSP. As Hillier, Civetta, and Pridham, (2010) note, teamwork arrangements are described but not well evaluated. Moreover, CSSP has not been analytically explored to systematically identify processes involved in these types of arrangements. Making firm recommendations about CSSP is challenging without adequate evidence (Collet, De Vugt, Verhey, & Schols, 2010; Davies et al., 2011; Donald, Dower, & Kavanagh, 2005; Dowling, Powell, & Glendinning, 2004; Fisher & Elnitsky, 2012; Fleury, 2006; Grenfell et al., 2013; Hillier et al., 2010; Howarth, Holland, & Grant, 2006; Hussain & Seitz, 2014; Lee, Crowther, Keating, & Kulkarni, 2013; Soto, Bell, Pillen, & For The Hiv/aids Treatment Adherenc, 2004; Winters, Magalhaes, & Kinsella, 2015). Theoretical underpinnings of CSSP were found to be largely absent from the existing literature (Winters et al., 2015, 2016) with only two articles putting forth suggestions for potentially relevant extant theories, by name only, with no elaboration on goodness of fit (Fisher & Elnitsky, 2012; Howarth et al., 2006).

Taking it further, the vantage point of work to date has primarily been at the micro/provider level (Reeves, 2011; Suter 2009) with the boundary between the independent sectors left largely unexplored (Winters et al., 2016). Research was needed to determine what occurs at the boundary between sectors, where tensions and synergies emerge beyond the

individual level. Professionals working within and across sectors not only need to navigate interprofessional boundaries within their home sector but must also grapple with the social, philosophical, political, and cultural differences that exist at the boundary between sectors. More awareness of how different organizational and strategic governance structures are involved in shaping CSSP was needed to advance our understanding of the phenomenon.

This paper presents the findings from a secondary analysis study using data collected from the *Towards Flourishing Mental Health Promotion Strategy* in Manitoba, Canada. In the following section, I will provide a brief overview of the recently identified priorities in the Mental Health system in Canada and in Manitoba. I then highlight the main components of mental health promotion and the *Towards Flourishing* initiative.

Mental Health in Canada

One in five Canadians will experience a mental health problem or illness, costing the economy more than \$50 billion annually (The Mental Health Commission of Canada, 2012). Twenty five percent of Manitoban's received medical care for a mental health related concern, which is higher than the projected national average of 20% (Province of Manitoba, 2015). Furthermore, the Canadian Mental Health Association (Canadian Mental health Association, 2016) states that almost one half (49%) of those who feel they have suffered from depression or anxiety have never gone to see a doctor about their concern. Stigma is thought to be a strong contributing factor for the under-treatment of mental health concerns (Corrigan, 2004; Mann & Himelein, 2004; Sartorius, 2007). Individuals experiencing a mental health crisis have historically made initial contact with police (Fry, O'Riordan, & Geanellos, 2002), emergency departments, (Clarke, Brown, Hughes, & Motluk, 2006; Clarke, Dusome, & Hughes, 2007) clergy (Burns, Jhazbhay, Kidd, & Emsley, 2011; Farrell & Goebert, 2008), college and university campus

personnel (Drum & Denmark, 2012; Pinder-Amaker, 2012), or traditional healers (Maar et al., 2009), many of whom are not specifically trained to respond to mental health concerns (Fry et al., 2002; Laing et al., 2012), nor do they report feeling comfortable doing so (Broadbent, Jarman, & Berk, 2002; Clarke et al., 2006; Fry et al., 2002; Winters et al., 2015). Key historical events have shaped the perception of mental health and how mental health services are offered (Davis, 2006; Kirby & Keon, 2004). Figure 4 provides an overview of events. In 2012 national and provincial mental health strategies were introduced with strong threads of endorsement toward promotion and prevention (The Mental Health Commission of Canada, 2012; Manitoba Government MH strategy 2012). The priorities outlined in the mental health strategies stem from the Declaration on Prevention and Promotion from Canada's Ministers of Health and Health Promotion/Healthy Living titled *Creating a Healthier Canada: Making Prevention a Priority* (2010). Among other areas of health, the declaration specifically recognizes the importance of promoting positive mental health and mental fitness throughout the lifespan as contributing to a foundation for optimal overall health and well-being.

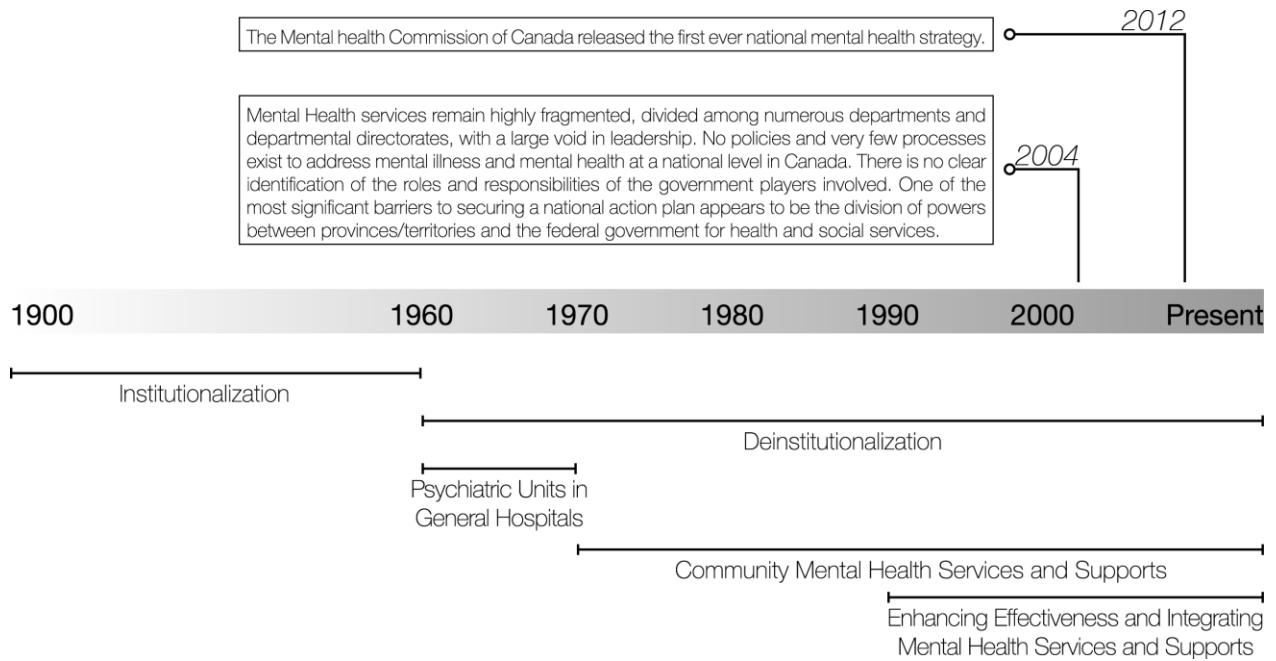


Figure 4 Chapter 4 Timeline of historical events in mental health care in Canada¹¹.

¹¹ Content derived from Kirby and Keon (2004) and Davis (2006), designed by Shannon Winters and graphic created by Emil-Peter Sosnowski.

Mental Health Promotion

Historically mental health has been viewed as the absence of illness (Westerhof & Keyes, 2010; World Health Organization, 2004) rather than being viewed as an individual's state of mental well-being. Mental health refers to an individual realizing his or her own abilities, having the ability to cope with the normal stresses of life, working productively and fruitfully, and being able to make contributions to his or her community (World Health Organization 2001). Further, mental health is the capacity for each of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face (Public Health Agency of Canada 2016). Mental Health Promotion (MHP) is the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health (Public Health Agency of Canada, 2016)

The Towards Flourishing Mental Health Promotion Strategy

A Public Health Families First Home Visiting (FF) program in Manitoba provides a range of supports to families with children who are living in what are considered high-risk conditions for healthy baby development. Some of the risks include: teenage parents, financial difficulties, and/or mental health concerns (Healthy Child Manitoba, 2010). One of the gaps identified through an evaluation of the FF program was that there was a paucity of mental health support for the families it serves (Healthy Child Manitoba, 2010). In response to this finding and other contributing factors, a cross sector service provision (CSSP) demonstration project called *The Towards Flourishing Mental Health Promotion Strategy* (TF) was developed through a partnership between the Winnipeg Regional Health Authority (WRHA), Healthy Child Manitoba Office (HCMO) and the University of Manitoba (U of M). TF was embedded into FF and aimed

to promote the mental health and well-being of families and children connected to FF (Chartier et al., 2015).

Elements of TF include: adding a mental health promotion facilitator (Facilitator) role to support the home visitors and public health nurses, a mental health screening package to identify risk, mental health promotion educational materials for parents, and MHP training for the Families First Home Visitors (HVs) and Public Health Nurses (PHNs). TF is based on the dual continua model for mental health promotion described by Keyes (2002) and stresses that regardless of whether an individual is experiencing a mental illness or not, there is capacity within every individual to improve their mental health (Westerhof & Keyes, 2010). The presence of mental health is described as flourishing and the absence of mental health as languishing (Keyes, 2002). Flourishing individuals report frequently experiencing positive emotion and endorse items reflective of positive psychological and social functioning whereas languishing individuals endorse relatively few of these items.

Study Purpose

Few authors have theoretically explored CSSP in any depth. Extensive research exists that informs how people work together on an individual/provider (Micro) level but findings are scarce when it comes to understanding how organizational/regional (Meso), and policy/strategic governance (Macro) level arrangements impact the ability of sectors to work effectively together (Winters et al., 2016). The original TF study evaluation focused on all components of the implementation of the project. The original study evaluation looked at collaboration but given the magnitude of the overall evaluation, this concept was only minimally explored. I adopted grounded theory methods (Charmaz, 2014) to undertake a secondary analysis of the original

study data to generate a mid-level theory that increases our understanding of the processes involved in CSSP.

Research Question

The following research question guided the current study: *What processes shape cross sector service provision at the boundary between mental health and public health sectors in the Towards Flourishing Mental Health Promotion Strategy?*

Methods of Inquiry

The current study is a secondary analysis of existing data collected during the 2014 evaluation of the Towards Flourishing Mental Health Promotion Strategy (TF). Secondary analysis is commonly used in quantitative research and is becoming more common in qualitative research. However, secondary analysis has been used relatively less frequently in Grounded Theory. As (Whiteside, Mills, & McCalman, 2012) point out, this is interesting considering that Glaser and Strauss's (reference?) early work on GT suggested that secondary datasets are appropriate data sources. In this section I will present how I came to conceptualize the goodness of fit between the two.

Towards Flourishing – the Original Study

Through my position with the Winnipeg Regional Health Authority I was tasked with conducting the qualitative component of a robust evaluation of the implementation of TF within the province of Manitoba. The original evaluation centered on exploring the impact of TF on maternal mental health. The project aimed to evaluate the impact of embedding Towards Flourishing elements into the Families First Home Visiting Program by exploring to what extent TF improved the program's capacity to detect mental health problems and promote better mental health among parents and their families participating in the Program. The evaluation framework

included both qualitative and quantitative elements. The qualitative element of the original study intended to answer the following questions:

- How acceptable and effective has the new curriculum been for parents/families?
- How acceptable and effective has the training of Families First home visitors (FF-HVs), public health nurses (PHNs), and mental health promotion Facilitators (Facilitator) been in helping families improve their access to mental health services, resources and supports?

The original study was evaluated in 2014 and produced an astonishing nine hundred and forty pages of transcripts resulting from semi structured interviews and focus groups conducted with five stakeholder groups. See table 10 for a breakdown of Stakeholder groups. Participants were spread out across the province and each regional health authority was represented (Winnipeg, Southern, Northern, Prairie Mountain, Interlake/Eastern) (Winnipeg Regional Health Authority, 2014). See table 11 for a breakdown of stakeholder by region. Stakeholders came from the Mental Health sector (n=12) Public Health sector (n=46) and a neutral location (n=2). The immensity of data collected, timeline, and scope of the original project meant that only a subset of the transcripts was analyzed, leaving a large portion of the data unexamined. Furthermore, collaboration was evaluated by focusing primarily on the interface at the provider level, not at the interface between higher level factors of both sectors. The concept of cross sector working was not specifically explored outside of the individual level.

Table 10. Chapter 4 Stakeholder Data Sources.

| Stakeholder Group | Abbreviation | Participants (n=74) |
|--------------------------------------|--------------|------------------------|
| Service Users | FAM | n=14 |
| Families First Home Visitors | HV | n=17 |
| Public Health Nurses | PHN | n= 28 |
| Mental Health Promotion Facilitators | FACILITATOR | n= 6 |
| Decision Makers | DM | n= 9 |

Table 11. Chapter 4 Stakeholder by Region.

| Stakeholder Group | HV | PHN | Facilitator | DM | Total |
|--------------------------|-----------|-----------|-------------|----------|-----------|
| Province | x | x | x | 4 | 4 |
| Winnipeg Region | 6 | 8 | 2 | 2 | 18 |
| Southern Region | 3 | 2 | 1 | 1 | 7 |
| Interlake Eastern Region | 3 | 3 | 1 | 1 | 8 |
| Prairie Mountain | 2 | 5 | 1 | x | 8 |
| Northern Region | 2 | 8 | 1 | 1 | 12 |
| Unknown | 1 | 2 | x | x | 3 |
| Total | 17 | 28 | 6 | 9 | 60 |

*Service User data were not included in this total as data from this group were only used for theoretical sampling

All interviews and focus groups were transcribed verbatim. Memos were audio recorded and transcribed following each interview and focus group. See Appendix 3 for the interview guides used in the original study. Below is a table of the breakdown of data available for the secondary analysis:

Table 12. Chapter 4 Data Available for Secondary Analysis

| Stakeholder Group | Total Pages | Words |
|---|-------------|----------------|
| Decision Makers | 166 | 54199 |
| Public Health Nurses and Home Visitors | 196 | 68789 |
| Facilitators | 260 | 77907 |
| Service Users | 318 | 82465 |
| TOTALS | 940 | 283,360 |

TF is an ideal model for studying CSSP because it was intentionally designed to bring together two sectors (mental health and public health) to better meet the mental health needs of families receiving support in the FF Program (Chartier et al., 2015). The role of the Facilitator was created to augment the capacity of public health staff in meeting the mental health needs of families in the home visiting program. Training was delivered to both public health and mental health staff to increase their understanding of mental health promotion. By way of design, TF intended to improve access to mental health services, resources, and supports for families and to streamline referral processes. In addition, the TF project aimed to facilitate cross sector service provision by strengthening collaboration between public health and mental health systems (Chartier et al., 2015). Given the intentional cross sector design of the TF, it provides a rich setting to explore what processes shape cross sector service provision.

Theoretical Framework

Researcher and Research Position

Glaser and Strauss (1967) wrote about *discovering* grounded theory from an objective external reality, through systematic means, by a neutral researcher. Early work is now regarded as entrenched in a positivist paradigm, although that was not the original authors' intent (Charmaz, 2014). Charmaz (2014) challenges this approach of generating a grounded theory from a positivist paradigm, in that she asserts that theories are not simply there to be discovered but rather, are to be constructed. Charmaz (2006 p. 9) adopts grounded theory methods but diverts from the traditional view of GT in that:

Like any container into which different content can be poured, researchers' use of basic grounded theory guidelines such as coding, memo-writing, and sampling for theory development, and comparative methods are, in many ways, neutral... but how researchers use these guidelines is not neutral, nor are the assumptions they bring to the research.

Similar to Charmaz (2014) the current study builds on the belief that we are part of the world we study and the data we collect. Assuming the position that there are multiple interpretations of phenomena (Ponterotto, 2005) and that all of our experiences shape our interpretations, Charmaz suggests that researchers must reflect on the impact that our past and present beliefs, values and positions in society have on the research process (Charmaz, 2014). I strived to be transparent about examining my assumptions (Finlay, 2002). Additionally, I concur with Charmaz (2006 p. 9) that the theoretical rendering I present below offers an interpretive portrayal of the studied world, not an exact picture of it. Finished grounded theories are, therefore, constructions of processes in a social world.

