

Implementation of Manitoba's Mental Health Strategic Plan: A Case Study Application of the
Advocacy Coalition Framework

by

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A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

In partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

Faculty of Social Work

University of Manitoba

Winnipeg

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Abstract

This study examines the factors, processes, challenges, and successes that affected the implementation of Manitoba's mental health strategic plan, "Rising to the Challenge: A strategic plan for the mental health and well-being of Manitobans". A case study application of the Advocacy Coalition Framework describes this policy response in terms of its policy subsystem, relevant contextual factors, and the extent of policy-oriented learning. Interviews with policy makers, mental health organization administrators, and front-line workers involved in the implementation of this strategy were conducted along with a review of relevant documents. The factors that contributed to the challenges and success in implementing this strategy include limitations in financial resources, policy purpose and design, public and political support, the implementation and evaluation approach, system complexity, the economic and political environment, applicability to front-line practice, time constraints, organizational supports, leadership, and advocacy. Recommendations are made to improve the Advocacy Coalition Framework and implementation processes.

Acknowledgements

I would like to begin by thanking my thesis advisor, Dr. Sid Frankel. I am extremely grateful for the invaluable knowledge, guidance and support you provided me. Your encouragement and confidence in my ability to succeed was instrumental in helping me persevere over the course of my graduate studies. I would also like to thank my thesis committee, Dr. Keith Lowe and Dr. Karine Levasseur. Your feedback and advice helped me find the direction I needed to strengthen my work. Thank you for all of your support and encouragement.

I would also like to thank the University of Manitoba for the financial support I received through the University of Manitoba Graduate Fellowship, the Margaret Mary Burns Award in Social Work, and the Faculty of Graduate Studies Travel Award and Special Awards Fund. This enabled me to focus my time and energy on my thesis research and to achieve my educational goals.

Last, but certainly not least, is my incredible family. I would like to thank my brothers, Joel and Riley De Blonde, for dragging me out of my apartment, lifting my spirits, and for supporting me through my many thesis meltdowns. I would also like to thank my dad, Dr. Garry De Blonde, for his unconditional love and unwavering support. I cannot thank each of you enough for always being there when I needed you and for always believing in me. I could not have done this without you.

Dedication

I dedicate this to my mother, Diana De Blonde.

The journey through your loss has filled me with countless questions, emotion, and resolve. Part of that journey led me here. Your memory serves as a catalyst for change. I am proud to continue your fight on your behalf and for all who are impacted by mental illness and suicide. Your love, spirit, and strength will continue to live on and guide my work.

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Chapter I: Introduction

This study examines how policies regarding mental health are implemented. More specifically, it describes the implementation of the Government of Manitoba's mental health strategy, *Rising to the Challenge: A strategic plan for the mental health and well-being of Manitobans* (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). This policy was used as a case study to describe important factors related to implementing mental health policy. For brevity, the policy will simply be referred to as *Rising to the Challenge* for the remainder of this document.

Research problem

This study aims to address an interrelated set of problems. The first problem is the prevalence of mental illnesses and low levels of mental health. In Manitoba we are seeing some of the highest prevalence rates compared to other provinces in Canada. Statistics Canada's most recent Canadian Community Health Survey Mental Health Profile shows that in terms of the lifetime prevalence of any selected mental or substance abuse disorder, Manitoba's prevalence rate is 40.2% which is the third highest among the provinces and above Canada's prevalence rate of 33.1% (Statistics Canada, 2012). In terms of medical care, 25.6% of Manitobans received treatment for a mental illness between 2011/2012 and 2015/2016 (Manitoba Health, Seniors and Active Living, 2016). The number of people who are affected by mental illness and mental health problems is much greater when those who are not in treatment, family members of someone with a mental illness or mental health problem, and their support systems, are taken into consideration.

Also contributing to this social problem is the high rate of suicide related to poor mental health. From 2010/2011 to 2014/2015, there were 988 deaths as a result of suicide in Manitoba

(Manitoba Health, Seniors and Active Living, 2016), an increase from the 960 deaths by suicide reported in the previous statistical report (Manitoba Health, Seniors and Active Living, 2015). Suicide signifies a tragic cost of this problem in Manitoba. It is recognized that suicide, mental illness, and low levels of mental health continue to be a substantial problem for Manitobans; the increasing prevalence of these problems provides a rationale for the development and implementation of public policy for mental health issues.

The second problem associated with mental illnesses and low levels of mental health is the lack of a proactive and coordinated response. As was just mentioned, it is evident that mental health problems and illnesses are prevalent in Manitoba; even with the number of services that currently are available to those who are struggling, people are still falling through the gaps in the system and are not getting enough, if any, of the services they need. This has been seen by comparing prevalence rates with treatment rates (Kohn, Saxena, Levav, & Saraceno, 2004). It is important to recognize the remarkable work that is being done by mental health professionals with a variety of services; the problem lies not in the services or the people providing them but in the systematic response to these issues. Manitoba's systematic response to mental illnesses and problems, along with the improvements needed in the provincial mental health system was the catalyst for the development of the mental health strategic plan that has been chosen for the focus of this study.

The third and final problem that will be the main focus of this study is in regard to the execution of a systematic, strategic response to mental health issues in Manitoba. The problem is that there is no evidence that the policies that have been developed are being implemented appropriately, which means that the solutions that are being determined are not necessarily being put into practice and reaching those in need. Neglecting the policy implementation stage of

policy making creates a huge gap between policy and practice. Much work is being done to create solutions, such as money being put towards research and on developing programs and policies; but if the implementation of these policies is neglected, people with mental illnesses will not benefit from the tax dollars spent on this and will continue to suffer through their illnesses (Proctor et al., 2009). Creating and designing social policies are motivated by a desire to improve a policy problem; without a focus on implementation, the processes that are supposed to lead to the desired outcomes may end up resulting in a policy with little to no impact. Implementation is an essential part of the policy process that needs to be given more attention in the policy planning stages in order to ensure desired outcomes.

Purpose

As was briefly mentioned, this study examines mental health policy implementation. Its purpose is to describe the policy implementation of Manitoba's mental health strategic plan. A case study approach was used in order to gather a detailed description of the processes involved in the implementation of this particular case. The description of this process is aimed at determining the relevant factors related to the successes and barriers that were evident during the implementation of this policy, along with determining the strengths and weaknesses of the implementation approach that was utilized.

Research Contributions

This study makes important contributions to the study and practice of mental health policy implementation. By describing the barriers and the challenges that implementers are experiencing with the policy, policy makers and implementers will be able to address these issues in order to reduce the likelihood that they will hinder the process in the future. Also,

describing any successes that have been seen in the process enables a planned approach to be formed around what works for policies like this and what does not. Examining the strengths and weaknesses of the particular approach that the policy makers are using to implement this plan will also create opportunities to adjust the strategy that they are using and turn to other approaches that have been seen to work effectively in the mental health field.

This study also contributes to understanding policy implementation specifically in the mental health field. Rather than implementing policy using generalized frameworks, this study uncovers some of the more unique challenges that occur with mental health policy, which can help policy makers in the field plan this more effectively. This study is being completed at a time where this information may be of particular relevance to policy makers. The current Progressive Conservative Government in Manitoba is creating a new mental health and addictions strategy. Incorporating the findings of this study into the implementation planning for their strategy could increase implementation success and the likelihood of greater policy impacts.

The case study approach enables readers to gain a deeper understanding of the inner workings of this process. The literature review provides evidence of some case studies like this; but is mostly comprised of generalized articles about theory and mental health policy implementation. This case provides an opportunity to learn about the dynamics and planning that occur within this process. Everything from implementation planning, to the resources involved, to the communications between individual implementers will contribute to this understanding. An indepth study like this enables us to take note of the more particular dynamics that may go unmentioned in broader theoretical and conceptual studies.

The overarching theme for what this study contributes to the literature is the careful planning of implementation processes. It is intended that this study can encourage policy makers

to make implementation a more thoughtful process. By doing so, we would be able to create meaningful policies that can truly create positive impacts for those suffering from mental health issues.

This study also makes contributions to the theoretical literature. According to the most recent literature, the theoretical framework that is used in this study, the Advocacy Coalition Framework, has not been applied to mental health research (Jenkins-Smith, Nohrstedt, Weible, & Sabatier, 2014; Weible, Sabatier, & McQueen, 2009). This research has created an opportunity to see how the framework operates within a different field of study. Recent literature also notes how the framework has evolved in terms of how it is applied and how much of it is applied (Jenkins-Smith et al., 2014). The discussion chapter of this thesis provides a detailed account of the implications that this study has for the Advocacy Coalition Framework.

Finally, this research contributes to policy practice in social work. Policy implementation is a relevant and important topic for social workers; it relates to the day-to-day work of social workers as their work is guided by social policy (Popple & Leighninger, 1998). Social workers are included among the street-level bureaucrats (Lipsky, 2010) who are responsible for putting policies into practice. By using the synthesis model of implementation social workers can mediate some of the issues that they encounter. For example, policy divergence is often found when there is a conflict in interaction between agency preferences and street-level bureaucrat preferences; the discretion that social workers can use when implementing a policy that effect their clients may be different than the directions for implementation that are given from their agency (Oosterwaal & Torenvlied, 2000). Rather than having this lead to policy failures, social workers can work with the various actors in the policy network to reformulate the policy over a significant period of time. This way conflict will be able to be used productively to produce

policy-oriented learning. The discussion chapter also includes a detailed discussion of the implications of the findings for front-line practice.

Organization of Thesis

Chapter I of this thesis provided an introduction to the strategy being used as a case study for examining mental health policy implementation in Manitoba. It also outlined the interrelated set of problems that this thesis aims to address and the purpose of this study. This chapter concluded with a summary of the research contributions that this study makes.

Chapter II provides a review of the relevant literature that helps provide an understanding of mental health policy implementation. It begins by defining important terms that are frequently used throughout this thesis, including policy implementation, mental health system, and strategy. Following this is a review of the range of policy implementation theories, which include the top-down approach, the bottom-up approach, a number of other approaches contributing to the theoretical literature, and finally the synthesis approach and the Advocacy Coalition Framework. The second chapter concludes with a review of the literature regarding mental health policy implementation. It includes a summary of the challenges and facilitating factors to implementing mental health policy found in the literature, empirical case studies examining the implementation of various mental health programs and policies, and it also includes a review of articles that make direct reference to *Rising to the Challenge*.

Chapter III describes the methods used for this study. It begins by listing both the primary research question and the ten sub questions that this study aimed to answer. It then describes the case study method used to examine *Rising to the Challenge* and the use of the Advocacy Coalition Framework as the theoretical foundation of this study. Finally, the processes selected for collecting and analyzing data are explained.

Chapter IV presents the findings from the data analysis process. The chapter starts with a critical analysis of the Rising to the Challenge strategy document to determine the strengths and weaknesses of the document, whether it is within the scope of provincial government jurisdiction, and how it relates to best practice approaches for developing mental health policy. Following this analysis there is a section that includes the narrative analysis for each of the ten interviews that were conducted for this study and the themes that emerged from each. A cross-narrative analysis is then included to explain the relevance of each theme to the implementation of Rising to the Challenge and to explain the commonalities and difference in how the themes were expressed across the interviews. Following the cross-narrative analysis is a section dedicated to the analysis of the documents that were gathered to examine this policy response. The chapter concludes with a discussion of how the findings have answered each of the research questions included in this study.

Chapter V provides a discussion of the findings and their implications. It begins with a summary of the findings, which highlights the strengths and weaknesses in the implementation process for Rising to the Challenge, as well as how the Advocacy Coalition Framework applied to this case study. Following this section is a more detailed analysis of the ACF application and the implications that this study has for the theoretical framework. The next section includes a discussion of the implications of this study for practice in terms of both policy practice and social work/front-line practice. Following this is a discussion on how the findings relate to the mental health policy implementation literature. The limitations of this study are outlined in the following section. Finally, the discussion chapter concludes with suggestions for areas of future research.

Chapter II: Literature Review

A review of the relevant literature is presented to provide a basis for understanding mental health policy implementation. The review starts by defining key terms that are used throughout this thesis. The terms that are defined include policy implementation, mental health system, and strategy. Following this section is a review of the literature on policy implementation theory. Different theoretical perspectives in this field are described, including top-down policy implementation approaches (Alexander, 1989; Bardach, 1977; Hogwood & Gunn, 1984; Pressman & Wildavsky, 1973; Sabatier & Mazmanian, 1981), bottom-up policy implementation approaches (Elmore, 1982; Ham & Hill, 1984; Hjern, Hanf, & Porter, 1978), and synthesis policy implementation approaches (Elmore, 1985; Sabatier, 1986; Stocker, 1989; Winter, 1990). The synthesis approach and the Advocacy Coalition Framework (ACF) (Sabatier, 1988), a framework offered through Paul Sabatier's synthesis approach, are described in more detail as they have been determined by this author to be the most ideal theoretical underpinning for this particular implementation analysis. Concluding the literature review is a section describing mental health policy implementation, which includes a number of empirical case studies outlining the challenges and successes that have been found when implementing policy in this particular field.

Definition of Terms

This section of the literature review is dedicated to defining the key terms that will be used throughout this thesis. The discussion includes a review of the literature on each term and an analysis of what has been included to constitute various authors' definitions of the terms. Following this analysis, this author accepts and omits elements of these definitions to develop a

final definition that is most appropriate for the purpose of this thesis. The rationale for using and omitting certain elements is also presented. The terms that are defined are policy implementation, mental health system, and strategy. Policy implementation requires definition because it is the policy process at the core of the analysis that was conducted; understanding its function and place in the policy-making process is essential for this thesis. Mental health system requires definition because of the focus on policy implementation within a particular mental health system; Manitoba's mental health system will be described along with a general definition of mental health systems. Finally, the term strategy will be explored because of its relevance to the case study in question. *Rising to the Challenge* is described as a strategic plan; what this term means and its relation to policy and the implementation process is discussed.

Policy Implementation.

Social policies go through a variety of stages during their development. Issues emerge, policies are initiated, formulations are made, and policies are executed (Birkland, 2011). This thesis focuses on the stage of the policy process that is concerned with implementation. There is a vast body of literature on policy implementation with slight variations on how to define it. The most common definition found across the literature is that policy implementation is the execution of a policy decision where the connections between policy and practice become practically inseparable (Mazmanian & Sabatier, 1983; McKenzie & Wharf, 2010; L. A. Pal, 2006). This definition is sufficient for a basic understanding of the term; however, different scholars choose to emphasize important concepts found within the process of policy implementation. Mazmanian and Sabatier (1989), for example, consider policy implementation as a cause and effect relationship between the efforts of policy actors and the policy impacts where others find it important to make a conceptual distinction between the action on behalf of the policy and the

ultimate impact (O'Toole, 2000). These different views ask the question of whether policy implementation is defined as a process or as the sum of its parts.

Various researchers emphasize implementation as consisting of a number of stages within their definition. Mazmanian (1983) refers to it as a process running through stages beginning with the passage of a statute, and moving along to the policy decisions of implementing agencies, compliance with those decisions, impacts, and finally any needed revisions to the statute. Other researchers have also emphasized the successive phases rather than one event, like Brownson, Colditz and Proctor (2012), who add that implementation does not stop at the level of initial uptake and that the stages can be seen as the factors included in the causal pathway between policy and outcome; these authors also add that further stages are necessary for the long-term utilization of implementation plans. These views add the concept of process to the definition of policy implementation.

A related focus for this term is structure. Mazmanian (1983) saw policy implementation as a structured process that includes the policy decisions made, the identified problems to be addressed, and the objectives to be pursued. Structure has also been seen as a necessary component of implementation, especially in terms of reducing potential problems. As noted by McKenzie and Wharf (2010) the more change required by the policy and the larger the organization, the more problems will occur as the policy is implemented; structured implementation can reduce these conflicts. Structure has also been noted as necessary in policy implementation in order to take into account how policy changes affect a given system, the various departments, and community organizations (McKenzie & Wharf, 2010). These views on what policy implementation is explain how it is a planned stage in policy making that requires attention from policy actors.

Another emphasis in the literature on policy implementation is on commitment; without the commitment of the relevant policy actors to policy action plans, implementation cannot exist. Researchers who have studied this concept have noted that various organizations involved in policy implementation react differently to the introduction of a new policy depending on how it will change their practice; for example, organizations often do not have sufficient time to devote to implementation (Lipsky, 2010; McKenzie & Wharf, 2010). Based on this research, policy implementation relies heavily on the commitment of the actors involved.

Based on the previous discussion, for the purpose of this thesis policy implementation is defined as *the structured execution of a policy decision that turns policy into practice through its policy action planning stages with the commitment of implementing actors*. This definition includes the idea of the implementation stage of policy making as having stages within itself, the idea of structure, and the idea of commitment; these were chosen because of this author's use of the Advocacy Coalition Framework (ACF) as an analytical tool. The framework emphasizes a process of strategizing, compromising, and reassessing policy decisions over a period of time among various coalitions which are committed to a cause based on their shared beliefs (Sabatier, 1988), which directly relates to this definition of policy implementation. The only concept that was omitted was the causal relationship between the actions of policy implementers and policy impact because it ignores the influence of external factors, which is an important variable in the ACF.

Mental Health System.

The literature regarding mental health systems is filled with studies concerned with improving elements within these systems. Definitions of the term 'mental health system' are not as easy to come by. However, the elements that constitute a mental health system are noted

frequently in the literature. One overarching definition of a mental system was offered by Olson in his comparative study of four national mental health systems; he states that, “a mental health system comprises all organizations, institutions, and resources that produce actions whose primary purpose is to improve mental health” (Olson, 2006). The rest of the literature that was reviewed on this topic discusses in further detail the components that constitute this definition; that being said, their contributions relate closely to this general definition of a mental health system.

One important element that is a part of a mental health system is structure. Ashley and Orenstein (1990) used general systems theory in their work on mental health systems and described the structure as the organizations, institutions, and resources for delivering and financing mental health services. These structural elements can vary greatly among different mental health systems; the structure of Manitoba’s mental health system in particular is described later in further detail.

Another important element to consider is the function within the structural aspects of a mental health system. Ashley and Orenstein (1990) go on to express that the structure of a mental health system also includes the roles occupied by various individuals who perform different functions that contribute in different ways and degrees to the general goal of enhancing a society’s mental health (Ashley & Orenstein, 1990). This emphasis on function also highlights the importance of who is included in a mental health system and what roles they occupy. A description of a mental health system should include providers, patients, and payers, health plan managers, regulators, and policymakers along with the ways they interact in their roles as members of the system (Olson, 2006). Most descriptions of mental health systems found in the

literature included these formalized, practitioner or financier roles for defining a mental health system.

Mental health systems, as they exist today, also rely heavily on those who make up the informal mental health system; yet this is not as much of a focus in the literature. On one side of the informal system you have practitioners who are not directly related to the mental health system. It has been noted that a majority of individuals with mental health needs receive services in primary health care settings and not in specialized mental health settings (Olson, 2006). This treatment of mental health clients by general practitioners alone has been seen as a concern to some because of a lack of integration of mental health services with the primary health care system (Davis, 2006; Olson, 2006). While on one hand, the primary health care system may be able to relieve some on the pressure of the mental health system and may be able to effectively treat some mental health concerns, many people will not be receiving the services that they need from someone with mental health training and experience.

The other sides of the informal mental health system that deserves considerable attention are the family, friends, and natural supports in peoples' lives. At times, this informal support network provides the most significant supports in people's lives. They are the support during and between a person's interactions with practitioners, and sometimes are people's only supports at all. While these supports were not found to be mentioned often in most of the literature, there seems to be a growing emphasis on the role these people play in supporting mental health, including resources to assist these supports in knowing what they can do to support someone they know who is in need (Canadian Mental Health Association, 2004; Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). The informal support network that consists of a person's natural supports needs to be included in understanding what a mental health system is.

The definition of mental health system for the purpose of this thesis also needs to be considered in the context in which it is operating. The policy that is being used as a case study operates within Manitoba's mental health system, which is also affected by how the Government of Canada is involved in mental health. The constitutional powers that Canada has over health issues helps define its role in mental health care. The Government of Canada's main role is to provide money to provinces and territories, which leaves the regulation and operation of mental health services a provincial/territorial responsibility (Jackman, 2000).