Applying a Critical Lens

Data for the current study were viewed with a critical lens and attention was paid to how power imbalances (social, structural, and political) may be involved in shaping processes related to CSSP (Charmaz, 2014; DePoy, 2016). Issues of power can result from imbalances related to equity, equality, status, hierarchy, race, class, and/or gender (Charmaz, 2014; Creswell, 2003) and these imbalances may be evident at the micro (individual), Meso (organizational) or macro (policy/strategic governance) level (Crotty, 1998). Charmaz (2014, p. 326) asserts that taking a social justice lens means taking a critical stance towards actions, organizations, and social institutions and encourages the adoption of GT methods to study social justice issues particularly because:

The critical stance of social justice research combined with the analytic focus of grounded theory broadens and sharpens the scope of inquiry. Such efforts locate substantive and collective experiences in larger social structures and increased understanding of how the structures work. In this way integrating a critical stance offers a corrective to narrow and limited grounded theory studies. Novel aspects of experience give rise to new interpretations and actions. This view of emergence can sensitize social justice researchers to study change in new ways, and grounded theory methods can give them the tools for studying it.

Stigma is a long standing, highly problematic component of mental health and has been shown to be a contributing factor to individuals not seeking treatment and support when they need it (Corrigan, 2004; Link & Phelan, 2001; Link, Yang, Phelan, & Collins, 2004; Sartorius, 2007). In the current study, issues related to stigma were attended to and unlike much of the extant literature focused primarily on the micro level (Link & Phelan, 2001), efforts were made

to consider how stigma contributes to shaping processes related to CSSP at all levels (micro, meso, macro).

As with all lenses used to view data in grounded theory it is important to regard them as sensitizing concepts (Charmaz, 2014, p. 327) and maintain detailed memos and for the researcher to critically reflect on emerging elements of the theory to ensure that the theory is emerging from the data themselves, not from pre-conceived notions (Charmaz, 2014). In the case of the current study, my assumption about possible power dynamics were rigorously considered through memo writing and those memos were compared iteratively with data to ensure that the emerging theory was grounded in the data themselves.

The Use of Literature in Grounded Theory

Despite Glaser and Strauss arguing for delaying a literature review to ensure that researchers are not swayed by the received view of existing work in the area, Charmaz (2014) takes a more flexible approach. Charmaz (2014) cautions that researchers must guard against forcing the data to fit pre-existing categories but that using the literature can help ensure that we are not rehashing old empirical problems and dismissing the literature. In keeping with the critical lens described above, reviewing the literature can be a means to understanding the status quo, or received view (DePoy & Gitlin, 2016). I chose to rigorously explore the literature in the area of Mental Health Crisis specifically and CSSP in general prior to conducting the analysis of the existing data. These reviews identified a clear gap in our understanding of what processes shape CSSP from an organizational or strategic governance level. While analyzing the data I attended to the risk of having the literature force me to categories that were evident in extant text; I viewed my understanding of the literature as sensitizing concepts which gave me initial but tentative places to start, or “points of departure” (Charmaz, 2014, p 31).

Through exploring the literature, it became evident that theoretical underpinnings for CSSP were missing. Grounded Theory methodology was considered appropriate because it aims to construct situated theories of social processes. The literature provided the current view of CSSP, and was used to identify prior empirical arguments and to ensure that important insights from the literature would not be dismissed. Additionally, through initially reviewing the literature I discovered that much of the existing literature had almost exclusively focused on CSSP at the individual level, on elements such as having time to connect or role clarity (Fisher & Elnitsky, 2012; Fleury, 2006; Winters, et al 2016). The individual perspective was an important approach to take but it was clear that much remained unknown about the synergies and tensions that exist within and across the boundary of the different sectors. This important finding was used as a point of departure for constructing the grounded theory presented in this dissertation whereby the authors intentionally set out to explore CSSP from Micro, Meso and Macro levels.

Secondary Analysis

Using the entirety of data collected in the original study, the current study focused on exploring provider, strategic, organizational, contextual, and structural components that occur at the boundary between the mental health and public health sectors. The aim was to systematically generate a theory of what processes were seen to shape cross sector service provision among independent yet interconnected sectors.

Secondary analysis is the use of an existing data set to explore a research question that differs from that of the original study (Hinds, Vogel, & Clarke-Steffen, 1997). The approach of the current study aligns with an approach outlined by Hinds, et al. (1997), where researchers re-analyze all or part of an existing body of data by focusing on a concept that may have begun to emerge but was not fully explored in the original study. Secondary analyses are becoming

attractive options in qualitative research given the massive amount of data that get collected but are not able to be fully analyzed (Hammersley, 1997; Thorne, 1994). Secondary analysis can be helpful in terms of maximizing the extent to which existing data can be utilized to answer research questions. Additionally, given the multiplicity of interpretations possible, secondary analyses can extend our understanding of an area that may otherwise be left dormant, by viewing the data from various angles and perspectives (Thorne, 1994; Whiteside, Mills, & McCalman, 2012).

When considering the feasibility of conducting a secondary analysis the researcher must navigate the fine line between ensuring that the study is similar enough to produce fruitful findings, while not overlapping completely with the original study so as to render a duplication of efforts (Hinds et al., 1997; Whiteside et al., 2012). The data must be relevant and enough to produce new insights into the focused content area.

Despite the positives, there are several cautions to consider when embarking on a secondary analysis. First, a secondary analysis is typically conducted by someone other than the original researcher and this can lead to a number of issues related to ensuring the quality of the data collected (Hammersley, 1997; Hinds et al., 1997; Thorne, 1994; Whiteside et al., 2012) and for gaining access to a complete set of the original data (Hinds et al., 1997). Second, differences in interpretation of the spoken elements of the interviews may lead to probing by the interviewer in such a way that it influences the direction of the initial interview (Hammersley, 1997; Thorne, 1994; Whiteside et al., 2012). Thirdly, assuming the researcher of the secondary analysis differs from that of the initial study, immediate and tacit understandings of the nuances related to the told story may be difficult to reconstruct later (Thorne, 1994). Finally, participants consented to have their story used for a particular purpose; if the secondary research question departs greatly from

the original purpose, further consideration will be needed on the part of the researchers to ensure that participants are informed of this new direction (Hammersley, 1997; Thorne, 1994).

In the following section I provide the reader with an overview of GT and will move into discussing how I merged elements of secondary analysis with Grounded Theory methodology.

Constructivist Grounded Theory

Charmazian Constructivist Grounded Theory (GT) informed the overarching methodology of the current study. Grounded theory is the discovery of theory found in the data themselves (Glaser & Strauss, 1967). It provides a way to learn about the world we study and a method for developing theory to understand that world (Charmaz, 2014). GT involves using data to begin making analytical sense of participant's meanings and action. Grounded theory methods consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data (Charmaz, 2014). The focus of GT is to identify process(es) which Charmaz (2014) defines as unfolding temporal sequences that may have identifiable markers with clear beginnings and endings and benchmarks in between. The temporal sequences are linked in a process and lead to change. The intent of grounded theory is to construct mid-level theories which lie somewhere between working level theories applicable only to the local context and formal theories that can be applied universally (Charmaz, 2008). Constructivist grounded theories are situated in the local context, historically, temporally, and socially but may be relevant to larger audiences (Charmaz, 2014).

Grounded theory has primarily been used to study complex social processes from the individual perspective, but authors have begun using the methodology to look at organizational influence on process (Charmaz, 2014). The current study explored how the combination of individual/provider (micro), organizational/regional (meso) and policy/strategic governance

(macro) factors were seen to shape processes involved in cross sector service provision. While attending to individual provider level factors, the focus remained at the boundary where the two sectors intersect given that this location had not been studied in great detail.

A completed grounded theory will meet the following criteria: a close fit with the data, usefulness, conceptual density, durability over time, modifiability, and explanatory power (Charmaz, 2014). It is important to note that while attending to individual level factors, the focus remained at the boundary where the two sectors intersect given that this location had not been studied in great detail. Identifying how CSSP occurs at the boundaries facilitates a deeper understanding of what is involved when two independent, yet interconnected sectors come together to improve service provision.

Although the debate regarding the philosophical underpinnings of grounded theory has been on-going since 1967, scholars in the area have, for the most part, agreed on the methods of GT (Charmaz, 2014; Glaser & Strauss, 1967). Grounded theory methods include: simultaneous involvement in data collection and analysis, constructing analytic codes and categories from data (not from preconceived logically deduced hypotheses). The constant comparative method is strongly advocated for in GT as it helps to make comparisons during each stage of the analysis while ensuring that the researcher remains close to the data. Memo writing is used to elaborate categories, specified in properties, to define relationships between categories and identify gaps. Finally, once the theoretical categories have been constructed, theoretical sampling is employed to substantiate emerging processes of the grounded theory.

Secondary Data Analysis Utilizing Constructivist Grounded Theory Methods

Grounded theory methods of analysis were adopted while performing the secondary analysis of existing data. In this section I will outline how I adopted each component of the

grounded theory analysis process. I began by constructing the “bones” of the analysis through initial or open coding (Charmaz, 2006 p. 43). This step involved categorizing segments of the data with a short name that simultaneously summarizes and accounts for each piece of data (Charmaz, 2006 p. 43). Charmaz (2014 p. 113) stresses the importance of coding as being the “pivot link between collecting data and developing an emerging theory to explain these data... (through) coding, you decide what is happening in the data and begin to grapple with what it means.” During this stage I attended to gaps that were emerging in the theory (Charmaz, 2014 p. 118).

As I moved through each phase I remained close to the elements outlined in Charmaz's (2014 p. 120) ‘Code for Coding’. I remained open, stayed close to the data, kept codes simple and precise, preserved actions, and compared data with data as I moved quickly through the data. Additionally, Charmaz (2014 p. 125) offers strategies to help researchers as they construct a grounded theory and these were helpful in persevering through the immense pool of data. I broke the data into their component parts or properties while defining the actions on which they rest. I attended to tacit assumptions while explicating implicit action and meanings. I grappled with and explored the significance of emerging points. The analysis process was truly iterative, comparing data with data and identifying gaps in the data at every phase.

To help see actions and identify significant emerging processes I used Charmaz's (2014 p. 127) questions as a guide. Questions include: What process(es) is at issues here? How can I define it? How does this process develop? How does the research participant(s) act while involved in this process? What does the research participant profess to think and feel while involved in this process? What might his or her observed behavior indicate? When, why, and how does the process change? What are the consequences of the process? Charmaz’ code for coding,

the strategies suggested, and the guiding questions, were used during initial coding, and subsequently during each additional phase of data analysis. I will describe this in more detail in the following section.

Focused Coding in grounded theory “permits you to separate, sort, and synthesize large amounts of data... using the most significant and/or frequent earlier codes to sift through large amounts of data” (Charmaz, 2014 p. 138). In this step I had to decide which initial codes made the most analytic sense to categorize data incisively and completely (Charmaz, 2014 p. 138).

Moving on to the next step, axial coding, I began relating categories and subcategories, by specifying the properties and dimensions of the category. In this step I reassembled the data fractured during initial coding to give coherence to the emerging analysis (Charmaz, 2014 p. 147). The final step in analytical coding which Charmaz (2014 p. 63) calls theoretical coding, is where I constructed codes specifying possible relationships between categories that help to theorize the data.

Abduction is described by Charmaz (2014) as a type of reasoning that occurs when a researcher encounters a surprising or puzzling finding and must entertain all possible theoretical explanations of the observed data by taking an imaginative leap. The researcher then returns to the data to ensure that idea is supported by the data. Abduction was adopted for the current study in that it allowed researchers to bring creativity into the process of generating grounded theories.

Another important component of grounded theory is Memos. Memos are notes that the researcher maintains throughout the duration of the analysis phase that help in developing theoretical ideas. Given that this is a secondary analysis of data I personally collected, I not only maintained new memos but also reviewed memos that I wrote during the original project. Both

sets of memos provided ways to compare data, to explore ideas about codes, and to direct further data-gathering (Charmaz, 2014 p. 163) see appendix 4 for examples of selected memos.

Theoretical sampling was an important component of the current study. Theoretical sampling is a strategy for obtaining further selected data to refine and fill out the major categories that constitute the theory (Charmaz, 2014 p. 193). Researchers conducting secondary analyses are confined to conducting theoretical sampling with a preexisting data set (Birks & Mills, 2011; Szabo & Strang, 1997). In the past authors have responded to the need to theoretically sample data by comparing the newly emerged theory with a portion of the data that had been left out of the initial coding step (Whiteside et al., 2012). I adopted this approach in the current study and built in two additional mechanisms for theoretical sampling. The service provider and decision maker data from the original study worked to build a strong foundation for constructing the theory. Once I had developed tentative theoretical categories from data from those groups, I then compared the categories with the portion of the data that I left unanalyzed. This was done in an effort to theoretically sample against the emerged theory (Whiteside et al., 2012). Additionally, the data from the Family (service user) stakeholder group was also compared with the theoretical categories to see how the emerging theory aligned with their experience of being part of TF (Charmaz, 2014). As an additional measure, further data collection was built into the study protocol in the event that it was required to fully construct a theory related to the processed that shape CSSP. This multifaceted approach to theoretical sampling was done to further identify the edges of the emerging concepts and flesh out the theory.

Conducting a secondary analysis of the TF data is advantageous for many of the reasons mentioned above. Given the immense amount of data collected in the original study evaluation I was only able to analyze a portion of data within the original project timeline. A fuller more in-

depth analysis of the massive pool of existing data was possible given that the current study narrowed the focus to processes that shape CSSP specifically. Coming to the data from this angle allows for new insights to be drawn, adding to our understanding of the concept.

Ethical Considerations

The Western University Health Research Ethics Board approved the current study. The University of Manitoba Health Research Ethics board and research review boards of participating Regional Health Authorities approved the original study. Original study data were obtained through a member of the original research team and were stored securely in a protected location.

Findings

Five interconnected processes emerged from the secondary analysis of the *Towards Flourishing* data. Codes were abstracted into categories through a constant comparative analysis and consist of properties relating to micro, meso and macro levels. See Table 13 for a breakdown of selected codes that informed these categories. The constructed processes that make up a grounded theory were abstracted from emerged categories involved in shaping cross sector service provision across mental health and public health sectors. The five processes are: 1) Establishing and growing the project based on need, priorities, and evidence; 2) Fostering meaningful and enduring engagement from both sectors; 3) Aligning with what already exists; 4) Preparing and supporting stakeholders; 5) Adapting to and challenging the contextual landscapes (social, historical, political) of both sectors. See Figure 5 below for an overview of the emerged model.