Important legislation in Canada exists to help define how the federal government provides this financial support to provinces. The Canada Health Act specifies the conditions that must be met by provincial and territorial insured health services and extended health services before a federal cash contribution will be made (Canada Health Act, 1985 c. C-6). The Act also defines important concepts, such as which services are considered to be insured health services, what physician services are and what extended health care services are. Important aspects to note from the Act are that insured services are largely restricted to care delivered in hospitals or by physicians, and that the definition of hospital does not include a hospital or institution that primarily operates for the treatment of the mentally disordered (Canada Health Act, 1985 c. C-6). This Act also excludes uninsured health and social programming, under which a wide range of mental health services fall.

Two of the federal cash contributions, or federal block transfers, that should be mentioned here are the Canada Health Transfer and the Canada Social Transfer. The Canada Health transfer is one of the largest transfers provided to provinces and territories for long term funding for health services as defined in the Canada Health Act (Department of Finance Canada, 2011a). The Canada Social Transfer is meant to assist provinces and territories to support post-

secondary education, social assistance, social services, early childhood development, early learning, and childcare as defined by the Federal-Provincial Fiscal Arrangements Act (Department of Finance Canada, 2011b; Federal-Provincial Fiscal Arrangements Act, R.S.C., 1985, c. F-8). This is the source of support for the many mental health programs in Manitoba that would fall under the social services definition. Also, important to note regarding this particular transfer is that it finances social programs in a way that provides provinces and territories flexibility in how the funds are spent (Department of Finance Canada, 2011b) rather than defining what exactly the money is for, as the Canada Health transfer does. This could either benefit or hinder community based mental health services, depending on how much provincial support is behind them, as that will largely determine what kind of funding will be provided to them.

Aside from how federal funding is provided, the Government of Canada is responsible for other activities that affect mental health services. Canada also has jurisdictional power over the control of activities that put human health at risk, regulating matters of national health and welfare, and providing health resources to Indigenous communities (Jackman, 2000). These jurisdictional powers may be utilized with mental health issues when they become issues of national concern or if they were related to an epidemic, like issues of depression and suicide. They also may be utilized to provide mental health services to Indigenous communities, which may not have sufficient access to services due to remote locations.

In Canada, there is a decentralized mental health care system in terms of both fiscal and service delivery structures; this stemmed from the mid-20th century mental health reform where we also saw the shift from institutional treatment to community based care (Morrow, 2004). With the shift to community based care, the mental health system in Canada became very

complex. It has been critiqued as not being a system at all, but rather a convoluted array of services that are delivered at the federal, provincial, and local levels along with the services of private practitioners and self-help organizations (Canada. Parliament. Senate of Canada. Standing Committee on Social Affairs, Science and Technology., 2004). These services also include those provided by family physicians, psychiatrists, clinical psychologists, registered psychiatric nurses, social workers, and occupational therapists. This array of services has created issues in structuring a mental health system for Canada without sufficient continuity. This system of various services, clinics, treatments, and supports vary in capacity and quality, often operate in silos, and are frequently disconnected from the health care system; this has resulted in a very fragmented mental health system for Canada that has become increasingly difficult for people to navigate (Canada. Parliament. Senate of Canada. Standing Committee on Social Affairs, Science and Technology., 2004). In order to address this fragmentation within and across provinces, the Mental Health Commission of Canada was established, whose role was also to evaluate and develop the first national mental health strategy in Canada; the strategy *Changing Directions, Changing Lives* (Mental Health Commission of Canada, 2012) has only existed for a few years. Research on how it is progressing and affecting mental health at national and provincial/territorial levels will be useful in determining how Canada's role has and can change to better address mental health issues.

Because of the move to a decentralized mental health system, the responsibility for mental health services lies in the jurisdiction of provincial governments; the Canadian government, as mentioned remains involved in primarily a funding capacity, but also plays a role in research, program and policy development to provide additional support to mental health in Canada (Health Canada, 2015). For a better understanding of Canadian mental health care, we

need to take a deeper look into how it operates provincially and territorially. Provinces and territories hold constitutional jurisdiction for the establishment and management of public hospitals, authority over the design, management, and delivery of health care services, the protection and promotion of health at the local level, and the regulation of health records, health insurance, and the training of health professionals (Jackman, 2000). With so many responsibilities localized to the provinces and territories, differences among them in the way they operationalize these should be expected.

There are benefits and challenges to the localization that has occurred as a result of Canada's decentralized mental health system. Localization can be very beneficial because policies and services can be tailored to local needs and contexts. This was recognized in the development of the national mental health strategy in that it was intentionally designed to lack precise directives for implementation so that it is open for provincial/territorial governments to adapt it to their particular needs, supports, and barriers (Mental Health Commission of Canada, 2012). One of the challenges that presented itself from this perspective is the distribution of resources within provinces/territories. Depending on the diversity of needs, there can be a lack of resources in particular areas. For example, rural and northern communities are not receiving resources that they need due to their location, especially compared to the resources that available in major cities. Mental health services have been found to be less comprehensive, available, and accessible than in urban areas, along with a shortage of mental health professionals (Canadian Mental Health Association, 2009; Jennissen, 1992). These issues can vary and need to be addressed by the organizations that operate the mental health systems provincially and territorially.

A number of the provinces' and territories' health systems are operated by regional health authorities. In Manitoba, regional health authorities were given the responsibility to govern and operate health services, including mental health services, in 1997 and 1998 (Government of Manitoba, 2015b) with the intention of more comprehensive and better-coordinated services (Davis, 2006). Their responsibilities include the planning, delivery, and ongoing management of some mental health services (Government of Manitoba, 2015b). While regional health authorities exist across Canada, a look at the mental health system within Manitoba will be needed to define the boundaries that it operates under. Manitoba has a wide variety of organizations and support services included in both its formal and informal mental health system. Other than the services provided by the Regional health authorities, Manitoba's mental health services also come from the Selkirk Mental Health Centre, other hospital facilities, various government departments, and many community-based organizations (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a).

The government departments which are involved with mental health services and policy are also affected by how the provincial government is structured. In Manitoba there are a number of governing bodies that make up the provincial government including the cabinet, its committees, the Executive Council Office, the Department of Finance, the Treasury Board Secretariat, central agencies and central departments (Dunn, 2006). The leader of all of this is the Premier who provides leadership and direction along with deciding who the ministers will be (Vogt, 2010). The premier's decisions and party ideology can have significant impacts on how much political support mental health issues will have during an administration. However, the cabinet, ministers, and legislative assembly also carry a significant amount of influence regarding government programming and policy.

The cabinet is the main governing body for administering and initiating policy (Dunn, 2006). The decisions made by the cabinet are almost always the final decisions of the government, especially in majority governments where the ministers in cabinet would have power over the rest of the legislative assembly (Vogt, 2010). However, the legislative assembly still carries a significant amount of influence at different stages of the policy process since policies and decisions that are deliberated within the assembly are subject to its approval (Russell & Cowley, 2016). When there is a significant amount of opposition to a policy, especially occurring in cases of minority governments, it becomes much more complicated for policy deliberations to be decided (Paun & Hazell, 2010). The more opposition there is to a policy, the more concessions the premier and cabinet must be prepared to make; compromises on policy decisions become a necessary part of the process in these situations (Paun & Hazell, 2010). Sometimes formal coalitions will be formed to increase a minority government's amount of policy decision-making power, or policies may be revised in anticipation of opposition to reduce the potential of defeat (Paun & Hazell, 2010; Russell & Cowley, 2016).

When the current strategy under study was approved, Manitoba had a New Democratic Party (NDP) majority government. This makes it less likely that there would have been a significant amount of opposition to the initiative; however since it is not a piece of legislation, the final decision does not need to be made by the legislature. The policy document itself does not officially indicate who it was approved by. Strategies like this can also be used as a way to set objectives and expectations for government through the direction of public services or changes in funding policy rather than through legislation (Paun & Hazell, 2010). Strategies would not be under the same level of scrutiny or have the same approval process as policy initiatives involving legislative changes, which must be enacted by the legislature. For policy

initiatives to be deliberated on in cabinet, the minister responsible for them would need to bring them forward.

Bringing forward policy initiatives is not the only responsibility a cabinet minister has. Ministers are also responsible for leading a government department, all policy and administrative decisions within that department, and ensuring that their department follows through with cabinet decisions (Dunn, 2006). Mental health policy initiatives in Manitoba are brought forward by the minister of Health, Healthy Living and Seniors. The ministers also have a collective responsibility for all decisions brought to cabinet so decisions on policy happen most often through consensus; while this is the preferred option, the premier does have the authority to make the final decision (Vogt, 2010). Once a mental health policy is approved through cabinet, it would be expected that all cabinet ministers must support it (Vogt, 2010) and it will be followed through by the Department of Health, Healthy Living and Seniors.

Aside from the ministerial decisions made in cabinet, there are other governing bodies that are involved in ensuring a policy comes to fruition. Manitoba's legislative review committee reviews and approves departmental legislation before it is brought to the legislative assembly, which helps create and amend provincial legislation (The Legislative Assembly of Manitoba, 2015; Vogt, 2010). Government policies also need to go through a sub-committee of the cabinet called the Treasury Board. It is the Board's responsibility to manage the government's finances and public funds in order to meet its objectives by assessing strategic policies, determining their economic and social benefits to Manitoba, and by reviewing the expenditure plans of all departments (Manitoba Finance, 2015c; Vogt, 2010). The current strategy under study would have been reviewed by the Treasury Board as part of the Department of Health, Healthy Living and Seniors' objectives along with legislation in Manitoba.

Important legislation that affects Manitoba's mental health system includes the Mental Health Act, which outlines the requirements for admission and treatment for patients entering psychiatric facilities (Mental Health Act, 1998, c. M110), the Mental Health Bill of Rights which outlines what rights a person with a mental illness has in Manitoba (Legislative Assembly of Manitoba, 2014), the Health Services Insurance Act, which outlines what services are available to people with health insurance along with what the costs of these services are (Health Services Insurance Act, C.C.S.M, 2014, c. H35), the Social Services Administration Act, which outlines the forms of assistance a Manitoba resident is provided other than those provided in the Health Services Insurance Act, which include rehabilitation services, case work, counseling, and referral services (Social Services Administration Act, C.C.S.M, 2014, c. S165), and the Regional Health Authorities Act which outlines the composition, structure, and responsibilities of various geographic regional health authorities along with what health services they cover, including mental health services (Regional Health Authorities Act , C.C.S.M, 2014, c. R34). The particular branch within the Department of Health, Healthy Living and Seniors that deals with mental health services and policy is the Mental Health and Spiritual Health Care Branch; the Branch works with Manitoba Health, the regional health authorities, other organizations, and various stakeholders to develop provincial policies, strategies, and planning related to mental health services (Government of Manitoba, 2015b). This branch led the development of the mental health strategy under study.