Understanding Processes that Shape Cross Sector Service Provision in the *Towards Flourishing Mental Health Promotion Strategy*

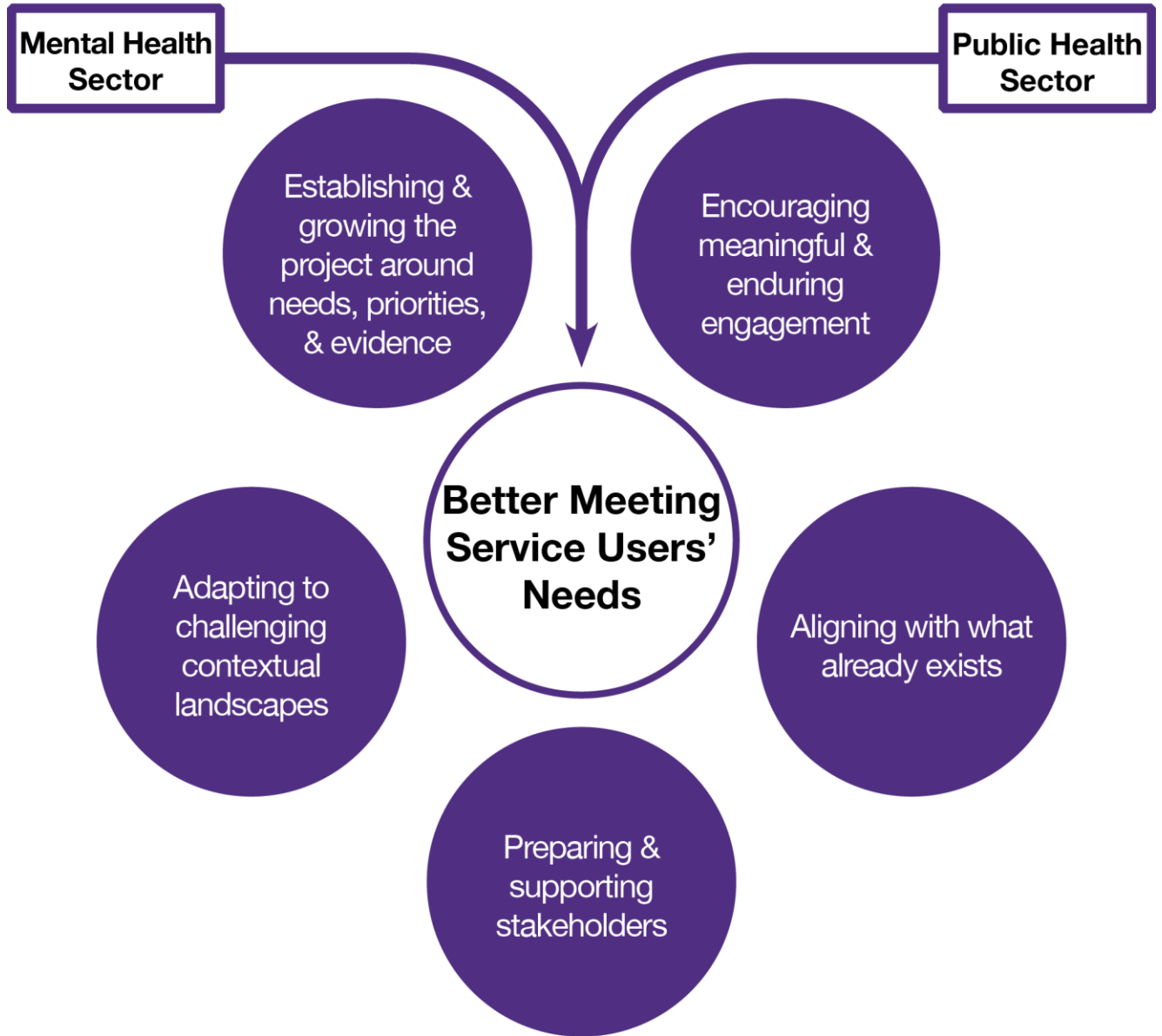


Figure 5 Model of CSSP.

*Content by Shannon Winters, Graphic Design by Emil-Peter Sosnowski.

Table 13. Chapter 4 Selected codes of analysis at three levels.

| |
|---|
| <p>Macro (Strategic Governance Level)</p> |
| <p>national provincial strategies encouraging mental health promotion, changing contexts, amalgamation wreaking havoc, large regions making connecting a challenge, PHAC requiring evaluation and integrated KT, mental health needs are not being met nationally, mental health need exceeding available supports, people not getting the help they need, funding for MH remains low, no new money, falling through the cracks</p> |
| <p>Meso (Regional/Organizational Level)</p> |
| <p>having nowhere to refer FAM, opening up a can of worms, knowing TF was evaluated increasing confidence and trust, .5 EFT making scheduling challenging, securing funds to sustain TF, meeting too late to plan for sustainability, pulling money from somewhere else, working without new money, being co-located, sharing finances for project, HV responsibility exceeding remuneration, scope creeping, HV role changing, involving university means regional stakeholder are able to meet, bringing key stakeholders together, keeping stakeholders informed, rolling out in manageable size regions</p> |
| <p>Micro (Individual/Provider Level)</p> |
| <p>feeling included, normalizing MH, reducing stigma, having a voice, feeling left out, recognizing that change is needed, feeling supported, being well-trained, feeling nervous, being uncertain, passing off families with high mental health needs, appreciating that TF is based on evidence, fear of losing TF or mental health promotion Facilitator, uncovering better understanding of the other sector, nervous about missing something big, choosing to use tools, choosing not to use tools, responsibility exceeding skills, having pre-existing relationships, wanting more training, having something to offer the family, using tools in personal life, using tools in general public health work, finding tools simple and easy to use</p> |

Direct quotations from stakeholders will be depicted in *italics*.

1. Establishing and Growing the Project around Needs, Priorities, and Evidence

Addressing the Needs of both sectors

Needing to Reconsider how Mental Health Services are Offered to Better Meet Needs of Service Users

Stakeholders from all groups reported a need to offer services in a more collaborative manner between the two sectors. They seem to agree that historically the needs of service users

were not being met. A Facilitator indicated that historically PH *staff did not feel comfortable supporting the families themselves, they would often refer out.* Additionally, unmet needs were thought to result in part because MH and PH sectors were mostly separate, *in the past they were working in silos; Mental Health focuses on mental health, Public Health focuses on the public health.* Taking it further, a number of stakeholders noted that although the two sectors did have a history of working together, they typically only interacted for single *one-off* instances. As one DM shared, *connecting was not strategic or systematic and it usually had an illness focus.* As one Facilitator cautioned, *it's not just about medication and seeing a psychiatrist, it's about good mental health.* A strong pattern noted across all stakeholder groups was the perception that MH is everybody's business and how MH needs were responded to needed to be reconsidered. Stakeholders also seemed to agree that how mental health is discussed needed to be reconsidered.

Reducing Stigma and Normalizing MH

To varying degrees, all stakeholder groups spoke about the need to reduce stigma and normalize MH while recognizing that it will take time to do so. Another common pattern noted was that the introduction of TF seemed to instill a sense of hope that things would change. As one DM hoped, *MH is not like diabetes where people rally around you and there's all kinds of resources. Mental Illness is so stigmatized. I just really hope that TF will create greater awareness in families everywhere.* Similarly, stakeholders equated increasing the frequency and variety of settings where MH related discussions occur with normalizing MH and in turn, reducing stigma. For example, one PHN reported that *if you bring MH up in all areas it becomes normalized.* As a HV candidly shared, *so, I mean, we're normalizing, normalizing, normalizing right?* One DM credited TF as playing a major role in normalizing MH and reducing stigma: *with TF raising awareness at every level, within the school system, within the workplace, you know*

just out in the community and in your home, MH will begin to become normalized. And it's my hope certainly that the stigma will eventually be minimized. Another HV shared that *TF opens the door for people to talk about mental health and that there is a difference, like everybody can benefit from coping skills and improved mental health and that doesn't necessarily mean that you have to have a diagnosis of mental illness to benefit.* These sentiments were echoed by FAM participants as well, the more MH was discussed, in various setting, and at various times, the more normalized participants found it to be. Below is a quote from a FAM stakeholder:

When I was younger mental health was always something that people, were like, oh you're crazy, so there was stigma there. But then when I got older, like in university, I guess maybe there was more education that was around or, things that people were talking about but like if you broke your leg you wouldn't say no to a cast or Tylenol. Right? So why are you saying no to taking anti-depressants, so that you can like you know, you can live life properly. And so that just, it kind of, it makes more sense and not like, ooh this is a scary thought, something that people don't want to talk about.

Establishing and growing the Project around Priorities of Both Sectors

TF dovetailed with the priorities of both sectors and this played an important role in facilitating stakeholder engagement with the project. Making sure that the project aligned with the philosophies and priorities of both sectors meant both sectors had something to *grab onto* and knew that the project was based on a solid foundation that would be meaningful to the work they do. One Facilitator who also happens to be a public health nurse noted that *Public Health practitioners are familiar with upstream work, it's always been part of Public Health so TF makes sense.* Another Facilitator reported that *health promotion is on PH staff radar, front and center, so mental health promotion was an easy sell.*

This view of mental health was in alignment with the 2012 release of the national and provincials MH strategies (The Mental Health Commission of Canada, 2012; Manitoba Government MH strategy 2012) that strongly advocated for the inclusion of MHP in MH service delivery. A number of stakeholders spoke about the timeliness of the introduction of TF in regard to the recent prioritization of mental health promotion nationally, provincially, and locally. A number of DMs mentioned that national, provincial and regional leaders were increasingly coming together to discuss mental health and indicated that this was evidence that movement is going in the right direction. From a DM: *for the last three years when the premiers from all of the provinces and territories met, MH's been on their agenda, and they have decided that what they really want to champion and promote is the area of promotion and prevention.* Despite the support for MHP, uncertainty was commonly noted from DMs: *they know that the best place to put their money is prevention, but they also have a lot of pressures on them because what do they take it away from? There's no new money.*

Having national, provincial and regional support for MH, MHP, and TF largely shaped processes related to CSCP in terms of having increased attention of policy makers and for increasing engagement. Being aware of research findings related to TF also shaped CSSP over the course of the project and will be further discussed in the next section.

Establishing and growing the Project based on Evidence

Bringing Together Different Levels of Knowledge and Action

DM, HV, PHN and Facilitator stakeholders spoke about the impact of evaluation shaping CSSP. Evidence resulting from the Families First program evaluation revealed that there was a gap in PH staff's capacity to respond to the MH needs of the families in the program. Becoming aware of this gap helped bring PH staff onboard with TF. As one Facilitator noted: *a lot of people*

already knew that MH support was an important thing that PH needed to provide to families because they had seen the research and it showed that there was a lack of MH support. A number of stakeholders shared that establishing TF on a foundation of international, national and local evidence really strengthened the project. Stakeholders mentioned an increased level of trust in TF knowing that it was based on both Corey Keyes (2002) model of mental health promotion, as well as on findings from a local level evaluation of the Families First Home Visiting Program. One DM shared from what I understand, Towards Flourishing is based on good evidence and research. Corey Keyes is well respected. A Facilitator also spoke about appreciating that the project was grounded in evidence, I like Corey Keyes understanding of the continuum. As one DM observes, TF brought academic knowledge and research rigour, paired with what some people would call “other worldly kinds of knowledge”. A PHN appreciated that I can say, you know, these are proven strategies, research based and it’s nice to have something that’s actually research based and you can back it up with something. So it’s tangible, something tangible to give families. Additionally, a HV liked going into a visit with all this information so that families don’t think that we’re giving it to them just off the top of our head. We’ve got proof, we’ve got research, it’s all legitimate. And I think it helps them when they see that there’s back up, there’s all this research done.

Having evaluative components built into TF from the beginning was appreciated by a number of stakeholders. As one DM stressed: *it is important to put something together that’s planned, with an evaluation component and someone overseeing it, to have that staged follow through. Another DM noted that we need to evaluate what we’re doing so that we know we’re investing in what works so. That’s a really good strength of TF. I mean it was an expectation but it’s also a good strength.*

Basing TF on an exposed need, national, provincial and local priorities, as well as existing and well-respected evidence seemed to lead to greater engagement, trust and appreciation of the potential for TF. Further, knowing that the project would be evaluated on an on-going basis increased the level of confidence stakeholders had related to offering TF. The second emergent process of encouraging meaningful and enduring engagement from both sectors is strongly linked to the process introduced here and will be discussed in the next section.

2. Encouraging Meaningful and Enduring Engagement from Both Sectors

Many stakeholders spoke about the importance of bringing the right people together, early on in the project, and making sure that people were kept informed over the course of the project. For the most part stakeholders reported appreciating the level of involvement they had with TF and that their inclusion in planning and development was sufficient and appropriate. As one DM shared: *it's all about partnering with people that have the right expertise; you don't have to own the whole thing. We just need to all come together.* Several challenges were highlighted that precluded stakeholders being engaged with the project as much as they would have liked and will be presented below.

Bringing Together the Right People at the Right Time

Bringing together a combination of people from Regional MH and PH programs as well as stakeholders from the university and government was seen as critical to moving TF forward. Specifically, a DM shared that one of the *strengths of the project was bringing together the Regional Health Authority, the University, and Healthy Child.* Another DM indicated that by having the University involved it opened opportunities to fund certain elements that the Regional Health Authorities would not be able to. *The RHAs are so separate in their funding, structures, and the way in which they interface that having additional partners outside helps to create the*

mechanism for being able to do things you couldn't otherwise do, like travel to meet as a group, the RHA won't sanction any overnight travel. As one Facilitator shared, because this was a research project each of the health authorities was given a pocket of money to fund the Facilitator role and the person in this role acted as the liaison between the MH and PH programs. As a caution, one DM stressed the importance of ensuring that all relevant partners from various departments of government be involved as this was important for moving the project forward. In their opinion the Public Health branch was not engaged, I think TF went from Healthy Child, to WRHA Public Health, and never really landed with Manitoba Health. Findings from the current study suggest that having outside funding facilitated the engagement of various groups that might otherwise not be able to be involved but the inclusivity of stakeholders could be given further consideration.

Numerous stakeholders spoke about valuing the bridge that TF built that connects the MH and PH sectors and will be discussed in more detail in process 3. From a DM, *I think TF has built the bridge that says, MH has a whole lot to offer to PH. While another DM saw linking the systems as a huge piece for getting people help and support when it's needed. One DM said probably the biggest strength of TF, from my perspective is increasing MH capacity and integration within the Public Health sector. It sounds very simplistic, and I don't want to oversimplify it but essentially what it means is that we are working together.* The frontline stakeholders spoke a lot about the importance of coming together, with the families' involvement, to work across the boundary between the two sectors. As one Facilitator shared, *through TF we even had the opportunity to have people sit around the table and say I'm providing this, I am providing that. We all met and had a consultation around the best resource, and the client was there as well.* An HV spoke about recognizing signs of MH concerns earlier because of their

involvement with the family. *If you think about it, we have a relationship with these families right from when baby's born, we've been in there every week and we see these families and they build up that relationship, that trust.* The nature of the CSSP work of TF created opportunities to improve the care families received and this was noted in a powerful quote from a FAM respondent who credited the discovery of her postpartum depression to the PH staff who had been trained in TF:

She (HV) kind of took care of me. Like she's the one that noticed my postpartum depression. She's the one who first caught it. I was just sitting here talking to her, and just burst into tears one day and she (pause) we couldn't figure out why like I just (pause) couldn't function and that was around (pause) my daughter was two months I think. Yeah but I was having symptoms of it before that, I guess I just didn't (pause) pick up on them. So she picked up on it right away when I was, I was telling her how I was feeling. She's just like you know I think you should go to the doctor, and I'll get (PHN) to phone you and, and, and then I went to my doctor and yeah I was diagnosed with postpartum. Oh (the PHN) is just great, yeah if, I don't know what, like what would of happened if it wasn't for her and, and (the HV) like I just was feeling so down.

As we can see from the example above, working together across sectors was thought to produce positive outcomes for families involved with TF.

Keeping Stakeholders Informed

As mentioned in the previous section, stakeholders indicated appreciation in knowing that the project would be evaluated as it evolved. However, DMs were in agreement that it is not simply enough to evaluate the project, but in order to feel fully engaged information must be fed back to

stakeholders in a timely fashion. Perceptions were mixed regarding to what extent stakeholders were kept informed in TF. Some DMs reported feeling like this was done well: *There was a meeting with stakeholders, for engaging stakeholders and getting input from many people I think really set the stage for success. It created buy in right from the beginning.* Another DM appreciated that the project team held information sessions along the way to keep people informed: *I think they've had two sessions with stakeholders for getting feedback. One was kind of an update on what's happened so far, and then it was really opened up to the group, so you felt involved and you had a voice. By bringing them together again it created further engagement.* Another DM shared similar feelings about appreciating being kept informed. *Well I remember receiving emails occasionally, the researchers and the leaders of the project came to speak to our MH management team, from around the province, to give updates. So it just keeps everybody engaged and that ongoing communication throughout the project has been a real strength.*

One DM cautioned that informing stakeholders on the underpinnings of the project was also important *the whole prevention promotion strategy is not really very well known. And I can pretty much guarantee that if I'm not very familiar with it what's the chances anyone else is.* A number of DMs spoke about wanting to know project outcomes as early as possible so they could make evidence informed decisions when deciding whether TF is worth keeping. As one DM shared, *without outcomes I don't have enough information to go on.* Another DM shared fears about *trying to show something, prove something, there's a lot of powers that exist within the system that need to align to, to sustain TF. I'm just not sure that everybody's looking at the same time to try to find a way to sustain, or to really understand what the impacts will be if it isn't sustained.* One DM noted, *I know how challenging it is, because for outcome data you, you need time, it's sometimes impossible to get that outcome data in a short period of time. But I mean we, if we*

think of budget cycles in the government and in Health Authorities, we need information at least a year ahead to make a case. I would just say it is a challenge. Regarding the style of reporting to DMs, one suggested that *really what you need is, you need to have somebody coming to a leadership table and speaking at, on the quick snapper end of it.* Another noted that the reports *need to be succinct, 1-2 pages max.* Being kept informed and having important data for decision support was strongly noted by the decision maker participant group. Other DMs reported feeling like the conversation started too late: *it feels like it's too late, I mean not that we won't find a way to sustain it but now we're scrambling at the last minute. As opposed to having had a strategy along the way that.* Another DM shared, *you know the research may be profound but it may be that by the time the research comes out and gets disseminated that the people are all gone because nobody was out there, looking for funds and making it happen.*

Challenges Impeding Engagement

Complexity stemming from having numerous stakeholders involved, with varying organizational structures, led to challenges related to engagement. The amalgamation of health regions in the province will be discussed in more detail later in this paper but is introduced here because it greatly impacted the extent to which stakeholders could become and remain involved with TF. One DM shared frustrations: *within a year, or less than a year, the merger of the two health regions was announced, as much as I continued to be involved in TF, it was not as directly involved because I had other things that kind of took priority.* A Facilitator spoke about how the amalgamation was a barrier to being involved with FF in the way she would have preferred, *they don't want me to come to the Families First co-coordinator meetings because they have this new merged region with the workers from the other side that don't have Towards Flourishing. So they don't want me coming because the information doesn't pertain to half their staff, right.* Moving

from 12 health regions down to five led to a remarkable disruption to the implementation of TF and will be discussed in greater detail in later sections.