With all of the various departments, facilities, organizations, and informal supports involved, it becomes clear how important coordination is in maximizing the benefits of what exists in Manitoba's mental health system. This also relates to how important the concepts of structure, function, and formal/informal roles are in defining what a mental health system is.

Therefore, the definition of a mental health system for this thesis will be a revision of the definition from Olsen (2006) that was presented at the beginning of this section: *a mental health system is structured to comprise all organizations, institutions, support networks and resources that are found in primary health care and mental health care settings as well as informally in the community, that function to produce the necessary actions for the purpose of improving mental health*. Within this thesis, this definition can be used in reference to Manitoba's mental health system and the mental health systems outside of this province.

Strategy.

The final term that requires definition for this thesis is strategy. The case being used to examine mental health policy implementation is referred to as a strategy. A discussion of what this term means and how it relates to the term *policy* is presented below.

A review of the literature on strategy resulted in definitions of this term and the term strategic planning. During the course of this thesis these terms are used interchangeably and are considered synonymous. Most of the definitions in the literature make reference to a strategy reflecting a plan to move forward. Beckham (2000) presents a basic definition that describes strategy as a plan for getting from a point in the present to some point in the future in the face of uncertainty and resistance. Other researchers also make note of this by saying that a strategy is the means an organization chooses to move from where it is today to a desired state sometime in the future through a set of organizational processes, decision guidelines, and a means to measure the effectiveness of those strategies (Campbell, 1993; Duncan, Ginter, & Swayne, 1995). These definitions express the concept of organizational change but can also be used in regards to policy change. Another definition that was found includes the environment as an important factor in strategic planning; it described it as a process for assessing a changing environment to create a

desired future and determining how an organization fits into an environment based on its goals and plan of action (Evashwick & Evashwick, 1988). This is important for the definition of strategy for this thesis because of the emphasis on environmental considerations in the implementation process.

Strategic planning is also noted in the literature as an important and emerging trend in the policy making field. Most specifically, the work of McKenzie and Wharf (2010) expresses the importance of strategic planning in the policy process; they note how strategic planning has become a widely adopted approach over the past two decades within human service organizations as a means to launch new initiatives (McKenzie & Wharf, 2010). Manitoba's mental health strategic plan is just one example of a new initiative in policy. The authors go on to discuss what is included in their description of strategic planning; understanding the historical context of a problem, establishing a vision of the policy/service three or more years in the future, a situational assessment of both the internal and external policy environments, identifying issues, developing strategic options for each issue, and assessing feasibility and implementation challenges, are the tasks that are usually covered in a strategic plan (McKenzie & Wharf, 2010). The more comprehensive description of the case study in question later in this thesis indicates how this strategy is in line with these authors' interpretations of strategic planning.

As mentioned earlier, a discussion of the term *policy* is presented. This is because this thesis focuses on the policy implementation of a strategy. It is important to understand how the terms *policy* and *strategy* relate to one another. There are many interpretations of what a policy is. Some authors define policy as a statement by government officials of what they intend to do regarding an issue, such as a law, regulation, ruling, decision, order, or a combination of these (Birkland, 2011). This definition reflects legislative actions and ignores the policy actions of

those who are not involved in government. It also expresses a specific intention to do something; it is important to note that the literature also recognizes that the *lack* of statements, as described above, is also an implicit statement of policy (Birkland, 2011). For example, the lack of a mental health strategy in Manitoba could be viewed as a reflection of the government not seeing mental health as an important issue. Other definitions of policy are more inclusive to the different kinds of actions that are included in policy decision-making. Pal (2006) describes policy as “a course of action or inaction chosen by public authorities to address a problem or interrelated set of problems” (p. 2). This definition relates to Manitoba’s mental health strategic plan as it outlines a course of action to be taken in a 5 year time frame and is meant to address an interrelated set of problems associated with low levels of mental health and with the lack of a coordinated response. This writer accepts this definition of policy and regards the strategy in question as a policy response. This is meant to clarify how the policy implementation of a strategy can be studied by using this definition.

Based on the previous discussion of strategy and how it relates to policy, strategy is accordingly defined as *a plan of action within a given policy environment where goals, objectives, and actions are determined in order to move a social problem to an improved state in the future*. This definition includes elements of the definitions found in the literature, such as organizational planning and moving towards a vision of the future. The definition also places this plan of action within a policy environment to recognize the role of strategic planning in policy while also recognizing how this occurs within environmental considerations.

Range of Policy Implementation Theories

Theories regarding policy implementation began to surface in the literature in the 1970s. Many different theoretical perspectives have been developed which appear to be built on

previous theories. All of the theoretical perspectives in the literature can be categorized into three approaches to policy implementation; top-down approaches, bottom-up approaches, and synthesis approaches. This discussion begins with the first generation of policy implementation research, which primarily encompassed the top-down models. It will then move on to the second and third generations of research, which embodied the bottom-up models and synthesis models respectively.

Top-down Approaches.

The top-down approach was the earliest documented attempt at studying implementation. In general terms, it focuses on the goals and strategies for implementing policy as structured by statutes and policy makers (Birkland, 2011; Winter, 2006). Three main contributions to this approach are outlined below.

Pressman and Wildavsky (1984) contributed some of the earliest works for policy implementation theory and the top-down approach. Their seminal study examined why an urban employment program, the Oakland project, had failed (Pressman & Wildavsky, 1984). Their analysis of this project contributed an important concept and model to implementation research. They coined the term “clearance points” to describe a process marked by a sequence of tasks that would need to be accomplished before the process could continue; their proposed model consisted of attaching a probability to a chain of independent clearance points that would assume, for example, that there is an 80% probability of agreement on each clearance point (Pressman & Wildavsky, 1973). The authors used this model to describe key factors in the implementation process and to explain why the Oakland project failed. The failure of the project was said to have been caused by great variations among the many actors involved in the implementation in regards to their levels of commitment, perceptions of urgency, and capacity

(L. A. Pal, 2006); this model suggests that implementation would have been successful had the head office taken charge of the project, had the objectives been stated clearly, and had the clearance points been kept to a minimum to avoid a higher likelihood of implementation barriers (Pressman & Wildavsky, 1984). This model created a baseline for implementation research and was adapted by many other researchers in hopes of creating improvements to our interpretations of policy implementation.

Ernest Alexander, who attempted to add some flexibility to the model, proposed one adaptation of Pressman and Wildavsky's model. He expressed that the overall probability of clearance would increase considerably by recognizing that actors may attempt clearance multiple times, that clearance points are not always independent from each other, that previous clearances can increase the probability of future clearances, that program reduction strategies can be used to shorten the chain of clearances, and that higher than 99% probabilities of clearance can occur in some cases (Alexander, 1989). Alexander's adaptation added a realistic perspective to the original model's concepts, while maintaining the control of policy implementation in the hands of the top-level policy makers.

Also adding to Pressman and Wildavsky's model was the work of Eugene Bardach. He looked at policy implementation as a game metaphor and offered strategies, like avoiding complex implementation designs, writing out possible scenario consequences ahead of time, and adjusting tactics along the way, in order to make the implementation 'game' go smoothly (Bardach, 1977). His work is notable in that it added the perspective of strategic planning to the top-down implementation approach.

Further work in the top-down policy implementation tradition focused on determining a structure for the process. Researchers developed checklists in order to determine what factors

needed to be present in order for implementation to be successful (Hogwood & Gunn, 1984; Sabatier & Mazmanian, 1981). Hogwood and Gunn offered a checklist of requirements that included adequate time and resources, valid theory, clear and reasonable causal connections, agreed upon objectives, clear communication, and a correct sequence of tasks; the authors also note that meeting these requirements is unlikely due to the many insurmountable external factors (Hogwood & Gunn, 1984). Sabatier and Mazmanian, on the other hand, present a similar list of objectives required for effective implementation but add recognition of system level considerations and exogenous variables; political and socioeconomic considerations are expressed to be important factors for the implementation process, as is the cooperation and commitment of implementing agencies and interest groups (Sabatier & Mazmanian, 1981). The contributions of these researchers categorized and structured the top-down approach and created an understanding of the critical factors needed in regard to this approach to implementation.

The contributions of these first-generation policy implementation researchers focused on this process in a hierarchical manner with power and control being in the hands of top policy makers. This approach can be very useful to policy implementers. The structure it denotes has been proven to be effective when present and the checklist of variables required for effective implementation has been seen as useful for understanding implementation strategies (Sabatier, 1986). This approach is best chosen when studying the implementation of single, dominant policies that exist in relatively stable environments (Sabatier, 1986). While top-down implementation may be a strong approach in certain cases, there are weaknesses associated with it as well. Sabatier offered a few limitations to this approach that included that few policies are able to have clear and consistent objectives, that it does not provide a realistic time frame for implementing policy, and that it neglects the strategic initiatives of other actors by focusing so

strongly on the central decision makers (Sabatier, 1986). It has also been noted that the conditions for effective implementation are rarely evident in practice (McKenzie & Wharf, 2010) and that it is inevitable for front-line workers to exercise some level of discretion as they attempt to put the policy into practice (Ryan, 1995). Limitations like these continued the evolution of policy implementation research. New approaches that deviated from the hierarchical approach to implementation made way for the second generation of implementation research.

Bottom-up Approaches.

Second generation research essentially took the opposite approach from top-down theorists and is appropriately called the bottom-up approaches. Essentially, these approaches view implementation as starting with those who implement policies at the point of contact with the target population and as moving upwards to influence policy at higher levels (Birkland, 2011). The contributions to this approach highlight the importance of the perspective of front-line workers for implementing public policy.