Engagement with TF was shaped by many factors. Creating ways to bring a diverse group of stakeholders together was at times a challenge but was appreciated when it did occur. In the following section, we discuss how aligning with elements already in existence relates to the processes already presented and those that further contribute to shaping processes of CSSP.

3. Aligning with what Already Exists

The Reach of Families First Enhances Access to Towards Flourishing

Stakeholders from all groups mentioned believing that Families First was the ideal program in which to embed TF. As one DM stated: *this research project was strategic because of the reach that Families First has*. Similarly, another DM expanded on the reach of FF. *One of the reasons why the Families First visiting program is the ideal sort of initial contact is because Families First home visitors tend to be seen as very supportive providers who are connected throughout the system in a variety of ways*. A PHN further contributed to the notion of reach and access. *We have access to new moms right off the bat. TF has really helped us to bring something to families in Manitoba, early in a proactive way that hopefully will reduce MH illness*. A Facilitator shared that the access the FF staff *have to the families carries a lot of weight. The home visiting program is already in the home, FF staff already have a relationship with that family*.

Maximizing on Existing Relationships

Many stakeholders expressed that a relationship between PH and MH existed prior to the introduction of TF. From a PHN, *we have always had a connection with Mental Health 'cause we have always been referring clients as necessary*. However, two HV emphatically noticed that the

relationship between us and Mental Health has been a lot stronger and we've just had more of a connection and more of a working relationship between Mental Health and us and that's been really good. One DM mentioned that the integration between the programs has flourished.

Interestingly, the metaphor of a bridge was organically introduced by several stakeholders. One DM boldly stated that *I think it's (TF) probably the leading reason for better working relationships across Mental Health and Public Health.* Another DM, *I think it has been the bridge from all the things I can think of that we've done in the past, I think this would be the, the primary defining connection between Mental Health and Public Health so that's been great.* Similarly, another DM reminded us *I think it's built the bridge that says, Mental Health has a whole lot to offer.*

Integrating two components into one

Similar to what was mentioned above, numerous stakeholders indicated that the philosophical underpinnings of PH align well with those of MHP, which TF is based on. As one DM shared *TF fits in very nicely with what they're (PH) already doing.* Similar to PHN thoughts, *the everyday strategies go very nicely in the (FF) curriculum.* A HV shared that the expectations of TF align with their FF HV job description, *TF strengthens families, their ability to reach out for more help and it strengthens our relationship too and supporting that parent child relationship and that's our job description.* A number of HVs expressed feeling that certain elements were already something they do in their work, *our FF curriculum talks about post-partum depression and stuff so it's already kinda introduced.* The simplicity of the tools and how easy they are to use was mentioned by all stakeholder groups. A number of respondents mentioned using the tools in their personal lives, as well as in their professional lives. As one

Facilitator shared, *the materials are excellent that we have, I'm proud of our materials. Our tear offs and our workbooks and what not are excellent. So, that's a really good tool for them to have.*

Using Resources Already in Place

In the wake of wide spread fiscal constraints, many of DM spoke about the need for health regions to look at how to best use the resources they already have, in the event that new resources are not an option. One DM shared, *we're not always gonna get brand new resources and positions right? It's not like you can start a brand new parallel program with new staffing resources. So I think that what we've done here is looked at who are the right folks to do some of this work.* Another DM had similar insight; *TF can promote mental health and can be embedded in a delivery program that we already have that's reaching some very vulnerable families.*

It should be noted that in general, when asked, most respondents reported positive feelings toward TF however several important elements specifically related to CSSP were raised through a secondary analysis of the data and will be presented here because of the substantial contribution they make to deepen our understanding of CSSP. It is not meant to convey that the overall feelings toward TF were negative.

Feeling like a Dumping Ground

Feeling like the FF program was a “dumping ground” for any idea that someone wanted to test was a common theme heard from the PH staff. PH staff spoke candidly about their frustrations. One HV shared:

If they're gonna continue to pile on new programs, which are beneficial for the family, they need to do something for us. And it might sound conceited and rude, but if you're going to keep throwing us under the bus and giving us more and more and more and more stuff, and if we're gonna be taking on mental health and mental health trainings,

which we'll need to do to continue in mental health, then realistically we should be getting paid more. Move us over to "Prof Tech" instead of support. Prof Tech would be professional. Where we're considered entry level.

Another HV spoke about frustrations with their role constantly changing. *So there's a real lot of frustration about, what is my job, because we have a curriculum, the curriculum has changed.* Another HV expressed feeling overwhelmed and made a choice about when to include TF and when to focus on the original role she was hired for. *I find it the same thing overwhelming with all the new stuff, so I tend to just stick to what my goal was (laugh) which is the (FF) training, and I'll add the other stuff in if it's necessary but I don't worry about it.* Further, another HV spoke about how other programs have used FF as a program to trial new projects in the past. *They've added new pieces on however often they want. We've had other programs trialed with us, (laugh) this is another one.* Many HVs and some PHNs indicated that the work the HVs were expected to do exceeded their training and payment structure. This was an issue uncovered through the original evaluation; however, this perceived discrepancy in remuneration for work seemed to contribute greatly to shaping CSSP in TF.

Aligning with the findings about the existing reach of FF, relationship between sectors, simplicity of integrating the TF elements into the FF program and available resources was viewed by participants from all stakeholder groups as contributing to the success of TF. Taking this process further, aligning with several elements may make staff feel like their program is a dumping ground and requires preparing and supporting stakeholders involved in TF. This brings us to the fourth process that emerged from the current study, presented below.

4. Preparing and Supporting Stakeholders

Participants from all stakeholder groups spoke to the importance of preparing and supporting stakeholders when attempting to integrate new material into an existing program. Facilitator were described as having an understanding of both MH and PH by a number of stakeholders. As one PHN noted, *I think just having a Mental Health worker with the Towards Flourishing program makes a big difference because they understand Public Health and the role of the Families First. Whereas, the other Mental Health workers don't necessarily have the same understanding.*

Recognizing the Importance of being Well Trained

Facilitators reported feeling like the PH staff was well trained with the TF materials. From one Facilitator, *the training works really well, you know it introduces them really well to the strategy.* Several Facilitators reported that they themselves also received the FF training when they began working in their roles. *Somebody has decided to provide the FF training to the Mental Health Promotion Facilitators as well. And, of course I had to take the Towards Flourishing training as well right, to kind of understand exactly what the Families First workers are doing. It gives me a good understanding of what the Families First workers are doing and how well they're trained, which is extensive training.* Facilitator who were hired early on in the project spoke about not receiving any training when they came on board, but still feeling supported.

Despite Facilitator indicating perceptions that PH staff were well trained, not all PH staff reported feeling comfortable offering MH support to families. Similarly, one DM noted that when a more elaborate need was identified or when *anything started to look a little unusual* (PH staff) *just backed away from it really quickly.* Scope creep was commonly raised by many stakeholders. One PHN questioned *what's our role here, as a nurse, as a counselor, as a social worker and you*

know nursing has all kinds of components but some people feel more comfortable I think dealing with mental health issues than others. Another PHN shared similar concerns, it sort identifies the difference between maybe our background in training as a nurse. I'd feel very uncomfortable about discussing something that happened 15 years ago if it doesn't seem relevant to today's situation. However, I don't have a counseling, you know social work background or training. So I think that there's that big discrepancy there, and I find the mental health component of our roles challenging. One HV staff spoke candidly about guarding the scope of her position and not letting it creep too much, so it's really shifting the entire visits. Our whole focus is more on Positive Mental Health, more on counseling. So it's helpful to have, the TF Facilitator in the community so I can say "alright here it is, these are yours now, you deal with it" cause that's where our job kind of ends right. Another HV shared similar feelings about wanting the Facilitator to handle MH cases when they reach a certain level of need, I might not be relating to the Mental Health worker on the intake, whereas if it comes from another Mental Health worker I think they have better training and understanding in that area to make a referral to a psychiatrist.

Interestingly, the Facilitator often took an opposite position -- many of them commented on the improvements they saw among PH staff's comfort level in discussing MH concerns. *Well I think it's made them more comfortable at (pause) using mental health tools for themselves, rather than just thinking that they need to give it to the Mental Health system professionals. So they've been more comfortable in discussing mental health issues with their clients and offering tools to them, and maybe more comfortable in accessing services as well.*

Valuing the Role of the Facilitator

At the time that data collection was taking place for the original study it was unknown whether TF would continue after the research project was over and a number of PH staff reported being nervous about providing MH support to families if they lost the support of the Facilitator. From one HV, *I would definitely want to have the Mental Health Facilitator because they do bring up a lot of issues. If not then I would still like to have the Mental Health Facilitator for our own use.* From another HV, *there has been rumour that we might be losing our TF Promotion Facilitators, and then what do you want me to do with all this information. Then I have nowhere to go with it.* The possibility of losing the Facilitator was discussed by DMs as well. One DM shared *that coordinator piece is really important, I mean if you don't have that support I think it would be really hard, you really need folks that are going to support the work. You really need that coordinator piece to keep it sustained.*

Gaining a Better Understanding of the Other Sector

Stakeholders spoke about the benefit of CSSP for enhancing each sector's understanding of what the other sector does. A Facilitator spoke about the different sectors supporting one another and bringing different perspectives that can really enhance care to families: *I think it provides an opportunity. I think I can provide perspective that's outside of their practice, and I think that that can be an asset 'cause a nurse thinks like a case manager and the home visitor thinks like the home visitor and I think like a Mental Health Promotion Facilitator and a clinician, so the three heads right. So I can support the home visitor around incorporating some of the mental health promotion into their work.* A DM from Public Health shared that they *really think it's helped to complement our (PH) work.* A PHN spoke about learning a lot about MH, *but the other side of it I think that Mental Health has probably gotten a better understanding of what*

Families First and Public Health does. A DM from PH hopes Mental Health has learned something more about Public Health work. So that way when you talk about collaboration right, those are, the key elements and collaboration is mutually beneficial to both parties. Right, and I think it's a win-win for, for Manitobans

When a need is identified the question becomes where to house the solution to the problem. In the case of TF, determining where to house the project was a decision made based on the extensive reach the existing FF program had across the province. A number of elements shaped CSSP in positive and negative ways including financial constraints, maximizing on existing relationship, being prepared and supported, feeling like the FF project was a dumping ground, and getting a better understanding of what the other sector does. In the following section, these issues will be further unpacked as they relate to challenging contextual landscapes between the two sectors where TF was housed.

5. Adapting to Challenging Contextual Landscapes (Social, Historical, Political) of Both Sectors

Making an Economic Business Case for TF

As one DM shared mental health is a huge, huge issue today. We're not ever gonna have enough inpatient beds and enough psychiatrists and psychologists. It's huge. So I think we need to refocus the system if there's no new money. It would be very hard to get new monies so how do we re-shift some of the funding. DMs weighed in on the perceived economic benefit of embedding TF into the FF program, primarily the economic discussion centered on TF being a promotion and prevention project. As mentioned above, there is strong support for MHP both nationally and locally however DMs shared that it can still be challenging to secure funding for upstream projects. As one DM noted, taking a promotion and prevention approach to MH was critical because the treatment approach cannot keep up to the demand. You know it's, it can't be

about treatment wholly, we don't have enough clinicians, even close to use a treatment model. Another DM noted that it's really beneficial to Manitobans that we have something like TF here. To help with some of those things so they don't go into a downward spiral. I'm thinking if you can get somebody upstream, it's gonna cost a lot less than if they're on medications and drugs for stress and anxiety and whatever else right? Similarly, one DM spoke about the pressure of having no new money sources so do you stop doing knee surgeries, do you reduce the number of laser eye surgeries? But yeah it's still a case worth making for sure. Because the MH services are offered primarily by the HV, who are supported by the Facilitator, DMs reported perceptions that TF was not a resource intensive model. From one DM, it has not been hugely expensive because it's building on an existing workforce that's out there. There's some cost, but when you think of the, the breadth of impact that role could have overall in each Regional Health Authority, it's money well spent I would say. Another DM noted that TF has taught people that you don't have to go off and get your clinical psychology degree in order to make a huge difference in the lives of parents and children. Additionally, by embedding it into an existing program you're not needing a new system, you're leveraging and integrating it into the existing system.

Resource Challenges (Part-Time Staff, Turnover and Inadequate Remuneration) Shaping Engagement

Facilitators work at the boundary between the two sectors and all Facilitators interviewed spoke about wanting to have more time to connect with the PH staff but they were either in part time positions or they had large geographical regions to cover. Participants from all stakeholder groups noted that meeting with the other sector and building trust was seen as critical. One Facilitator reported that meeting was *perhaps the most important element of making sure the arrangement was leading to better service provision. As one Facilitator shared, I can't keep up with the going out and spending that much time with the teams. But I feel like it's really*

important, and it probably is one of the things that's vital to the, to the buy in. Further, one Facilitator worried that if she was unable to meet with the PH staff regularly that they would just forget about her *that to me has been the hardest thing because people will just forget about you and write you off.* Another Facilitator noticed that she could not fully support the PH staff and as a result there was *some confusion around the value of TF and Positive Mental Health.* It was not just the Facilitator who worked part-time. A number of the PH staff also had reduced work hours or conflicting schedules. As one Facilitator shared, *scheduling time to meet can be a challenge,* and this is particularly troubling given the critical nature of *responding in a timely fashion when PPD is a possibility.* *One works Monday, Tuesday, Wednesday, one works Thursdays and Tuesdays. You're not gonna wait like a month for something like that.* PHNs and HVs echoed the frustrations related to scheduling, *that's been a frustrating piece trying to get everybody to come together to sit down at those meetings.*

Another area for consideration for CSSP arrangements is that sufficient person power is necessary to making sure the scope of the project can be fully realized. One HV spoke about having to do FF work at home after hours because now that TF was added, *I just don't think we have enough manpower to kind of fully maximize our current roles right. Because there's a lot that we need to do and I want to do all of it but I find that I'm taking work home.* A Facilitator shared similar feelings, *as much as I'd like to, I'm up for a good challenge, and but it's tiring, like sometimes I'm exhausted.* A Facilitator spoke about the growing interest in TF and having had more sites added, which led to being spread even more thinly across a large region, *so as the project went on, more and more teams joined, right, and I have six sites. I started out at two teams and then three, then four, then six right.* Another Facilitator stated that with the addition of

new staff, *it's really hard to keep people trained and if they're not trained of course then they're not implementing the strategy.*

According to several stakeholders, discussions have occurred in the past about remuneration for the work the HVs do not matching the pay they receive. Unfortunately, according to one DM and one Facilitator, this *discrepancy between responsibility and pay has led to significant turnover of HVs in the past.* As many stakeholders noted, turnover can create a number of challenges to TF. As one DM shared, *I think we've seen some limitations with the Families First program; it's my understanding that the workers especially probably in the North, that their wages are maybe not as high as what they could be, or in comparison to other paraprofessional kind of staff so they've had a hard time keeping the Families First home visitors.* One DM spoke about the high learning curve of the HV training and that a lot of time and effort goes into preparing them for their role. The DM questioned whether it was a good use of resources to train individuals if they are not going to stay in their positions long. *I know that there's a lot of information to learn, and it's a high learning curve I think for new Family First visitors. You're providing training to people and if they're not going to stay in their positions for a period of time, then the turnover is a challenge.*

Amalgamation Wreaking Havoc

Regional boundaries in Manitoba have been shifting over the last decade with a major amalgamation of health regions happening just after TF was rolled out across the province (Healthy Child Manitoba, n.d.). The number of regions decreased from 11 to 5 and both departments and positions were shuffled in the process. This shift greatly shaped processes of the CSSP of TF. Most stakeholders mentioned that amalgamation greatly impacted their work in one way or another, at various points and in relation to various aspects of TF. As one DM noted, *the*

merger definitely affected things because it was a real shake up within in the system. As one PHN stated, these regions are so humungous now, it was big enough before we merged, but now it's kind of ridiculous. Similar to the struggles experienced in relation to being part time, following the merger of health regions Facilitator and PH staff now cover large geographical areas to get their work done. As one Facilitator shared, working in the rural area it's pretty hard to get to every site, if not impossible. Like my (base) office is about a three hour drive to the furthest site. Because of the large geography of the province, many stakeholders report being creative and using technology to try to connect. From one Facilitator, I've had to be creative in terms of staff meetings and I'll do phone consults sometimes and it's worked pretty good for the most part. If there was more of me in different areas that would help.