A core belief in this approach is that policy should be directed by those who understand the policy problem. Researchers assert that the closer people are to the source of a problem, the greater their influence should be (Elmore, 1982; Hjern et al., 1978; Lipsky, 1971; Lipsky, 2010). Hierarchical control in the hands of top policy makers lacks effectiveness from this perspective because of their separation from the problem at hand. The concept of “backwards mapping” is central to this approach, and it describes how a specific behavior at the lower levels of the implementation process creates the need for policy; the behavior or problem to be solved initiates a process of determining objectives, organizational operations, and desired outcomes (Elmore, 1982). Other contributions to this approach involve determining who needs to be involved in this process. Benny Hjern developed a networking technique whereby service delivery actors are

asked about their goals, strategies, and contacts; the contacts that are gathered are then used to determine the different levels of actors involved in planning, financing, and executing programs (Hjern et al., 1978). This technique helps formulate a structure related to the concept of “backwards mapping”. Michael Lipsky made significant contributions to this approach with his work on street-level bureaucrats who are considered to be those working directly with target populations, like social workers. He viewed their roles as having high levels of discretion with generally high levels of autonomy from organizational authority; this unique role permits them to make and implement policies as they see fit based on significant aspects of their interactions with target populations (Lipsky, 2010; Winter, 2006). These contributions express clearly that street-level bureaucrats have important perspectives and influence that top-level policy makers do not and should, therefore, be the ones in charge of the implementation process.

Bottom-up policy implementation theorists added important components to the literature by advocating for the de-centralization of government controlled programming and implementation strategies. This has been seen as a strong approach by building on the knowledge of experienced actors in the field (Ham & Hill, 1984), by having an increased awareness of unintended consequences from not focusing narrowly on formal policy objectives (Hjern et al., 1978), and by being better able to deal with strategic interaction among various actors over time (Hjern et al., 1978). This approach is best used when there is not one single dominant policy, but where many policy statements and organizations are involved in a policy problem (Sabatier, 1986) and maybe more useful for program level decisions than for overarching policies. While the bottom-up approach can be useful for certain policy areas, there are limitations to be considered, as well. This approach has been criticized for overemphasizing the ability of front-line workers and street-level bureaucrats to influence the central policy level (Hjern et al., 1978),

for miscalculating the resource and organizational constraints affecting street-level bureaucrats (Ryan, 1995), and for its reliance on the perceptions of front-line workers rather than on an explicit theory (Hjern et al., 1978). In consideration of the strengths and limitations of the bottom-up approach, policy implementation theorists continued to search for a singular approach, which made way for a variety of interpretations on how policies can most effectively be implemented.

Other Approaches.

As policy implementation theory continued to develop, other approaches were presented to help analyze implementation. The three approaches presented below include related concepts to top-down and bottom-up approaches. Their purposes serve to refine the focus of these theories and to address the concerns of the earlier approaches. It should be noted that additional approaches exist in the literature aside from these, but including them would go beyond the scope of this thesis since they have not been supported as much by other researchers; nor have they been applied widely to study various policy areas. These three approaches have been chosen because they emphasize the important concepts and themes that are contained in virtually all implementation theories.

One additional approach that gained some attention in the literature is the institutional approach. It focuses on the institutions and organizations that are involved in implementing a policy. Factors include how to achieve inter-organizational harmony, stable implementation routines, institutional problem solving, and dividing tasks among subsystems (Hanf, 1978; Ripley & Franklin, 1982; Scharpf, 1978). Institutional theorists propose that the coordination of these factors, the various actors, organizations, and programs will lead to the successful implementation of policy (Ryan, 1995). This approach can be seen as useful for both top-down

and bottom-up approaches. Either approach can benefit from incorporating cooperation among its implementing organizations.

Another approach, stemming from the top-down approach, to consider is using statutory-coherence models. This approach sees effective implementation as being a result of how effectively a structured statute is followed (McFarlane, 1989). Other models have used this to explain poor outcomes when legislation inadequately ranks policy objectives, allocates financial resources, applies regulations, and integrates implementing organizations (Mazmanian & Sabatier, 1983). Statutory-coherence models illustrate the strength seen in the top-down approach of structure being an important factor in policy implementation.

A third approach to make note of in the literature is the contextual models of implementation. These approaches move away from the focus on what individual actors and organizations are doing by moving towards broad societal variables. Some theorists suggest that an interpretive analysis is needed whereby a policy's language and meaning are examined in order to reduce the challenges that may come along with multiple stakeholder interpretations (Yanow, 1993). Other theorists suggest that the environment in which a policy is formed needs to be examined and argue that implementation outcomes will depend on how compatible policy directives are with the pre-existing contextual influences (Love & Sederberg, 1987). Other theorists have analyzed implementation by using a political-economy framework and argue that forces, such as power relations, production costs, supply and demand of services by stakeholders, and appropriate technological uses are what drive implementation (Hasenfeld & Brock, 1991). Contextual factors are important to consider in policy implementation because policy problems do not exist without them. The inevitable existence of environmental variables can always lead to unexpected outcomes if they are not expected to play into the implementation process.

All of the approaches that have been discussed thus far have important implications for policy implementation. As each theory seems to build off of a previous theory or aims to analyze implementation using a slightly different or more refined focus, it is a challenge to understand when to use what theory for what kind of policy. Researchers who have conducted extensive reviews have criticized implementation theorists for being unable to create a single, unifying policy implementation framework (O'Toole, 2000). However, a single approach to policy implementation may not be what we should be aiming for since policy problems, systems, and environments can vary so greatly from one another. Mental health policy in Manitoba can benefit from being analyzed using concepts from both the top-down and bottom-up approaches. This approach is referred to as the synthesis approach and is described in detail below and used for the analysis of Manitoba's mental health strategic plan.

Synthesis.

The synthesis approach became popularized in the third generation of implementation research. Many attempts have been made to remove the distinction between the top-down and bottom-up approaches (Ryan, 1995). Richard Elmore did this by combining his concept of backwards mapping with forward mapping; he argued that implementation success depends on amalgamating the policy instruments and resources of policy makers with the incentive structure of the target groups (Elmore, 1985) to determine what needs are to be met and how best to go about meeting them from the target group's perspective. Stocker developed the regime framework, which identifies the values to be served among all implementation actors in the implementation process; he argues that the cooperation between the top-down value of compliance and the bottom-up value of conflict resolution is vital for this approach (Stocker, 1989). Winter followed these up with his integrative approach where he takes from both top-

down and bottom-up approaches, but also integrates sociopolitical processes such as the environment prior to the policy being implemented, organizational behavior, street-level bureaucrat behavior, and other changes in society (Winter, 1990). Each of these approaches contributed important concepts to the third generation of implementation and discovered important ways to synthesize top-down and bottom-up approaches.

However, Paul Sabatier developed one of the most noteworthy attempts of a synthesis. His approach combined top-down and bottom-up approaches, but also added a couple of other important concepts that are discussed below. These additional reasons are why Sabatier's synthesis approach has been chosen as ideal for investigating how policies should be implemented and used for the analysis of Manitoba's mental health strategic plan.

Sabatier's Synthesis Model and the Advocacy Coalition Framework.

Sabatier, like the other synthesis theorists, attempted to take the best from the top-down and bottom-up approaches. One way he did this was by using the bottom-up approaches unit of analysis that included all of the actors involved with a policy problem and an understanding of their perspectives and strategies (Sabatier, 1986). By doing so, this model incorporates the knowledge of those closest to the problem. Sabatier also includes the way in which socioeconomic conditions and legal instruments affect the process, which is representative of the top-down approach (Sabatier, 1986). By making this synthesis, Sabatier is able to use the many actors and strategies involved in a policy problem in explaining the effectiveness of implementation, while also providing a structure that is needed in the implementation process among the various perspectives in consideration.

One of the premises that is essential to this model, which sets it apart from the others in the synthesis perspective, is the time allocated to the implementation process. Sabatier (1986)

applied his perspective to a period of a decade or more. A review of the literature showed that the 4-5 year time-span of most implementation studies leads to premature judgments of policy failures and misses important features of the process; while studies that incorporate the longer time frame saw much more improvement since implementation actors were able to take the time to identify problems and develop strategies to fix them (Mazmanian & Sabatier, 1983). Adopting the time-frame of a decade or more increases the opportunities for policy change to occur.

The idea of policy change within a longer time frame leads us to another concept that sets Sabatier's approach apart from the others, policy-oriented learning. This refers to the continuous alterations of thought and behavior resulting from experience in terms of the attainment or revision of policy objectives (Hecl, 1974). In other words, it is the learning that occurs during the policy implementation process as a result of experience; intentions may change, strategies may change, and the environment in which the policy is operating may change. Sabatier offers three areas that may be essential to policy-oriented learning; the first area is improving one's understanding of what variables are important to the stated objectives along with competing objectives; the second area is in regard to reexamining one's core beliefs by acknowledging inaccurate assumptions regarding goals if these present themselves; and the third area relates to identifying and responding to external challenges by incorporating new solutions (Sabatier, 1988). The opportunities to see and respond to these changes become more likely when policy-oriented learning is occurring within a longer time frame.

Another essential concept of Sabatier's approach concerns the policy actors who are seeking to attain their policy goals. According to Sabatier, the support of advocacy coalitions made up of actors from different public and private organizations that share the same beliefs and which seek to achieve common policy goals over time is essential for effective implementation

(Sabatier, 1986). It is the organization of these groups that can actually implement policy ideas into practice. By seeking out allies with similar policy goals and coordinating their actions, advocacy coalitions are able to improve their strategies and learn how to work with competing coalitions, and, in turn, increase their levels of success (Weible & Sabatier, 2007). The way in which various advocacy coalitions work with and against each other, coordinate various policy goals and beliefs, and incorporate external factors out of their control into the implementation process are essential to the implementation process.

In order to organize all of this Sabatier developed a framework for his synthesized approach called the Advocacy Coalition Framework; a diagram of the ACF can be found in Appendix A. Before describing the structure of this framework, it is essential to include two other premises that are unique to this framework. Sabatier argued that the most efficient way to study policy change over time was by focusing on policy subsystems, a group of policy actors from different organizations and implementation levels who are interested in a policy area such as mental health and who engage in coordinated activity over time (Sabatier, 1988). The subsystem includes everyone who plays a role in changing policy in a given area and can be made up of various coalitions. Coalitions each seek to turn their goals into policy and must compete with other coalitions in the subsystem to dominate policymaking (Weible & Sabatier, 2007). The way that coalitions act within subsystems is reviewed when describing the figure in Appendix A.

Another premise is in regard to how coalitions are united. Coalitions are organized around beliefs; they aim to turn their beliefs, value priorities, and perceptions of causal relationships into policy (Sabatier, 1988). Different coalitions will have different belief systems and compete to have their goals and their beliefs translated into policy. Sabatier notes that three

types of beliefs characterize a coalition's belief system. First there are a coalition's deep core beliefs, which are made up of fundamental beliefs such as whether or not people are inherently good or bad; these deep core beliefs generally remain stable over time (Sabatier, 1986). Second, there are a coalition's policy core beliefs which include its fundamental positions on policy strategies, such as distributing authority among governing officials or choices concerning policy instruments; alterations to these beliefs are usually due to changes outside of the policy subsystem, like large scale socio-economic changes or changes in system wide governance (Sabatier, 1986). Third, there are the secondary aspects of a coalition's belief system which include the instrumental decisions needed to attain their policy core beliefs, such as budget allocations or statutory interpretation; changes to these beliefs occur much more often and are often the result of policy-oriented learning over time (Sabatier, 1986). These different levels of beliefs are important to mention because they are what holds a coalition together; they are used while competing with coalitions of other belief systems, and help to explain how change within and outside coalitions can contribute to policy change over time.

The figure that Sabatier offers to outline the ACF, found in Appendix A, helps to illustrate the variables that are involved in explaining policy change over time. On the right side of the diagram is the policy subsystem. Here it shows two coalitions which each adopt a strategy to have its policy goals met based on its separate belief systems and the resources each coalition has at its disposal. In between the two coalitions, we find the policy brokers. This group of actors serves as mediators who work to find a reasonable compromise when there are conflicting strategies from different coalitions (Sabatier, 1988). Policy brokers may include elected officials, civil servants, or the courts (Weible & Sabatier, 2007). These interactions lead to some sort of a

collectively chosen government program, which, in turn, leads to both policy outputs at the operational level and policy impacts.

The other variables in the diagram illustrate what is occurring outside of a given subsystem. The relatively stable parameters, external events, long-term coalition opportunity structures, and short-term constraints and resources of subsystem actors are provided to show how subsystems operate within a broader political environment (Weible et al., 2009). An example of a relatively stable system parameter in the environment in which the mental health policy subsystem operates as described by the basic attributes of the problem area and fundamental socio-cultural values could be the level of mental health stigma a community exhibits and whether or not stigma is valued as a problem that is worth solving. An example of an external event as described by changes in a systemic governing coalition or changes in socio-economic conditions could be a change to a new governing party which views mental health as more or less important than the last party or a change in budget that could significantly decrease or increase the amount of money available to work towards fixing a problem. The long-term coalition opportunity structures refer to the degree of consensus needed for major policy change and to the openness of political systems (Weible et al., 2009). This relates in part to the decentralized nature of the mental system in Canada, which encourages more participation than highly centralized governments. All of the political environment variables affect the constraints and resources of subsystem actors as can be seen in the center of the figure. As with the examples above, if there is a high level of stigma in a community with a low budget allocated to the mental health system, this will add constraints and significantly affect the resources of the actors involved who will not be able to make their desired changes to policy. These exogenous factors are important because they can impact implementation in ways that are partially out of

the control of those responsible for implementing a policy (Nilsen, Stahl, Roback, & Cairney, 2013).

The figure also makes note of internal feedback loops within the policy subsystem. These refer to the process of policy-oriented learning that was described earlier; based on the decisions that were made with regard to the government program, the impacts that occurred, as well as any new information. Coalitions may revise their strategies and enter this process again. As the figure also shows, policy-oriented learning occurs as the policy subsystem ties back around to the external variables; if any of these variables have changed naturally, or as a result of policy changes, revisions to a coalition's strategy may be necessary. The potential extent of policy-oriented learning that occurs in this framework and the likelihood of reformulating numerous policy decisions, clarify why a time-frame of ten years or more is essential to this framework and to effectively implementing policies.

While the ACF is one of the most comprehensive theoretical frameworks for policy implementation, it also has limitations. The ACF has been criticized for limitations in its applicability, utility, and for the absence of important details regarding advocacy coalitions. In terms of applicability, the ACF has been criticized for its difficulty in application to policy studies. Studies typically use questionnaire or interview data within a perspective of ten years or more, which can be a challenge because of its costly and time consuming nature (Weible & Sabatier, 2007). This time frame also does not take into account how the timelines for most government policy decisions are intended to occur within election cycles, which in Canada occur over four years. These studies require diligence and resources that may not be possible for some investigators. The ACF can also be difficult to apply in many types of subsystems. The ACF is not as applicable to subsystems without clear coalitions or with only one overarching coalition

than as it is to subsystems with clearly defined or multiple coalitions (Weible & Sabatier, 2007). This study did not find evidence of clearly defined coalitions, which created difficulties in identifying how policy beliefs connected policy actors, how their resources and strategies impacted other policy actors with different beliefs, and if the role of a policy broker has merit in this case. Given the complex and fragmented nature of Manitoba's mental health system as described earlier, the absence of formally defined advocacy coalitions present some challenges to this study.

Another critique of the ACF asks the question as to whether or not it truly studies implementation. Matland (1995) stated that while the ACF is a legitimate framework for studying a broad policy area over a long period of time, it deviates from definitions of policy implementation that focus on specific policies rather than on all of the dynamics occurring within a policy field. It has also been noted that Sabatier's work with Jenkins-Smith moved away from implementation and towards policy change and formation (Winter, 2006). However, while the ACF does heavily focus on policy change over time, it does not exclude the analysis of more specific policy implementation processes. It simply includes broader policy arena factors that were identified as necessary for studying policy implementation.

Most of the critiques in the literature are in regard to details about advocacy coalitions. One limitation noted by Weible and Sabatier (2007) was that there is a lack of understanding of how advocacy coalitions use the resources and venues that are at their disposal. ACF applications on specific policies or in subsystems with clearly defined coalitions may be able to contribute to this understanding. They also went on to note that there is a lack of understanding as to why some policy subsystems favor one dominant advocacy coalition, two or more competing coalitions, or no defined coalitions at all (Weible & Sabatier, 2007). Further

understanding on this point is important, given that applications to subsystems that are not structured in the way that the ACF framework describes, could create anomalies.

Another critique found in the literature is in regard to the collective action of advocacy coalitions. It has been argued that the ACF makes inaccurate assumptions about collective action in regard to how coalitions are formed and maintained; the argument is followed with a suggestion that collective action problems, like distributing the costs involved in a strategy, need to be addressed by coalitions in order for them to emerge and operate (Schlager, 1995). Weible and Sabatier's (2007) position on this is that the belief systems of coalitions explain their coordination efforts. However, the belief systems alone do not describe the actions that coalitions do or do not take. In terms of coalition behavior, it is noted that the ACF needs to include more on the strategies which coalitions pursue to meet their policy goals (Schlager, 1995). Following the same argument, it was also found that many applications of the ACF assume that sharing common policy beliefs is sufficient for acting in concert (Kubler, 2001), which is not necessarily true. More specific information on coalition behavior and on how policy beliefs are translated into action may help make the ACF easier to apply. While the ACF does describe some instruments that advocacy coalitions use, such as influencing legislatures to alter budgets and legal objectives, affecting public opinion through the media, and altering the perspectives of policy-relevant actors with knowledge and information (Sabatier & Jenkins-Smith, 1999), these activities are rarely discussed in ACF applications (Weible et al., 2009). Despite the critiques of the ACF, it continues to be a widely used framework and continues to evolve while attempting to improve and address these critiques over time.

Some of the more recent literature on the ACF has highlighted how it has been applied in policy studies, areas that need further research and development, how it has been modified, and

how it has evolved since it began. In 2009, a review was conducted of 80 applications of the ACF to explore how it has been used and how it can be further developed (Weible et al., 2009). The review found that the ACF can be applied to various subject areas, across geographical areas, and with other policy process theories and frameworks; it is most commonly being used to study policy change, learning and coalition stability. It was determined that the areas that needed to be developed more to move this theoretical framework forward included the role of institutions and resource dependence, subsystem interdependencies, coordination within and between coalitions, and the stability and defection of coalition members over time (Weible et al., 2009). While the ACF has been applied to a small number of health policy studies, mental health policy has not been used as a substantive topic in ACF applications, aside from one case study identified in the literature review (Swigger & Heinmiller, 2014). This study provides an opportunity to explore further how the ACF applies to the unique characteristics of mental health policy.

Other research has critiqued the policy implementation research as a whole, which included, but was not limited to, the ACF. It was suggested that there is a need for a new research agenda and focus for implementation research (Winter, 2006). A number of different variables were suggested for future policy implementation research, some that already align with the ACF, and others that may help to improve its application to policy case studies. The suggestions include testing different partial theories and hypotheses rather than searching for a generalized theory, clarifying concepts in how they relate to causal relations, and focusing on behavioral outputs as the most operational variable of policy implementation (Winter, 2006). The ACF does certainly benefit from testing partial and numerous hypotheses (Sabatier, 1988); but it could benefit from clarifying concepts and their causal relations, such as how policy oriented

learning specifically contributes to policy change and improvements over time. The ACF could also benefit from focusing on behavioral outputs as a measure of implementation, such as how front line workers understand, retain, and adopt policies into their practice.

In this application of the ACF to mental health policy in Manitoba, it is important to note some of the revisions that have been made. In a recent publication, Sabatier and colleagues describe four areas where the framework has evolved since it began (Jenkins-Smith et al., 2014). First, the theoretical foundation has been strengthened by making existing hypotheses more precise and by adding new hypotheses. Second, existing concepts have been modified and clarified, including the model of the individual to describe the motivations and cognitive constraints of policy actors and the belief system to define the boundaries of beliefs. In addition, a belief type that binds coalition actors together called ‘policy care policy preferences’ was added and the policy subsystem concept was elaborated to emphasize overlapping and nested priorities. Third, concepts have been added, which include purposive and material groups to understand group interests, strong and weak coordination to understand actions within coalitions, mature and nascent subsystems to account for how developed a subsystem is, coalition opportunity structures to understand the opportunities and constraints within subsystems, and coalition resources to understand the capacity of coalition actors. Fourth, the framework has evolved with increasing complexity where determining how to apply it and modify it in the future has become a necessity; for example, some researchers are now using only parts of the framework for analysis rather than using it in its entirety (Jenkins-Smith et al., 2014). In terms of the analysis of *Rising to the Challenge*, modifications of the ACF were necessary to study the implementation of this strategy. While the conceptual framework and premises were useful in this case, both advocacy coalitions and policy brokers were not formally defined. Additionally,

the timeframe in which implementation was studied was over a five year period rather than a ten year period of time. These modifications are discussed in greater detail in the discussion chapter.