Following the merger, and the way that the regional boundaries were reconfigured, TF now has a site in every region. Many stakeholders noticed that once the merger happened there were changes in how TF was prioritized. A DM of a newly amalgamated region found that *Towards Flourishing got really pushed to the back burners for them because all of sudden they had regions that were twice as big or they lost their job. Another DM echoed similar thoughts, within a year the merger of the two health regions was announced so, I was not as directly involved because there were other things that I kind of had to be involved with. Other stakeholders noted increased expectation in areas that had not previously had TF in their region, but now did. They reported people wanting the service offered to their families as well. One DM shared, so now we've got this expectation I mean already we've got people on the east side of our region who want TF. So how are we gonna deliver this. Following the merger, a Facilitator noted that in her region directors from both Public Health and Mental Health become operationalized in such a way that they were now both in charge of Towards Flourishing. So I had to engage new*

people. And then of course they're all just learning their role and Towards Flourishing is just one small piece of lots of other pieces so it gets pushed aside.

Opening up a Can of Worms

Stakeholders from each group noted that a major barrier impacting CSSP was not having sufficient resources to refer families to once a treatment need was identified. PH staff were very clear that they saw the value of doing the prevention and promotion work with families but many noted frustrations when facing long wait lists or nowhere to send families in need. As one PHN noted, *I think what this process has made us become aware of is the long waiting list. We can't get them in when they need to. The lack of service has come out to be a strong barrier.* Another PHN noted that the client will finally get the motivation to reach out for help but because of the long wait times they lose that courage. *So you'll finally get the client to the point where they have the courage to make the call, and then they'll be told to phone back. So by that time they'll sometimes have lost their courage or whatever to even wanna talk to that person. And yes it might not be that they're suicidal and it's a crisis, but I thought we were also supposed to prevent it from getting that bad.* Similarly, an HV questioned *what are we supposed to do in the meantime right. There's a two year wait, we have these Towards Flourishing strategies, yes, but I find that Towards Flourishing is for higher functioning individuals that have some understanding of stress management, but what do we do for those two years where you've gone through the strategies, the strategies are not helping.* One Facilitator spoke about the lack of resources seeming to be novel to PH but was an issue that MH staff was very familiar with, especially in rural areas where readily available resources are scarce. *That's rural Mental Health in general right. I mean we've always had those challenges. You try and hook people up with the resources and sometimes they're just not there. Families First workers sometimes, feels like*

they're alone right because they are sometimes the number one to that family. It should be noted that many stakeholders indicated that having the Facilitator on their team helped at times to fast track or streamline referrals to other parts of the system. However, most PH staff indicated that the lack of referral sources and long wait times were a major challenge.

Contextual changes were a constant over the duration of the project. Some changes, such as the introduction of the national strategic priorities for MH supported TF. On the contrary, the limited funding currently allocated to MH presented numerous challenges. In light of the shifting landscapes stakeholders spoke about TF making economic sense but continuously needing to navigate the cross sector work when part time positions, turnover, low wages, changing geographical boundaries and limited resources were a factor. In the following section the findings from the current study will be discussed in relation to their contribution to the field of CSSP

Discussion

Contributions to Cross Sector Service Provision

As mentioned above, the umbrella review conducted by Winters et al. (2016) found that theoretical underpinnings of CSSP were largely absent from the existing literature. In response to this finding, the current study put forth an theoretical representation of the processes involved in cross sector service provision with the intent of moving the field of study forward. The emergent grounded theory was constructed based on the data themselves and was not intentionally influenced by existing theoretical concepts. However, it is important to note that many existing theoretical and conceptual bodies of literature may be helpful in further fleshing out the grounded theory of CSSP presented in this dissertation. Once the grounded theory had been fully constructed from the original study data I then compared it with existing literature related to specific components of the emerged grounded theory. In this section I discuss both the

contributions of this work to the field of CSSP as well as provide a commentary on how concepts from the extant literature align with, challenge, or extend the presented theory of CSSP to further advance our understanding of CSSP.

Contributions to Policy/Strategic Governance

Based on the findings from the current study, placing the onus for CSSP solely on the individual providers would not be fruitful given that many factors that shape CSSP are located outside the control of the individual. For CSSP to be offered effectively in complex systems Micro, Meso and Macro factors must be considered. Focusing solely on individual factors and disregarding the organizational and political influence on CSSP would be problematic. For example, there was no way to predict the impact that the amalgamation¹² of health regions would have on all levels of the healthcare system and on the sectors involved with TF specifically. The impact was seen at Macro, Meso and Micro levels.

Another governance level element that was identified through the current study and viewed as positively impacting CSSP of TF was the recent release of national, provincial and local strategies that called for working more effectively across sectors and advocated for adoption of a mental health promotion approach to service delivery (The Mental Health Commission of Canada, 2012; Province of Manitoba, 2012). Interestingly, there seems to be a reciprocal relationship between policy and TF. The introduction of national and local policies that spoke to the importance of MHP and integrated care supported the roll-out of TF and led to further buy in by stakeholders at all levels. In turn, TF supported the uptake of the implementation of policies

¹² The reduction of the number of health authorities in Manitoba from eleven to five.

related to mental health promotion and integrated care (cross sector service provision) because TF provided a real world method for moving policy from simply being a document on a shelf, into action where MHP became a regular part of practice. The findings from the current study suggest that we cannot ignore the reciprocal impact that policies have at all levels (Macro, Meso and Micro) of service provision. Aligning policy with a project similar to TF could facilitate the implementation of policies of this nature in other areas. In turn, research findings related to the CSSP of TF can inform how policies could be improved to better align with the context in which they will be implemented.

Contributions to and from Education and Practice Literature

Findings from the emergent theory have implications for post licensure education and training initiatives in general. Based on stakeholder responses it appears that TF played an important role in changing the way PH staff regard mental health. Stakeholders reported moving away from viewing mental health and mental illness as the same thing, to taking a more positive view where mental health, like physical health, is something that everyone can improve. Most importantly, the findings suggest that incorporating TF into FF drew attention to the possibility for PH staff to help reduce stigma and normalize MH. In turn many stakeholders mentioned feeling like TF assisted PH staff to better meeting the needs of families in the FF program. Implementing a project similar to TF may lead to similar results elsewhere.

Communities of Practice

Etienne Wenger (1997) discusses the concept of boundary as it relates to practice communities extensively in his book *Communities of Practice: Learning, Meaning and Identity*. Two components of his theory about negotiating boundaries - boundary objects and brokering - may align closely with the theory of CSSP presented in this study. He defines *boundary objects*

as artifacts, documents, terms, concepts, and other forms of reification around which communities of practice can organize their interconnections; and *brokering* as connections provided by people who can introduce elements of one practice into another (1997, p. 105). In the case of TF, a change to service provision was sparked, in part, by the identification of a gap in MH services for FF families experiencing MH concerns. TF Providers spoke about recognizing the need for practice change prior to the introduction of TF but were immersed in responding to multiple, complex and simultaneous demands that they reported feeling they did not, at that time, have the skills to respond to MH concerns. TF intended to increase capacity of PH staff's ability to respond to MH needs of the families they worked with and it appears that the ease of use of the TF tools and simplified concepts were key elements that led the participants to incorporate TF into their work. In this sense, the TF materials could be viewed as boundary objects discussed by Wenger (1997), in that PH staff readily took up the TF materials and used them to bring the PH and MH sectors closer together. Interestingly, stakeholders from various levels, and from all participant groups reported finding TF elements to be meaningful to their professional and personal lives.

In the umbrella review conducted by Winters et al. (2016) a key theme was related to the importance of having someone in a coordinating or boundary spanner role as contributing to the effectiveness of CSSP. Similarly, this boundary spanner role aligns with Wenger's (1997) view of *brokering* as described above. The Facilitator, who held a boundary spanner or brokering role, seemed to contribute favorably to supporting PH staff in embracing their role of supporting families experiencing mental health concerns. Further, the concept of MHP is not always viewed as an easy concept to digest because it runs in contrast to the way MH has been viewed for decades (Davis, 2006). Given the complexity and relative novelty of the concept of MHP, having

the TF Facilitator available was reported as critical to supporting PH staff as they journeyed toward changing their practice in a fairly drastic way. Stakeholders from all participant groups strongly credited the uptake of TF by PH staff to both the ease of use of the TF elements as well as the supportive role of the Facilitator. These findings suggest that although not specifically named in TF, boundary objects and brokering may be essential elements of CSSP. The concepts of boundary objects and brokering could be further explored in relation to the findings of this study to further unpack CSSP in terms of contributions to bringing PH staff to a point where they feel prepared and supported to do the mental health promotion work of Towards Flourishing.

Reflective Practice

Stakeholders from all participant groups reported believing that some PH staff still felt uncomfortable responding to the mental health needs of families in the FF program. This echoes the findings from Winters et al. (2015) in that a number of providers from sectors outside of the mental health sector reported feeling like dealing with mental health concerns was both outside of their job description and something they did not feel comfortable dealing with (Broadbent, et al., 2002; Clarke et al., 2006; Fry et al., 2002). PH staff themselves spoke about a strong desire to have the Facilitator work directly with families who's mental health needs were out of the realm of what they thought they could handle. They indicated that certain client needs required skills that fell outside of their scope of practice. Facilitators on the other hand often spoke of their role as being a consultant or support to the PH staff and that their main priority was to increase PH staff's capacity to work directly with individuals experiencing a MH concern.

The desire to have clients work directly with the Facilitator may have stemmed from discomfort working in what Schön (1987, p. 42) refers to as the “swampy lowlands” or indeterminate zones of practice (Kinsella, 2007; Schön, 1987). It is here where situations in

practice seem messy or unclear (Kinsella, Caty, - Ng, & Jenkins, 2012). Schön contrasts the high hard ground of practice, where technical skills can be readily applied, with the swampy lowlands where situations are confusing, messy and technical skills are more challenging to apply. It is in the swampy lowlands where trial and error, intuition, and muddling through are often the approaches used. Schön goes on to discuss how technical skills are often harder to apply successfully when problems are complex and less clearly defined. In the current theory of CSSP, HVs and PHNs both spoke about concerns that they did not have the skills to work with individuals whose needs reached a certain level and strongly voiced their desire to change TF so that the Facilitator could meet directly with the clients. This is evident from the quote shared by an HV in regard to a service user whose needs exceeded what the HV indicated she could respond to: *alright here it is, these are yours now, you deal with it*. Facilitators and PH staff reported that clinical supervision already occurred but exploring what exactly the clinical supervision entailed was outside of the scope of this study. Regardless, given that a number of PH regularly spoke about the uncertainty of their new roles, incorporating elements of reflective practice into CSSP arrangements could perhaps aide staff from the different sectors in navigating the uncertainty they may experience and help to improve their clinical skills, similar to what Kinsella et al Caty, Ng, and Jenkins (2012) discussed. Future research could explore the fit between reflective practice and CSSP, especially when the arrangement requires a major, but necessary, shift to standard practice.

Contributions to and from Research Literature

Above we discussed how Communities of Practice and Reflective Practice might contribute to further advancing our understanding of CSSP, and below we will discuss how an existing research concept appears to be related to the emerging theory of CSSP.

Integrated Knowledge Translation

Several elements of the emergent theory align with Integrated Knowledge Translation literature (IKT). IKT is suggested as a method to address the underutilization of research findings (Kothari & Wathen, 2013) and calls for involvement of knowledge users to contribute to “shaping of the research questions, deciding the methodology, involvement in the data collection and tools development, interpreting the findings and helping disseminating the research results” (Graham & Tetroe, 2009, p. 48). Gagliardi, Berta, Kothari, Boyko, and Urquhart (2016) present a number of positive outcomes related to IKT including: increasing the value of research by decision makers, enhancing the relevance of the research, influencing service delivery and strengthening relationships, trust and goodwill among stakeholders. The original TF study purposefully involved stakeholders from all levels over the course of the project.

One substantial contribution from the current study is that stakeholder groups indicated that strategic and inclusive involvement during all phases of the project (planning, implementation and sustainment) encouraged meaningful and enduring engagement from the various sectors. As Kothari and Wathen (2013) indicate, traditionally KT was done through end of grant presentations and publication but integrated KT calls for the collaborative involvement of stakeholders. Involving stakeholders early, meaningfully and keeping them informed over the duration of the project were identified by stakeholders as contributing factors that shaped CSSP in TF. Bringing together people from regional Mental Health and Public Health programs as well as provincial government representatives from both sectors was reported as important. Additionally, many of stakeholders mentioned that the involvement of the university researchers was critical for ensuring effective CSSP of TF generally because of the depth and rigour the research brought to the project, and practically for things like being able to fund the cost of travel,

allowing decision makers to attend meetings related to TF planning, something not covered by their home organizations. Stakeholders shared that the stakeholder input gathering sessions held by the original researchers made them feel like they were part of the project and that their voice and input were valued. Moreover, respondents shared that they had a greater level of confidence in the project overall because they knew it was based on a previously identified need, but in addition, would be evaluated on an on-going basis as the project progressed. Stakeholders commented on their appreciation of the initial evaluation of FF that exposed the need for further MH support in the FF program, as well as the subsequent robust evaluation that explored the effectiveness of TF once implementation had begun. The original project researchers sought involvement from the front-line level all the way up to the Ministry level and this approach seemed to be recognized and valued by many of the individuals who participated in the interviews and focus groups.

IKT concepts were intentionally applied to the original study design and it appears from stakeholders that both receiving and contributing to knowledge related to TF also contributed to the effectiveness of CSSP of TF. Future research could explore more fully how the elements of IKT align with findings from the grounded theory presented in the current study. Similarly, developers of future CSSP arrangements might also purposively include elements of IKT given that it appeared to greatly shape CSSP in the TF project. Commonly projects end when the research funding period ends but by being proactive and engaging stakeholders at the appropriate time, vanishing of projects and relationships can be avoided. In the case of TF, the project transformed into a regular part of service delivery after the research study period had come to an end.

Contributions to and from Organizational Literature

Change Management Theory

The grounded theory that emerged from a secondary analysis of the TF data aligns closely with many models in the change management (CM) literature. This is understandable considering TF required a significant change to the way supports were offered to individuals with MH concerns in the FF program. Two of the CM models that closely align with the emergent theory of CSSP are from Hiatt, (2006) and Kotter, (2007). Findings from Hiatt's (2006) model of change include: Raising awareness of the need to change, supporting and participating in the change, having knowledge of how to change, having the ability to implement required skills and behaviours, and finally, sustaining the change. Kotter's model of change includes: establishing a sense of urgency, creating a guiding coalition, developing a vision or a strategy, communicating a change vision, empowering broad-based action, generating short term wins, consolidating gains and producing more change, and finally, anchoring new approaches in the culture. The similarities between the CM literature and our theory of CSSP are quite apparent but a novel contribution of the current study is that elements at the Meso and Macro levels were also taken into consideration. The above CM models focused only on Micro or individual level factors. For example, on the first page of Hiatt (2006) the author states, "Successful change, at its core is rooted in something much simpler: How to facilitate change with one person". We caution about a sole reliance on CM literature to inform the development of a novel CSSP arrangement considering that the focus is primarily on the individual (Micro) level of analysis. Current CM literature falls short of considering the extent to which Meso (organizational) and Macro (policy, strategic governance) level factors shape change. Regardless, a number of elements from CM literature may prove helpful in further fleshing out a theory of CSSP.

Practice Implications

Although not the original intent of the current study it is important to note a novel contribution of the current study. Through constructing the theory we began to shed light on the benefit and positive outcomes related to CSSP, which was largely absent in the existing literature (Winters, et al., 2016). Most importantly, it appears that the CSSP arrangement of TF led to a perceived view of improved quality of services by the family stakeholder group, but also from respondents in all other participant groups. The existing literature stresses that failing to work in a coordinated way across sectors could result in dire consequences for service users (Glasby & Dickinson, 2008; Kodner & Spreeuwenberg, 2002). From the concepts uncovered in the current study we can see that family stakeholder groups noted that the care they received may have potentially avoided a serious medical concern. Stakeholders particularly valued PH staff identifying potential postpartum depression earlier than may have otherwise occurred.

The introduction of TF materials was a welcomed addition to the FF program. Many stakeholders spoke positively about the easy to use tools and elements that were not only relevant to the work PH does with families, but also to their personal lives (whether they were high level DMs to recently hired HVs). For the most part, the introduction of the strategy to enhance the capacity of PH staff in meeting the MH needs of families was also welcomed. However, a number of PH staff expressed concern that this change was taking away from the work they were initially hired to do, support healthy child development, not work as Mental Health counsellors. Additionally, a number of PH staff reported uncertainty related to responding to MH need, even late into the implementation of TF. The role of the Facilitator greatly aided PH staff in being open to taking on this additional role and supports were put in place to ease the transition. Further, many PH service providers reported being fearful of losing the Facilitator role once the project

was over with. Many participants spoke candidly about choosing not to bring up TF with families on their caseload if they lost the Facilitator support. These important contributions related to CSSP could be helpful to future project and program planners in that they speak to the need to thoroughly consider the impact that a major change to service provision might have on the service providers. As was mentioned in the existing literature (Butler et al., 2011; Fleury, 2006; Green et al., 2014; Kodner & Spreeuwenberg, 2002; Lee et al., 2013; Soto et al., 2004; Winters, et al., 2016) and similarly the case in TF, supports such as a boundary spanner role can ease the transition into CSSP.

Scholars are divided on whether it is better to embed CSSP initiatives into existing programs or to create novel arrangements (Fleury, 2006; Grenfell et al., 2013; Lee et al., 2013; Winters, et al., 2016) however it was clear from the stakeholders in the current study that embedding TF into the FF was the ideal arrangement. The decision of where to house the project was facilitated by findings from the FF evaluation but determining the exact arrangement for how the project would be supported by both sectors involved considerable deliberations. These findings can help program planners determine where to best house future CSSP arrangements.

Policy/Strategic Governance Implications

Ensuring that sufficient resources are in place to accommodate and support the project was mentioned by all stakeholder groups as being important for facilitating the implementation and sustainment of TF. These findings are similar to existing research (Sloper, 2004; Winters et al., 2016). In the case of TF, each region was provided with a pocket of money that was sanctioned for the project but many DMs indicated that *when it runs out it runs out*. Many DMs began looking at sustaining TF early on, while others reported waiting until it was almost too late. All sectors involved in CSSP arrangements should be prepared to put resources and supports toward

maintaining the project once the research period is over, or risk losing any gains that were made during the research or pilot phase.

A novel contribution from the current study relates to the consideration of Macro level factors such as the amalgamation of health regions in the province. This strategic governance level change greatly impacted the ability of individuals to work across sectors. Flexibility was needed from individuals to be able to respond to an ever-changing political environment but it was impossible for them to predict the amalgamation of health regions or the impact it would have on TF. Anticipating major political disruptions should not be placed solely on the individual. These findings are relevant to decision makers contemplating the introduction of future cross sector service provision arrangements. Regions could be proactive with creating contingency measures. Furthermore, findings from this study could inform political level decision makers. When contemplating a major governance change, disruptions to service provision need to be adequately considered and not merely taken for granted as an unavoidable outcome.

Future Research Implications

Stigma

Stigma was a strong theme that extended through each of the five processes presented above. As Link, Yang, Phelan, and Collins (2004) state, society can no longer afford to view mental health as separate from and unequal to general health and argue for the need to address stigma associated with this sector. However, funding for MH remains significantly lower than that of other areas of the general health system (Mental Health Commission of Canada, 2015; World Health Organization, 2003). In addition, stigma has been said to be a strong contributing factor for the under treatment of mental health concerns (Corrigan, 2004; Mann & Himelein, 2004; Sartorius, 2007). A number of the stakeholders in the current study spoke about their desire

to reduce stigma, whether it be through discussing MH in all parts of their practice, or by attempting to normalize mental health by shifting the focus to being mentally healthy, as opposed to being strictly free from mental illness.

Existing research has minimally begun to look at how stigma toward service users can extend to the service providers working with stigmatized groups (Gaebel et al., 2015; Persaud, 2000; Sartorius et al., 2010). This small, emerging body of literature has almost exclusively focused on psychiatrists and indicate that negative views about psychiatry and psychiatrists are common among the members of other medical professions (Gaebel et al., 2015). Although researchers have argued that taking this view of stigma detracts from the real issue of stigma faced by MH service users, Gaebel et al. (2015) stress that not addressing the stigmatization of Mental Health professionals may increase the rate of those leaving the profession. There appears to be an absence of literature exploring stigma experienced by other MH professions. It is hard to say whether this desire to have the Facilitator work directly with clients and the persistent hesitancy of some PH staff to address MH concerns directly with the client is related to the extension of the stigma experienced by individuals experiencing a mental health concern, but this could be further explored in future research. Future research could explore how stigma experienced by clients accessing mental health services in turn extends to the staff who are working in helping positions.

Strengths and Limitations

The intent of this work was to produce a situated constructivist grounded theory that advances our understanding of cross sector service provision. For that reason, the emergent theory should be viewed as a rendering that is situated in the time and context in which it was created. Mental health is a growing concern in Canada, and in Manitoba specifically where the

rate of people who seek help for MH concerns is higher than the national average (The Mental Health Commission of Canada, 2012; Province of Manitoba, 2015). Existing literature points to the need for sectors to work together to better meet the MH needs of service users but up until now, very little literature was available indicating *how* this cross sector work was done (Winters et al., 2015). The current study points to a number of contributions to policy practice and research. There are, however, two limitations of the current theory. One is that due to recruitment challenges there were more decision makers from the Mental Health sector (6 from Mental Health /1 from Public Health) represented in the secondary data and it is hard to say to what extent hearing from additional DMs from the PH sector would have changed the outcome of the current study. Two, the original study evaluated a novel CSSP arrangement and for that reason the current grounded theory was shaped substantially by the concept of change. It is possible that an emergent theory constructed from a CSSP arrangement that has been in operation for a longer time period would be different. Future research should continue exploring both novel and long-standing CSSP arrangements.

Conclusion

The call to provide more effective services is strong and improving coordination of care is often suggested to be the solution to fixing the fragmented health and social care system (Kernaghan, 1993). However, it appeared to be taken for granted that we had a shared understanding of *how* to do this cross sector work. An evaluation of the Families First Home Visiting program revealed a gap in supports for families experiencing mental health concerns. Through a partnership with the University of Manitoba, Winnipeg Regional Health Authority and Healthy Child Manitoba the Towards Flourishing Mental Health Promotion Strategy was developed in response to this finding. The current study used secondary data from the TF study to

explore cross sector service provision and advance our understanding of the processes involved in providing care in a coordinated or joint manner. What resulted was a situated constructed account of the data through the interpretation of the current authors. The findings from this inquiry may be used to inform practice, policy/strategic governance, and research projects aimed at exploring cross sector service provision.

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Chapter Five: Concluding Thoughts

This chapter concludes my dissertation project which explores processes that shape cross sector service provision in health and social care. Each chapter of the dissertation is intended to stand alone but the ordering of the chapters was intentional. The chapters are presented to show the chronology of the research process, culminating with the generation of a situated grounded theory that begins to shed light on the processes involved in shaping cross sector service provision in the Towards Flourishing Mental Health Promotion Strategy. In the current chapter I will provide an overview of the thesis layout. I will then discuss the quality criteria used to evaluate qualitative research in general and Constructivist Grounded Theory specifically, as it relates to the current study. I include reflections on my experience of engaging in the research process. Next, I will discuss the goodness of fit between secondary analysis and grounded theory. Following that, I will discuss criteria for assessing grounded theory methodology specifically.

Overview of the Research Process and Dissertation Layout

Chapter one introduced the reader to the concepts of Cross Sector Service Provision. I also situate myself as the researcher, and the present the purpose of the current study. Chapters two and three were systematic reviews initially undertaken to get a better understanding of what the literature reports about cross sector service provision. Chapter two consisted of a published scoping review that explored mental health crisis response systems and informed the early development of the current study. Chapter three consisted of a published umbrella review that explored the plethora of literature related to CSSP by taking a higher level vantage point where existing systematic reviews were reviewed to provide a comprehensive overview of available literature. Chapter four consisted of an overview chapter of a secondary analysis utilising

constructivist grounded theory methods whereby the aim was to generate a grounded theory of the processes involved in CSSP. In the current chapter I will discuss considerations of quality criteria employed in the study and the goodness of fit between methodologies (Constructivist Grounded Theory and Secondary Analysis).

Quality Criteria for this Research

When evaluating the quality of the current study, the appropriate criteria are set out under the constructivist grounded theory methodology, and not measured against criteria fitting to other forms of research (Finlay & Ballinger, 2006). I engaged in reflective journaling at various stages during the research process. In an effort to remain transparent about decision-making and interpretation along the way, detailed notes were kept regarding the process of the research, my reflections and ultimate transformation as a researcher. In chapter one I share my story of how I came to this research topic and consider it to be the culmination of a number of professional and personal events that have occurred over the past decade. My story was presented as a way of situating myself within the research process so that readers could begin to understand how I view the world and how my beliefs and past experiences may have shaped interpretations (Charmaz, 2014; Crotty, 1998; DePoy, 2016; Finlay & Ballinger, 2006). In the following section I will further reflect on my process throughout this experience.

Reflections were recorded through two main forms, an audit trail and a reflective journal, each with a different purpose, see appendix 4 for examples of selected memos (including audit trail excerpts and reflections). The audit trail provided a mechanism for tracking decisions and changes that occurred throughout the iterative process of conceptualizing the study, preparing the necessary materials, obtaining proper approvals, conducting analyses, determining structure of manuscripts and of the overall dissertation, writing up the documents and finally when selecting

journals for submission (Crotty, 1998). The audit trail provided a means for recording major decisions and rationale about those decisions. In the following section I will share some of the key periods where the audit trail helped me to make links between emerging ideas that led to decisions that ultimately shaped the trajectory of the current study.

The scoping review of Mental Health Crisis Response Systems gave rise to the need to study mental health services as occurring within a system of various sectors. Although the current study does not focus on mental health crisis exclusively, elements of responding to a mental health crisis are salient features that shape CSSP in TF. The scoping review focused specifically on interprofessional working in mental health crisis response, which resulted in the realization that responding to crisis involves various sectors. Cross sector collaborations with mental health professionals occur within the healthcare system (Clarke, Brown, Hughes, & Motluk, 2006; Tummey, 2001), police services (Fry, O’Riordan, & Geanellos, 2002; Hanafi, Bahora, Demir, & Compton, 2008), clergy (Burns, Jhazbhay, Kidd, & Emsley, 2011; Farrell & Goebert, 2008), college and university campus personnel (Drum & Denmark, 2012; Pinder-Amaker, 2012), social services (Laing, Irwin, & Toivonen, 2012) and traditional healers (Maar et al., 2009). Engaging in the initial scoping review greatly informed the current study in that I realized it would likely be more appropriate to explore mental health services as occurring within a ‘system’ as opposed to looking at one ‘service’ given that the literature suggests that no one service can independently provide everything that an individual experiencing a MHC requires. Additionally, the findings from this paper gave rise to the need to explore cross sector service provision more broadly. This finding led me to go back to the existing literature to explore CSSP, resulting in the Umbrella Review. The findings from the Umbrella Review highlighted the paucity of theoretical underpinnings in the area of CSSP and pointed to the need for constructing the theoretical

foundation for a seemingly rhetorical concept for the fragmented health and social care systems. In turn, the umbrella review findings indicated that the most appropriate methodology to adopt for exploring cross sector service provision seemed to be constructivist grounded theory. Through examining my notes in the audit trail, it became clear that exploring mental health from the perspective of various sectors coming together to better meet the needs of service providers was the direction I wanted to take my study. From there, I began to explore potential CSSP arrangements that already existed in the health care system.

Given my understanding of and familiarity with the Towards Flourishing Mental Health Promotion Strategy project, namely the quality of data that had been collected but not fully analyzed, I curiously explored the possibility of using existing data to answer new research questions. I turned again to the literature and was surprised to learn that an entire body of evidence existed that supports the use of data in this way. I further fleshed out the idea of conducting a secondary analysis simultaneously with the original study team and my advisory committee. Both groups determined that it would likely be feasible to generate a grounded theory from the TF data. In an effort to maintain a connection to the original study research team my advisory committee requested that someone from the original study team sit on my doctoral advisory committee. Dr. Jennifer Volk agreed to join the research team for the current study.

Along with the audit trail, reflective journals were also maintained. The journals focussed on my interpretations and how I was coming to explore the data during analysis and write up. I will share an example of an “aha” moment that highlighted the importance of reflection. It happened when I was carrying out data collection for the original study. A master’s student was shadowing me for a portion of the data collection period to learn more about qualitative research. We were interviewing a service user who had a 2 year old and was pregnant. The student was

also pregnant, but I was not, and never had been. As part of the process, the student and I would take a few minutes after each interview and reflect on the experience, share our thoughts about potential interpretations, etc. The student noted that she got the sense that the service user did not appreciate having so many people telling her what to do when she was pregnant. This interpretation really surprised me because it had never crossed my mind at all in the interview. When I asked the student what part of the interview shaped her interpretation she said that from her experience being pregnant, everyone is always telling you what to do and that she could sense that the service user felt the same way. Because her interpretation was such a surprise to me, I led into a discussion about worldviews and how we come to the research process with different lenses but that we must reflect on how the lenses shape our interpretations. Importantly, it made *me* take a step back and reflect on *my* relative outsider perspective. Was I missing cues because I was not familiar with what it was like to be pregnant? Or to have children? Interestingly I was more used to doing insider research than being an outsider and for the first time it really struck me that I needed to carefully consider what I might be missing (Morse & Richards, 2004). I had been maintaining a reflective journal prior to that point but it was a good reminder of why it is so important to reflect on what I was attending to during data collection, and how I was interpreting the data.

Methodological Considerations

Goodness of Fit between Secondary Analysis and Constructivist Grounded Theory

For the current study I analyzed the entire complement of data collected from the original study to generate a mid-level theory of CSSP. The focus was significantly narrowed from that of the original research study in order to deeply explore how organizational, functional, and structural processes shape CSSP, at the boundary between the mental health and public health

sectors. Secondary analysis paired with constructivist grounded theory methods served as the epistemological and methodological underpinnings of the study and upon reflecting back on the goodness of fit a number of important considerations are evident. The original study team greatly assisted me with being able to conduct this work. I was fortunate to have a good working relationship with that team and am honoured that they permitted me to use the data for this novel in-depth exploration of CSSP. I was granted permission to re-analyze the full set of original study data to focus specifically on the concept of CSSP that began to emerge but was not sufficiently addressed in the original study (Hinds, Vogel, & Clarke-Steffen, 1997). The theory that emerged advances our understanding of the processes that shape CSSP and was made possible in large part due to the richness and depth in quality of the original study data (Hammersley, 1997; Hinds et al., 1997; Thorne, 1994; Whiteside et al., 2012).