There are various reasons for why this theoretical framework is appropriate for studying policy implementation in Manitoba's mental health system. As was discussed in the preceding section, Manitoba's mental health system is very complex. There are a variety of different organizations and roles in both primary and mental health care settings. The synthesis approach and the ACF are appropriate for studying this system because they use the perspectives of these various policy actors while providing a structure that can identify and describe some of the conflicts that arise when treating mental health in a province with such a complex system.

The time frame used in Sabatier's approach is also useful for researching mental health policy in Manitoba. *Rising to the Challenge* has been designed as a five-year plan (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). However, as we have seen, limited times frame can lead to premature judgments about the effectiveness of the strategy (Sabatier, 1988). According to Sabatier's approach, the five year period of time will not give policy makers enough time to implement objectives, observe them operating in practice, evaluate them, and revise them as necessary. Reformulating policy is almost inevitable when considering a policy with such breadth as this one has. Understanding the advantages that a period of a decade or more would allow for, like better evaluations and conclusions about the policy and an increased likelihood for policy oriented learning to occur, have helped when comparing these factors in the shorter time frame that *Rising to the Challenge* is utilizing.

In understanding this policy within the ACF, it was beneficial to identify different coalitions within Manitoba's mental health system. Since it has so many invested organizations and individuals it was helpful to describe mental health in Manitoba as a subsystem in which

different actors, organizations, and coalitions are working with mental health issues. Organizing different groups within the subsystem based on their belief systems makes possible the understanding of this policy's implementation process in a more systematic way. For example, professionals who adopt a recovery approach often value different policy goals than those who adopt a bio-medical approach to mental health. Identifying who are in these coalitions has helped in understanding how strategies are made and how dealing with those working towards different policy goals is handled.

Research on Mental Health Policy Implementation

Before concluding this review, the literature regarding how policy implementation relates specifically to the mental health field will be described. The literature on mental health policy implementation was extensive and heavily focused on the challenges with this process (Barry, 2007; Flisher et al., 2007; Hogwood & Gunn, 1984; Ingram, Schneider, & Deleon, 2007; Lester & Glasby, 2010; McCollam, 1999; Mechanic, McAlpine, & Rochefort, 2014; Pressman & Wildavsky, 1984; Shera & Ramon, 2013a). Empirical studies on particular mental health policies and their implementation were lacking in the literature; most work in this area is in regards to particular programs rather than policies. The relevant case studies will be presented to include the challenges that were faced, successes that were found and recommendations for policy implementation work.

Challenges.

The challenges that heavily populate the mental health policy implementation literature are important for understanding why mental health policies are often not effectively translated into practice. These challenges range from the macro level to the micro level of implementation.

This also illustrates the unique challenges within the mental health field as opposed to other areas of policy implementation. Ten challenges were found to be common in the literature.

The first challenge in implementing mental health policies relates to how they are designed. There is a considerable amount of mental health initiatives and policies that offer positive sounding plans and ideas to improve mental health; however, they lack a transparent approach to putting these ideas and policies into practice (Barry, 2007; Shera & Ramon, 2013a). A significant amount of time and resources often go into publishing policy and strategy documents without being accompanied by an implementation plan (Barry, 2007). Policy design also affects implementation when the policy itself is too general or if the policy objectives are unrealistic given the available resources (Flisher et al., 2007; Nilsen et al., 2013). What often occurs as a result of this is that local agencies are expected to figure out how to implement new policies which can be difficult in the social work and mental health fields, given the busy caseloads of front-line workers (McCollam, 1999). The lack of specific implementation plans in most mental health policy designs creates large gaps in making improvements to mental health; policies fall short and exist more as symbolic policies rather than solutions.

The second challenge in implementing mental health policy is the definitional ambiguity of mental illnesses and mental health problems. Mental health is an area that is still not fully understood and the interpretations of what these terms mean can vary greatly (Shera & Ramon, 2013a). Looking at various societies and their interpretations is an example of this as they may have different ideas for labeling behavior and determining what and who needs treatment (Mechanic et al., 2014). Another issue with the definitional ambiguity is causality. The cause of mental illnesses is debatable, complex, and mental illness is often seen as having multiple causes; these different characterizations complicate the management of mental health issues in

public policy by clouding the interpretations of the problem and the justification of policies that follow (Mechanic et al., 2014). Mental health treatment models have also been found to be ambiguous in how their concepts are defined and how they are understood by healthcare professionals. Mental health professionals often have difficulty describing the conceptual or theoretical basis of their work and find difficulties determining how to define concepts, such as recovery in biomedical treatment contexts (Ward, Reupert, McCormick, Waller, & Kidd, 2017). The definitional ambiguity of this social problem and the models designed for treatment significantly hinder the implementation process. Without a clearly defined problem or treatment model, it is hard to develop clear objectives and actions to implement them into practice.

The third challenge in implementing mental health policy is system fragmentation and complexity. On one side of this issue is the fragmentation of government roles. In federal government structures, as in Canada, mental health policies have an intergovernmental character in terms of financing, administration, and policy development (Mechanic et al., 2014). As mentioned earlier, Canada's federal government plays a different role in mental health policy than each of the provincial and territorial governments do. This division of responsibility limits mental health policy in maintaining a position in the political agendas of either level of government because it is being established and maintained through different levels of government (Mechanic et al., 2014). Rather than most of the responsibility for the development and implementation of mental health policy falling on the shoulders of local governments and agencies, it has been suggested that a more proactive approach from the centre has been seen as a way to propel policy objectives (McCollam, 1999; Mechanic et al., 2014). On the other side of this issue is the fragmentation among agencies at the service delivery level in a given mental health system.

The mental health system in Canada has become fragmented, as mentioned earlier, and provinces like Manitoba may also be experiencing some residual fragmentary effects in their systems as well. Mental health systems are complex in that they include public care, private care, and numerous community organizations; unfortunately, these organizations are often poorly connected (Mechanic et al., 2014) and at times completely unaware of other organizations' existence. The dichotomy between biomedical oriented practice and recovery oriented practice also contributes to this complexity. Concepts like recovery have been seen to not be embedded into medical care since the biomedical treatment of mental illness focuses on symptom reduction rather than the contextual factors of a person's care (Ward et al., 2017). Having stark differences in treatment philosophies within the mental health system creates difficulties in adopting policies if they do not adhere with a particular treatment system. The payment and funding methods that prioritize biomedical treatment also reinforce this fragmentation (Jacobs et al., 2010). The challenge to implementation comes with coordinating this complex system and avoiding fragmentation to ensure system wide policy implementation (McCollam, 1999; Mechanic et al., 2014). Communication, coordination, and networking are important factors to keep a system together. As can be seen in Manitoba's mental health system, the more organizations that are involved, the more challenging this becomes.

The fourth challenge in implementing mental health policy is the political process behind it. Political support is needed to implement a policy so that the appropriate funding and resources can be provided; unfortunately there has been a historic lack of support in this area (Barry, 2007; Shera & Ramon, 2013a). Mental health issues often are not a high political priority unless a policy 'window' opens where the problem, the politics involved, and the proposed solutions are feasible and all enter the policy arena (Mechanic et al., 2014). The window for mental health

policy often comes as the result of tragic events. This kind of response can also lead to crisis-driven policy making which is prone to neglecting the areas of greatest need and the provision of a planned system response (Mechanic et al., 2014). Even when responses do occur in policy windows or as a result of tragic events, this does not ensure that the issue will maintain a priority until it is resolved. Matters like this recede into the background once the novelty wears off and is no longer of political interest. The motivators for governments to announce policies and strategies can also be a matter of political interest; this relates to how strategies can be used as more of a symbolic response and a substitute for real action to create the appearance that they are addressing an issue. Also noteworthy is that when a particular political party is working on a mental health policy issue, it will usually only continue as long as it remains in power; if it is voted out of office it is unlikely that a new administration will use previous recommendations and reports (Shera & Ramon, 2013a). This implies that a lot of great policy may exist that is not being used and that the long term needs of mental health system improvement will fall to the wayside of the short-term interest of political parties (Shera & Ramon, 2013a). Mental health policy implementation can certainly be affected by these processes. It seems that we have to wait for a tragic event to occur in order to gain the interest of those who provide most of the resources for implementation and attempt to create this change in a short period of time. The unlikelihood of positive outcomes resulting from this is what makes the politics of implementation such a challenge.

The fifth challenge in implementing mental health policy is stigma. Stigma does not just affect perceptions about those with mental health issues; it is also a major barrier in implementing system wide change (Shera & Ramon, 2013a). It becomes very influential in a political system where public opinion and cultural beliefs essentially guide the policy process

(Mechanic et al., 2014). The way that mental illness is socially constructed affects how much attention it receives and the characteristics of the policies developed in response to service user needs (Ingram et al., 2007). Mental illness is still misunderstood and seen as an individual weakness, or often a social deviance in the case of many tragic events; these views can lead to policies that are restrictive, coercive, and limited (Mechanic et al., 2014). Without overcoming the negative attitudes towards mental illnesses, stigma will remain a challenge for implementing comprehensive mental health policies.

The sixth challenge in implementing mental health is the tension between the policy making level and the local implementation level. Implementation deficits due to top-down or bottom-up problems can occur when the policy or the implementation plan is not regarded the same way by these different levels (Lester & Glasby, 2010). Sometimes there is a lack of support or resistance to a new policy at the service delivery level (Flisher et al., 2007), which reduces the likelihood of a policy being implemented. Some have suggested that there needs to be higher recognition of how front line workers can influence implementation by being part of professional subcultures that affect policy ideas, knowledge, and learning (Nilsen et al., 2013). It has also been suggested that correcting the imbalance between these two levels by relinquishing some of the resources and control to local authorities will relieve this tension (McCollam, 1999). However, this view reflects a bottom-up approach to implementation and may only be appropriate in certain circumstances.

The seventh challenge in implementing mental health policy is organizational culture. If one of the organizations that is involved in implementing a policy does not have a culture of support for the plan, the objectives will not be met (Barry, 2007). This challenge is exacerbated by the fragmentation of service responsibilities across the province (Mechanic et al., 2014).

There are different characteristics that make up this culture of support, including strong leadership, clear and explicit performance objectives, clear lines of upward accountability, a proactive approach to managing the local health community, and an emphasis on developing and harnessing staff potential (Lester & Glasby, 2010). Front line workers' decisions to implement a policy are strongly influenced by their colleagues and managers as well as the amount of support they are given for implementation (Nilsen et al., 2013). As can be seen by these organizational cultural characteristics, it takes a lot of planning and support by implementing agencies to follow a policy plan through and this is extra challenging considering that this is required of numerous organizations involved in a policy network.