Although SA's are less common in qualitative research, they are becoming more attractive given the massive amount of data that get collected but are not fully analyzed (Hammersley, 1997; Thorne, 1994). As mentioned by Thorne (1994) there are numerous advantages to conducting a secondary analysis, such as maximizing the extent to which existing data can be utilized to answer research questions. Additionally, given the multiplicity of interpretation, secondary analyses can extend our understanding of an area that may otherwise be left dormant by viewing the data from various angles and perspectives (Thorne, 1994; Whiteside et al., 2012). The overarching research question of the original study was similar to the research question of the current study but differed enough to allow for the emergence of novel insights into processes that shape CSSP (Hinds et al., 1997; Whiteside et al., 2012).

Furthermore, pairing secondary analysis with constructivist grounded theory methods complimented one another. Having said that, it is important to note that the interview and focus

group questions in the original study were also constructed from a grounded theory perspective. It is hard to say whether data collected through perhaps a narrative inquiry, or other approach would have been such an appropriate fit with the current grounded theory study.

Secondary analysis literature suggests several cautions researchers must consider when embarking on that type of study. First, a secondary analysis is typically conducted by someone other than the original researcher and this can lead to a number of issues related to ensuring the quality of the data collected (Hammersley, 1997; Hinds et al., 1997; Thorne, 1994; Whiteside et al., 2012) and for gaining access to a complete set of the original data (Hinds et al., 1997). Second, differences in interpretation of the spoken elements of the interviews may lead to probing by the interviewer in such a way that it influences the direction of the initial interview (Hammersley, 1997; Thorne, 1994; Whiteside et al., 2012). Thirdly, assuming the researcher of the secondary analysis differs from that of the initial study, immediate and tacit understandings of the nuances related to the told story may be difficult to reconstruct later (Thorne, 1994). Finally, participants consented to have their story used for a particular purpose; if the secondary research question departs greatly from the original purpose, further consideration will be needed on the part of the researchers to ensure that participants are informed of this new direction (Hammersley, 1997; Thorne, 1994). Many of the cautions listed above were not relevant to the current study given that I was the researcher who undertook all interviews, focus groups and data analysis for the qualitative component of the original study (Hammersley, 1997; Hinds et al., 1997; Thorne, 1994; Whiteside et al., 2012) and the original study team approved the use of the data for the purpose of the current study and authorized the use of the full complement of the data (Hinds et al., 1997). Given the richness of the data source, lack of data depth or lack of quality did not seem to be an issue in the construction of the current theory. Because an immense amount of data were

collected in the original study, I did not note any major gaps in the constructed theory, in fact, saturation was reached in a number of categories prior to wading through the full complement of data. Charmaz, (2014, p. 213) defines theoretical saturation as occurring when gathering new data no longer sparks new theoretical insights, nor reveals new properties of the core theoretical categories. Thirdly, Thorne (1994) cautions that immediate and tacit understandings of the nuances related to the told story may be difficult to reconstruct later, but again, given that I had access to reflective memos that I maintained during the original study, and was very familiar with the data and data collection process, this issue was minimized. Finally, in regard to Hammersley (1997) and Thorne's (1994) caution that participants consented to have their story used for a particular purpose, fortunately collaboration was a question that four stakeholder groups were asked to comment on during the original study meaning that a completely novel concept was not the focus of the current study, simply a new vantage point for exploring the data was taken.

There are two potential limitations of the current study methodology. Data collection and analysis did not occur simultaneously and theoretical sampling was done in a relatively novel manner. Both concurrent data collection and analysis and theoretical sampling are important tenants of Grounded Theory methods (Charmaz, 2014) Researchers conducting secondary analyses are confined to conducting theoretical sampling with a preexisting data set (Birks & Mills, 2011; Szabo & Strang, 1997). In the current study, I chose to theoretically sample data by comparing the newly emerged theory with a portion of the data that had been left out of the initial coding steps similar to Whiteside et al. (2012). Two additional mechanisms for theoretical sampling were also built into the current study protocol. The data from the Family (service user) stakeholder group was compared with the theoretical categories to see how the emerging theory aligned with the service user experience of being part of TF (Charmaz, 2014). Further data

collection was built into the study protocol in the event that it was required to fully construct a theory related to the processes that shape CSSP. This multifaceted approach to theoretical sampling was done to further identify the edges of the emerging concepts and flesh out the theory. Given the richness of the data collected during the original study, further data collection was not deemed necessary because there was arguably more than enough data within the original study data set to fill out the emerging theory.

After having engaged in the process of conducting a secondary analysis I would recommend the approach for use in qualitative research in general and health services research specifically. A novel insight into the feasibility and utility of conducting a secondary analysis became evident to me over the course of conducting the current study. I work as an embedded researcher with the Winnipeg Regional Health Authority and our role is to conduct small to large-scale evaluations of health programs and strategies in the region. The projects we take on range in content area but substantial overlap often exists in terms of contextual elements. Conducting this study made me reflect on the potential for incorporating secondary analyses into my day-to-day work. Interviews take time to arrange and conduct and although some portion of data collected for new evaluations would have to be collected in a manner specifically tailored to the proposed study, researchers could explore the possibility of sharing certain datasets across projects. Secondary analyses are economical in terms of time use and money spent on evaluations and research (Hinds et al., 1997; Thorne, 1994). In addition, another possible advantage of secondary analyses relates to the ethics of knowledge dissemination given that participants often invest extensive time and energy into offering their perspectives. Participant contributions could be further honoured by conducting a secondary analysis of existing data to ensure that data are not

collected and left unanalyzed. For secondary analyses to be possible, researchers would need to be diligent in making sure the cautions mentioned above were attended to.

Reflections on Criteria for Constructivist Grounded Theory

At the end of our journey through the research process the findings make sense to us, however, as Charmaz (2014) notes, the reader was not on this journey with us and therefore we must be transparent about how we came to our conclusions and claims. In this section I will describe the measures taken to ensure credibility, originality, resonance and usefulness of the emergent theory (2014, p. 337) so the reader can judge the worth of the theory for themselves.

Credibility

From the time I became involved with the TF project I have been immersed in the data, which in turn has immersed me in the setting and topic area. I conducted all interviews, focus groups and data analysis for the original study as well as the analysis for the current study. In chapter four I present an overview of the findings from the current study and in that chapter one include text that is rich with direct quotes in an effort to be transparent about how I came to construct the various theoretical categories. In addition, I included the full analysis of the data in this thesis because I wanted the reader to have access to it. All nine hundred and forty pages of transcripts that resulted from the original study (from 34 transcripts including 74 participants) were included in the analysis of the current study. Given the plethora of data, range of participant groups, and detailed responses provided, I believe the data are sufficient to merit the claims made in this dissertation and cover a wide range of empirical observations. A constant comparative method of analysis was adopted where I compared codes with codes, codes with categories, categories with memos, as well as utilized the service user transcripts for theoretical sampling to ensure that the emerging theory was grounded in the data.

Originality

The categories that make up the processes involved in CSSP are unique in a number of ways. First, they offer a theoretical account of micro, meso and macro level factors that shape CSSP whereas many studies have only focused on the micro level. Further, theoretical underpinnings of CSSP were absent from the literature and the current study provides a mid-level theory that is both relevant to the specific study context and very likely more generally applicable to the growing body of literature in the area of CSSP. I encourage researchers to consider the emergent theory against extant literature and future empirical research to confirm, challenge or extend the theory presented here.

Resonance

The concept of CSSP is complex and this is evident with the categories presented in the current theory. The categories emerged from a diverse mix of stakeholders including decision makers (from various levels), service providers and service users. Responses from participants included rich, detailed descriptions of their experiences working across sectors. I have presented what I believe to be a complete portrayal of a situated theory of CSSP, which should be viewed as a rendering shaped by a combination of my worldview, the participants' worldviews, time, history, culture and political environment. I have attempted to illuminate taken for granted meanings and to draw links between the representation of individual experience with larger collectives and institutions.

Usefulness

The findings can contribute to advancing our understanding of CSSP processes at various vantage points. The current study deliberately attempted to uncover micro, meso and macro elements that shape CSSP, while ensuring that the theory was emerging from the data themselves,

not being forced to fit preconceived categories. The presented theory attempts to offer a constructed theory that people can use in their everyday lives. Given the variety of informants who contributed to this study, elements of the theory may pertain to any combination of service providers, decision makers, policy analysts, service users and researchers. Although specific to TF, the theory has the potential to suggest generic processes relevant to a wider audience.

Conclusion

The call to provide more effective services is strong and improving coordination of care is often suggested to be the solution to fixing the fragmented health and social care system (Kernaghan, 1993). However, it appeared to be taken for granted in the literature that there was a shared understanding of *how* to do this cross sector work. The current study used secondary data from the TF study to explore cross sector service provision and shed light on the processes involved in providing care in a coordinated or joint manner. The findings from this inquiry present amid-level theory that advances our understanding of CSSP and has implications for education and practice, policy and future research projects aimed at exploring cross sector service provision. The findings from this work contribute theoretical depth to research, policy and practice related to CSSP. Theoretical underpinnings were largely absent from existing literature and moreover, the focus was primarily at the individual provider level. As was evident from the current study, the processes point to the need to consider how the various levels (Micro, Meso, Macro) of each sector shape how services are provided. In addition to contributing a constructed grounded theory to the literature base the theoretical underpinnings were further fleshed out by aligning it with potentially relevant extant theories to add further depth to the young but emerging field of study. The processes identified in the constructed grounded theory offer clarity regarding *how* to provide service across the boundary between two independent, yet interconnected sectors.

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Appendices

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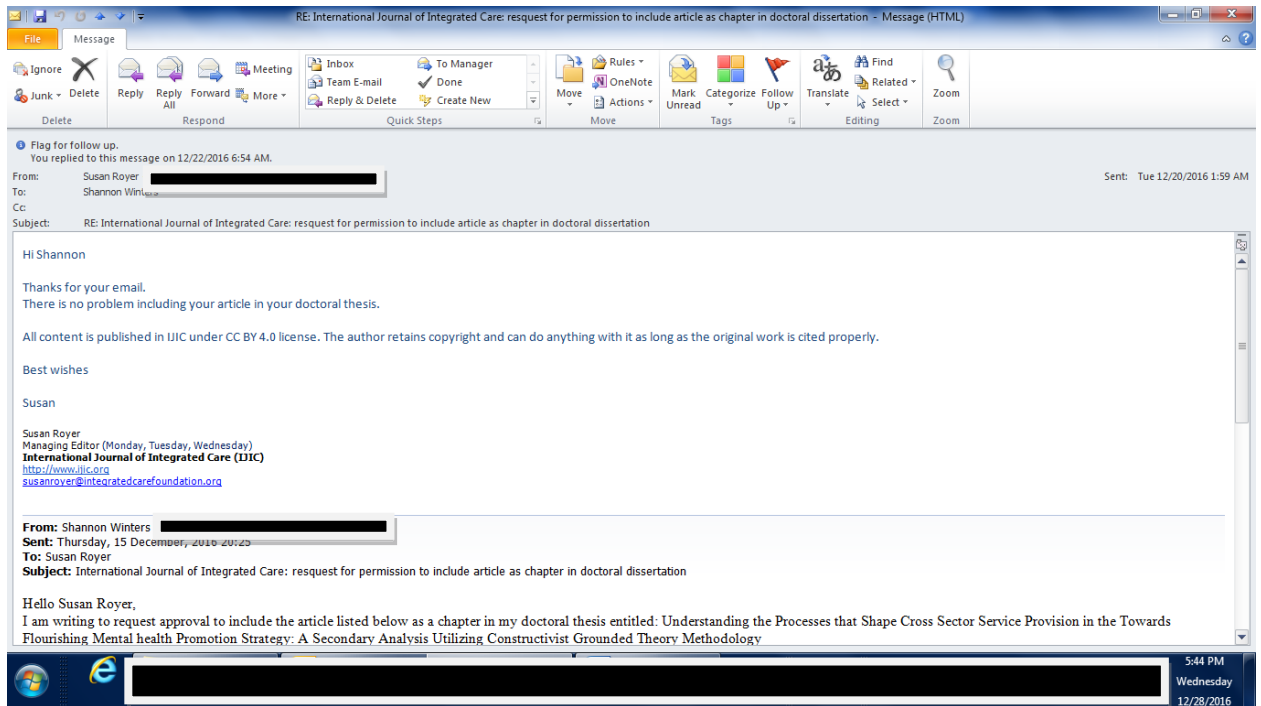
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Hello Dave Muller,
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Appendix 2: Ethics Approval



Research Ethics

Western University Health Science Research Ethics Board HSREB Delegated Initial Approval Notice

Principal Investigator: Dr. Lilian Magalhaes
Department & Institution: Health Sciences/Occupational Therapy, Western University

Review Type: Delegated
HSREB File Number: 107638
Study Title: Understanding Cross Sector Service provision: The Towards Flourishing Mental Health Promotion Project

HSREB Initial Approval Date: April 25, 2016
HSREB Expiry Date: April 25, 2017

Documents Approved and/or Received for Information:

| Document Name | Comments | Version Date |
|---------------------------------|---|--------------|
| Other | List of references | 2016/02/18 |
| Other | Original study interview guide (service provider - mental health promotion facilitator) | 2014/01/08 |
| Other | original study interview guide (service provider - Home visitor) | 2014/01/08 |
| Other | Original study interview guide (Service providers) | 2014/01/08 |
| Other | Original study interview guide (Parents) | 2014/01/17 |
| Other | Original study interview guide (service provider - decision makers) | 2014/01/08 |
| Western University Protocol | Received 21Apr16 | |
| Letter of Information & Consent | Cleaned LOI service providers and decision makers | 2016/03/24 |
| Letter of Information & Consent | Cleaned LOI Families | 2016/03/24 |


The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above named study, as of the HSREB Initial Approval Date noted above.

HSREB approval for this study remains valid until the HSREB Expiry Date noted above, conditional to timely submission and acceptance of HSREB Continuing Ethics Review.

The Western University HSREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use Guideline for Good Clinical Practice Practices (ICH E6 R1), the Ontario Personal Health Information Protection Act (PHIPA, 2004), Part 4 of the Natural Health Product Regulations, Health Canada Medical Device Regulations and Part C, Division 5, of the Food and Drug Regulations of Health Canada.

Members of the HSREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 0000940.


Ethics Officer, on behalf of Dr. Marcelo Kremenutzky, HSREB Vice Chair

Ethics Officer to Contact for Further Information: Erika Basile ___ Nicole Kaniki ___ Grace Kelly ___ Katelyn Harris ___ Vikki Tranj ___

Western University, Research, Support Services Bldg., Rm. 5150
London, ON, Canada N6G 1G9 t. 519.661.3036 f. 519.850.2466 www.uwo.ca/research/ethics

Appendix 3: Original Study Materials

Focus Group Guide for Mental Health Promotion Strategy –Public Health Nurses

Thank you for agreeing to participate in this focus group. Over the past year home visitors have been using the new resources from the Towards Flourishing project with parents in the Families First program. I would like to ask you about your views on the Towards Flourishing Mental Health Promotion Strategy and your experience working with some of these resources. As you know, the Towards Flourishing Strategy has added mental health promotion to the Families First Program and to public health practice in general: a 2-day training for public health nurses and home visitors, a curriculum of mental health topics and a set of Everyday Strategies for positive mental health and well-being for families; a screening process with a questionnaire package to assess the mental health of families; and a plan after screening to link families with appropriate mental health services and resources as needed.

Your role in overseeing and guiding these different levels of support for families is valuable – as is your role in promoting mental health in the families you serve. Your feedback on this process will be used to improve and refine the Towards Flourishing Mental Health Promotion Strategy and is very much appreciated. We are open to hearing your perspective both on what is working well and what is not working so well.

Preliminary questions:

What region are you from?

How many years of experience do you have as a public health nurse?

How long have you been working with Towards Flourishing materials and resources?

Are you involved in the Families First Program

What is your role in the Families First Program?

How many years have you worked in the Families First Program?

What was your understanding of the purpose of the Towards Flourishing Mental Health Promotion Strategy?

Probe:

- *What have you noticed about the way you practice now that you are familiar with the Towards Flourishing strategy?*
- *Are you doing something differently because of:*
 - *the training,*
 - *the tools and/or*
 - *the mental health promotion facilitator? Please explain?*
- *What have you noticed about the families that received the Towards Flourishing visits? Can you share an example?*

1. The **Mental Health Promotion Facilitator (MHPF)** is a new position introduced in Towards Flourishing to support Public Health teams in several ways. Please tell me a little bit about your experience working with the Mental Health Promotion Facilitator? What has that been like for you?

Probes:

- a. *How has this role assisted you in the work you do?*
- b. *How could this role better assist you in your work?*
- c. *Can you share an example where your team benefitted from the support of the MHPF?
Or a time when you could have used the support of the MHPF?*

2. Please share your general impression of the mental health screening process? How is that going?

Probes:

- a. *Do you find the MH screening summary useful in your work/helpful in planning services for families?*
 - b. *Did you use the screening package with mom's who were not involved with Families First?*
 - c. *What is most helpful about the MH screen? Least helpful?*
 - d. *What would you change about the screen?*
3. A core element of the Towards Flourishing Mental Health Promotion Strategy is to provide consultation for public health nurses through the mental health promotion facilitator role. What has your experience been like with that service?
- a. **(Winnipeg Public Health teams)** Was this done through the formal consultation process? Can you tell me a little bit about what that was like for you?
 - b. **(Both Winnipeg and Rural Public Health Teams)** Was this an informal consultation? Can you tell me a little bit about what the consultation was like?
 - c. We are interested in understanding how access to the consultation process can be improved.
 - i. In your opinion what is working well for accessing consultations?
 - ii. What barriers exist for accessing a consultation?
 - iii. Are any changes to the consultation process needed to better meet the needs of Public Health staff that support families? Please share your ideas with me?
 - iv. Has the working relationship between Public Health staff and Mental Health staff changed in any way as a result of the Towards Flourishing Strategy? If so, in what ways has it changed?

4. Towards Flourishing was created to fill a gap in the Mental Health Promotion component of the Families First program. How has the strategy shaped the mental health literacy of staff? Of Parents?
 - a. *What differences are you seeing in the mental health literacy of the Families First families?*
 - b. *What gaps remain?(let interviewee specify – might discuss resources for families and Families First not associated with improved depression outcomes)*
5. Moving forward and thinking about Towards Flourishing, ideally, what would you like the program to look like in 5 years

Focus Group Guide for Mental Health Promotion Strategy –Families First Home Visitors

Thank you for agreeing to participate in this focus group. Over the past year home visitors have been using the new resources from the Towards Flourishing project with parents in the Families First program. I would like to ask you about your views on the Towards Flourishing Mental Health Promotion Strategy and your experience working with some of these resources. As you know, the Towards Flourishing Strategy has added mental health promotion to the Families First Program and to public health practice in general: a 2-day training for public health nurses and home visitors, a curriculum of mental health topics and a set of Everyday Strategies for positive mental health and well-being for families; a screening process with a questionnaire package to assess the mental health of families; and a plan after screening to link families with appropriate mental health services and resources as needed.

Your role in overseeing and guiding these different levels of support for families is valuable – as is your role in promoting mental health in the families you serve. Your feedback on this process will be used to improve and refine the Towards Flourishing Mental Health Promotion Strategy and is very much appreciated. We are open to hearing your perspective both on what is working well and what is not working so well.

Preliminary questions:

- What region are you from?
 - How many years of experience do you have as a Home Visitor?
 - How long have you been working with Towards Flourishing materials and resources?
 - How many years have you worked in the Families First Program?
- 1) What was your understanding of the purpose of the Towards Flourishing Mental Health Promotion Strategy?
 - i) *Probe:*
 - b) *What have you noticed about the way you practice now that you are familiar with the Towards Flourishing strategy?*
 - i) *Are you doing something differently because of:*
 - (1) *the training,*
 - (2) *the tools and/or*
 - (3) *the mental health promotion facilitator? Please explain?*
 - c) *What have you noticed about the families that received the Towards Flourishing visits? Can you share an example?*
 - 2) The **Mental Health Promotion Facilitator (MHPF)** is a new position introduced in Towards Flourishing to support Families First and Public Health teams in several ways.

Please tell me a little bit about your experience working with the Mental Health Promotion Facilitator? What has that been like for you?

Probes:

- a) *How has this role assisted you in the work you do?*
- b) *How could this role better assist you in your work?*
- c) *Can you share an example where your team benefitted from the support of the MHPF?*

Or a time when you could have used the support of the MHPF?

- 3) Please share your general impression of the mental health screening process? How is that going?

Probes:

- a) *Do you find the MH screening summary useful in your work/helpful in planning services for families?*
- b) *What is most helpful about the MH screen? Least helpful?*
- c) *What would you change about the screen?*

- 4) A core element of the Towards Flourishing Mental Health Promotion Strategy is to provide consultation for public health teams. What has your experience been like with that service?

- a) Was this done through a formal or informal consultation process? Can you tell me a little bit about what that was like for you?
- b) We are interested in understanding how access to the consultation process can be improved.
 - i) In your opinion what is working well for accessing consultations?
 - ii) What barriers exist for accessing a consultation?

iii) Are any changes to the consultation process needed to better meet the needs of Public Health staff that support families? Please share your ideas with me?

5) Towards Flourishing was created to fill a gap in the Mental Health Promotion component of the Families First program, how has the strategy shaped the mental health literacy (understanding of mental health, mental illness and distress) of staff? Of Parents?

Probes:

i) *What differences are you seeing in the mental health literacy of the Families First families?*

ii) *What gaps remain?*

6) We'd like to understand what works well or needs improvement within the TF Curriculum. Thanks to the Monthly Summary that all the HVs have been completing, we have a good idea of which of the pieces of the curriculum have been used often, or very little.

a) For example, the **Flourishing** topic, **3 Good things**, **Nasal Breathing** are used a lot. Do you have any thoughts as to why those are being used often?

b) On the other hand, the **Reaching Out** topic, the **Belonging** strategy, and the **Self-Monitoring** strategy are used very little. Do you have any thoughts as to why they aren't being used very much?

i) What could we do to improve these strategies and topics?

7) Moving forward and thinking about Towards Flourishing, ideally, what would you like the program to look like in 5 years?

Interview Guide for Mental Health Promotion Strategy – Parents

Thank you for participating in this interview. We are interested in learning more about the experiences of families who are involved with the Towards Flourishing materials (*Show TF curriculum and hand-outs*). We would like to hear about what you and your family think is working well with these materials and what you think we should improve on. I am going to ask you few questions, please know that you only have to share information that you are comfortable with. You can choose to answer or not answer any questions and this will in no way change the services that you receive. Your input is very important in making sure that Towards Flourishing is helpful to families.

- Please tell me a little bit about your experience with the Towards Flourishing materials?
What has that experience been like for you?
- Can you tell me about an example of how the home visitor shared these materials?
(please share only what you are comfortable with).

Probes:

- Has learning about the everyday strategies been helpful to you? I am interested in hearing a little bit about that, would you be open to sharing the story with me?
- What has your experience been like talking about mental health?
- Probes:
 - What was helpful?
 - Were any of the topics difficult to talk about? Can you tell me a little bit about that?
 - What would make it easier to discuss that topic?
 - Which topics would you like to know more about?

- Have you used any of the strategies with your children? Can you tell me a little bit about what that looked like?
- What is your favourite strategy?
- Which strategy did you find least helpful?
- We are interested in making the program more helpful for families; do you have any ideas for how we could make the program better? Please share?
- Any final thoughts on your experience with the Towards Flourishing materials?

Interview Guide for Mental Health Promotion Strategy – Decision Makers

Preamble

Thank you for agreeing to do this interview. Towards Flourishing is a multi-level approach to mental health promotion within public health services throughout the province. This demonstration project had three primary goals:

1. To improve the mental health and decrease mental illness/distress of parents and their children in the Families First Home Visiting Program.
 2. To strengthen public health workforce capacity to address mental health promotion and support collaboration between Mental health and Public health systems.
 3. To create and sustain mechanisms for effective mental health promotion interventions in community settings across Manitoba.
- Based on your understanding of the initiative, in what way has Towards Flourishing impacted the three goal areas?

- Probe for each goal
- What have been some of the strengths of the Towards Flourishing Mental Health Promotion Strategy?
- What have been some of the limitations of the Towards Flourishing Strategy?
- How can the Towards Flourishing model/approach be used to address the mental health needs of different populations in Manitoba?
- Are there lessons learned from the implementation of Towards Flourishing that enhance our understanding of what is required to enhance capacity for mental health promotion within the health sector?
- Are there policies and organizational support for sustained efforts and programming for mental health promotion?
- How can the stories of Towards Flourishing (users' experiences) be used to develop a business case for more upstream investments in the population mental health.

Interview Guide for Mental Health Promotion Strategy – Mental Health Promotion Facilitators

Thank you for agreeing to do this interview. Over the past year home visitors have been using the new resources from the Towards Flourishing project with parents in the Families First program. I would like to ask you about your thoughts on the Towards Flourishing Mental Health Promotion Strategy and your experience supporting the public health nurses and Families First home visitors. As you know, the Towards Flourishing Strategy has added mental health promotion to the Families First Program and to public health practice in general: a 2-day training for public health nurses and home visitors, a curriculum of mental health topics and a set of Everyday Strategies for positive mental

health and well-being for families; a screening process with a questionnaire package to assess the mental health of families; and a plan after screening to link families with appropriate mental health services and resources as needed.

Your role in overseeing and guiding staff that support families is valuable – as is your role in promoting mental health in the Families First families. Your feedback on this process will be used to improve and refine the Towards Flourishing Mental Health Promotion Strategy and is very much appreciated. We are open to hearing your perspective both on what is working well and what is not working so well.

Preliminary questions:

- What region are you from?
- How many years of experience do you have working in the mental health field?
- How long have you been working with Towards Flourishing materials and resources?

1) Role development

- a) Please share with me a bit about your role as the Mental Health Promotion Facilitator?
 - b) Can you talk a bit about the training you received to prepare you for your role?
 - c) What experience and skills are required to be successful in the role of Mental Health Promotion Facilitator?
 - d) Tell me about what it was like for you building relationships with:
 - i) Home Visitors
 - ii) Public Health Nurses
 - iii) Families First team managers?
- (1) What worked well?

(2) What were some of the difficulties you experienced?

e) At the present time, in what ways do you deliver consultation support to Public Health?

i) On a weekly basis, how often would you say you have contact with the Public Health staff support?

f) Are there other opportunities to connect with public health staff? (Let interviewee specify – might discuss meetings or mentorship).

2) Supporting Families

a) Tell me your thoughts on what Towards Flourishing does for families?

i) Can you think of an example of how Towards Flourishing helps families?

b) Please tell me about your thoughts on the mental health screening process at your sites?

i) What is working well?

ii) What needs to be improved?

iii) In your opinion, is it preferable for the home visitors or the public health nurses to deliver the screening tools? Please explain why?

c) Can you tell me a little bit about how your role has shaped access to mental health resources and services for families?

i) Can you share an example of what has changed? (Let interviewee specify – might talk about whether or not they were able to facilitate an access strategy for families within the public health teams)

3) Supporting Public Health Teams

a) In what way do you think Towards Flourishing has shaped the way public health teams practice?

b) Can you share an example of a time when you supported a public health nurse and/or a Home Visitor? What did that look like?

- c) What is working well?
- d) What still needs to be developed?

4) Wrap up Question:

Ideally, what would you like the Mental Health Promotion Facilitator role to look like in a five years? Could you describe it to me?

Appendix 4: Selected Memos

Memos were included to help the reader understand the process I engaged in while conducting the various research elements. Through reading the selected memos the reader is provided with a window into what contributed to my thoughts and how I came to make decisions along the way. Items were pulled from three sources, the audit trail, reflective journal, as well as theoretical memos written during the analysis and write up phase. This is not an exhaustive list of all memos.

Does the fact that I have never been pregnant shape my interpretation of the data?

I don't actually know how easy it would be for a remove person to use secondary data – I am still very familiar with the date after being immersed in it for three years now

I find myself using the same verb over and over again believing, feeling, wanting - it's hard to come up with more appropriate terms

I find it very hard to not skip ahead and start theoretical coding, staying close to the data is hard, I always want to move further and start categorizing. I even had to go back and open code after I realized I had been categorizing for a number of lines. I found it really hard to stop myself from abstracting so quickly so in the end I ended up just making notes of what I thought might be categories and then just kept moving because otherwise I get stalled and get stuck in the data. I was afraid if I didn't know my thought somewhere my thinking would get lost but I also knew that it was stopping me from moving forward through the data.

I think my codes are too long. I think they need to be shorter

I need to do a lot more analysis because abstracting can go on a number of different ways and I need to make sure that I'm capturing all possible processes – sometimes it may seem like it's one thing but then upon looking closer its two or three processes

When do I introduce the original project - chapter 1? I don't know if this is the best spot because it's more like methodology for the project but it's important for the reader to know that there was an original project...

I must be careful to not force “conflict” to be a category, most of the literature speaks to it but the data I have do not support it as a category – this is surprising

I have decided to do chapter 5 as two chapters. One that provides an overview of the findings from the secondary analysis – the model. And a second chapter of the ties together areas for an existing literature that might further inform the theory

I'm having a really hard time breaking apart the content so that it fits nicely into two separate chapters there's so much overlap I might just do one long chapter.

It seems like so much of my theory is actually about change management

I might do three papers one that speaks to the individual or micro factors another one that speaks to the meso organizational factors in the third that speaks to the macro strategic governance factors.

I have now decided that that would be impossible there's way too much overlap between the three maybe I will draft a table that shows the different layers. That includes some of the codes from each of the different levels

Including important stakeholders early on seems to be a theme

Developing project components collaboratively and locally increases ownership in partnering with the right people

Maybe an overarching theme is creating space for collective decision-making

I'm having trouble again separating out the content into different chapters so I think I will go ahead with one long chapter and then figure out a plan for publications for the dissertation I think it'll be just one chapter

It seems like the initiative of TF was a mechanism in and of itself for moving policy and practice– Explore this further

I've decided to remove the process “scaling up in a controlled manner” because I think it fits under a number of the other processes and doesn't need to stand alone

How do I break these papers down? There's so much data to go through I thought of doing micro meso macro because we know a lot about the micro level factors but we don't know that much about the other two, but in order to do justice to what the participant shared I need to include all three. However there's just too much. I've only gone through four tabs on the spreadsheet and already it's too much

Later that same day – I decided on four themes for the paper and these themes cut across the micro meso macro levels – I'm not separating them out like I had originally thought there's too much overlap to split them meaningfully so despite running the risk of having too much data – being too long for a paper – I'm going to write papers this way the themes are

one – strategic inclusive collaborative representative involvement of stakeholders for planning implementation and sustainment of the CSSP initiative

two – developing the CSS P initiative based on local national and international evidence to increase ownership and engagement at all levels for both sectors.

Three – adapting to changing contextual landscapes [social historical political] to ensure continued relevance to the population being served.

Four - scaling up in a controlled manner.

Explore the idea that stigma may extend to the service providers, similar to psychiatry literature

I now think the processes will be:
establishing and growing the project I need priorities and evidence
fostering meaningful and during engagement from both actors
dovetailing with what already exists
adapting to challenge and contextual landscapes
preparing and supporting stakeholders

Components of the processes include viewing mental health is everybody's business –
connecting with others – experiencing uncertainty – being flexible – improving services –
allowing time for CSSP to become regular part of practice – changing the way things are
done – dovetailing with existing priorities.

Oh my goodness I don't even know what a process is anymore
I'm not sure what I should call people who receive mental health services. In my one
paper I called them consumers but now I don't really like the term. On the other hand I
don't want to call them clients or patients either because there are pros and cons to doing
that I'm thinking of saying service user but I need to think on this a little more

The processes are now
involving
embedding in existing program
research results and transferring knowledge
adapting and changing contacts
expanding

There are now seven processes
evidence in
existing priorities policies
involving
embedding into the program
feedback out
adapting and challenging context
scaling up in a controlled manner

I just realized I analyze the same text a bunch of different times because of the way I put
the data into the excel file.

No one uses micro meso a macro in the same way it's so frustrating so I will stick with
the one with the World Health Organization uses I think because it seems to make the
most sense

I'm now thinking the processes will be:
establishing and going to project based on need priority evidence
fostering meaningful supportive engagement
embedding the project into an existing program
adapting to challenge and contextual landscapes

Curriculum Vitae

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2004-2008 Bachelor of Arts
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