The eighth challenge in implementing mental health policy is not having adequate resources. Many policies are not able to fulfill their vision because they are under resourced, which minimizes their chance of achieving their outcomes (Barry, 2007; Shera & Ramon, 2013a). At times this can be because the proper health system is not in place, because a given organization does not have the tangible or financial resources, and because staff may not have the capacity to implement a policy in terms of numbers and training (Barry, 2007; Flisher et al., 2007). If extra resources are not provided, local organizations are left to change practices for implementing the policy against a background of budgetary constraints (McCollam, 1999). Without the appropriate resources needed to carry through strategic policy actions, there is not much chance of seeing positive outcomes.

The ninth challenge to implementing mental health policy is in ensuring clear roles and responsibilities for those involved. As policy implementation theorists' articulate, clear roles for policy makers, organizations, management, and frontline workers ensure that people know how they are expected to contribute to the outcomes of policy objectives and increase the chances for

successful implementation (Hogwood & Gunn, 1984; Pressman & Wildavsky, 1984; Sabatier & Mazmanian, 1981). This becomes very challenging in the mental health field because there is often a significant overlap between different programs and organizations (Lester & Glasby, 2010) as well as some gaps. It would be imperative to make note of these overlaps and gaps to understand how the distribution of roles and responsibilities affect the implementation process.

Finally, the tenth challenge in implementing mental health policy is time limitations. Creating comprehensive system or program change in mental health is a long-term undertaking (McCollam, 1999). Historically, changes in mental health policy and practice are very gradual and incremental, as was the case with the shift away from institutional care to community care (Lester & Glasby, 2010). There are many time limits that are set and these restrictions can hinder the implementation process (Nilsen et al., 2013). One example is that policies and programs are often dependent on funding arrangements that are short-term and insecure (McCollam, 1999). Another example is how governments are more likely to act on shorter term policy goals that can be achieved within an election cycle. Also, policies and programs are often given a certain number of years to meet their objectives, for example, the five years given to the current policy under study. These limits are unrealistic and often do not allow enough time to evaluate policy progress and reformulate it in order to achieve better results.

General Case Studies.

The empirical case studies that were found exemplify these challenges. Some are able to also articulate successes and recommendations for effective implementation. As mentioned earlier, most implementation studies are in reference to implementing evidence-based practices/programs (EBPs) into mental health settings. However, there does seem to be some

overlap with the concerns presented regarding implementing EBPs in mental health settings as is proposed in policy implementation theory; for this reason they will briefly be presented here.

One of the studies that examined the implementation of mental health programs came from the United States and focused on the organizational management perspective. Four executive directors and three clinical directors from seven mental health agencies were interviewed about their perceptions in implementing EBPs in agency settings using semi-structured interviews that lasted from 40-90 minutes (Proctor et al., 2007). The interviews began with questions about agency history, and moved onto awareness and understanding of EBP as a concept, the EBPs currently being used or discussed for use in the agency, and the organizational pressures and needs that influence their implementation processes (Proctor et al., 2007). The implementation challenges listed in this study are relatable to the challenges found in the policy literature. Challenges included the applicability of the EBP in the real world setting, access to information about the EBP for agency staff, having an agency infrastructure that supports implementation, time to experience the EBP working in practice, staff resistance to learning new practice methods, and the complications of staff shortages and workload pressures (Proctor et al., 2007). While implementation concerns were high, the study concluded with what was found to be helpful in implementation. Effective strategies included training, strong leadership, time, and a culture of support (Proctor et al., 2007). This study used a small number of participants in a small area, which, while leading to some important results, is not very comprehensive. Seeing how these experiences translate to the front-line workers in these agencies would have created a stronger case for what the barriers were and what are found to be effective implementation strategies. However, using only agency director experiences leads to a more in-depth analysis of this particular population; we are able to understand what goes into their consideration of what

will be implemented, along with executive directors' view of organizational factors that influence implementation. Manitoba's mental health system could benefit from these results considering the challenges that have been encountered here along with the effective strategies. Results could also be helpful for agency directors in Manitoba to understand these challenges at their particular level in the implementation process.

One of the studies exploring mental health service implementation was regarded as both a policy and program study. This study interviewed program directors that were involved in implementing mental health services in the aftermath of disasters throughout the United States (Elrod, Hamblen, & Norris, 2006). Thirty-six semi-structured interviews were conducted with directors of 37 disaster response efforts in 25 states; the results focused on preparing for the disaster, implementing the response, providing services to the community, integrating the program into the community and state systems, phasing out the response, and evaluating the response (Elrod et al., 2006). The challenges found in this study were further complicated by the sudden and immediate response needed in a crisis environment. These challenges included the fact that emergency mental health plans were rarely in place prior to a disaster, the need to designate resources and supplies, establishing multiagency relationships, decision making protocols, staffing inadequacies, and confusion regarding roles (Elrod et al., 2006). This study also provided strategies that were found to be helpful in this process. Actions that aided the implementation included having people with prior training on board to make the process quicker, functioning as a multidisciplinary team, accessing multiple sources to obtain information, and contacting people who had previously been involved in a disaster response (Elrod et al., 2006).

The sample chosen for this study was comprehensive in the choices of disaster types and number of states; the 37 different disasters varied in type, magnitude, scope and setting, and

findings still showed a significant amount of agreement among respondents (Elrod et al., 2006). What could have made this research stronger is if the responses of the front line emergency response workers, who were noted often in the study, were taken into account as well as those of directors. Manitoba's mental health system could benefit from considering the challenges and successes that were noted in this study to understand what might be necessary in making strong mental health policies. It also speaks to a more proactive approach to policy making rather than strictly reacting to emergent circumstances. Manitoba could benefit from examining trends that are occurring in order to put things in place now to prevent deterioration.

Another study examined mental health policy and program implementation in the United States and Puerto Rico. A Re-engagement program that provides case management to veterans with serious mental illness, who had been disengaged from follow up care for more than a year, was mandated through a national policy for all Veteran Health Administrations (VHA) with clients who met the requirements to implement (Smith et al., 2017). This study looked at how organizational culture impacted implementation. It included 158 VHAs in which the presence of a designated Local Recovery Coordinator (LRC) was determined a week before the program's initiation and six months afterwards, which indicated commitment to implementation (Smith et al., 2017). Data regarding organizational culture was gathered through an annual survey that asked all VHA employees about workplace satisfaction, culture, turnover, supervisors, and workplace perceptions (Smith et al., 2017). This study found that organizational culture was a facilitating factor for initial policy compliance, but less effective after six months. The presence of a LRC was the strongest indicator of implementation success after six months (Smith et al., 2017). This study was unique in that it focused on one implementation factor related to how supportive the culture of an organization is to a policy, which the literature has shown can often

be a challenge (Barry, 2007; Lester & Glasby, 2010; Nilsen et al., 2013). Their emphasis on the designation of LRCs also highlights the importance of strong leadership to long-term implementation success.

A mental health policy and program implementation case study done in England is also worth including in this review. It examined a mandate to achieve national and consistent implementation of Crisis Resolutions Teams (CRTs) across the country to provide short-term, home treatment for people experiencing a mental health crisis and to prevent them from having to use inpatient services (Lloyd-Evans et al., 2017). The researchers had a team manager or senior member of each CRT participate in a 90-item survey to determine how well CRTs have been implemented as intended; the survey included questions about team location and access, staff, training, collaboration with other organizations, interventions provided, discharge arrangements, and service improvement initiatives (Lloyd-Evans et al., 2017). The findings of this study identified that while CRTs were implemented across the country; there were inconsistencies in how they were organized and in the extent to which they provide services (Lloyd-Evans et al., 2017). The reasons for these inconsistencies highlight some of the challenges in implementing policies and programs in the mental health field.

The researchers identified barriers to implementation, such as the lack of role clarity, the lack of organizational cultures of support, and different stakeholder perceptions; it was suggested that implementation of this scale would require more robust model specification, policy guidance and monitoring, knowledge sharing mechanisms, and robust structures to support implementation (Lloyd-Evans et al., 2017). This study highlighted many of the same barriers found in the mental health policy implementation literature and provides recommendations for broad policy implementation initiatives. Since the scope of *Rising to the Challenge* has a broad

provincial focus, its implementation may have benefited from some of the structural and organizational recommendations provided by this study.

Research conducted for a doctoral thesis in Social Policy and Social Work described a policy and program implementation case study from England. The study examined the implementation of the Care Programme Approach (CPA), which ensured adequate community support for people with serious mental illnesses (Green, 2000). The study addressed three elements of implementation. It addressed whether policy implementation requirements would ensure that community supports would be guaranteed, whether there was congruence between implementers' and recipients' interpretations of the policy, and what was occurring among implementers to influence policy implementation (Green, 2000). In order to examine these three areas, the researcher used a variety of research methods. She used patient records and hospital data collection systems to audit accounts of the policy response and to review the quality of care that resulted; she interviewed 41 staff members about who and what agencies were involved in the response, what factors influenced their behavior, what their goals and priorities were, different power dynamics, and how practice was evolving. The researcher also conducted a series of discussion groups with a total of 39 service recipients to gather information about their experiences and thoughts regarding CPA; as well as how it could have been done differently (Green, 2000).

Based on the data gathered and analyzed through this research, a number of conclusions were made regarding the implementation of the Care Programme Approach. While some progress towards implementation was made, the requirement for implementation was not sufficient for involving practitioners from the different service agencies necessary for ensuring adequate community supports (Green, 2000). This highlights the importance of cross-

departmental and cross-sectoral collaboration in implementing mental health policy. This study also found that there were different interpretations of the policy between implementers and recipients where implementers prioritized professional knowledge over the immediacy of the service recipients' needs (Green, 2000). This highlights the gap between policy and practice and the need to better understand and utilize the perspectives of people with lived experience. The study also found that this professional knowledge prioritization created a major barrier for successful implementation, especially if implementation is directed through organizational channels (Green, 2000), which also speaks to the importance of organizational cultures of support and to ensuring clear roles and responsibilities for staff. The variety of research methods used to study the implementation of the CPA made this a strong study. By gathering data from service providers and recipients, the researcher was able to identify differences in their interpretations of implementation. By gathering hospital record data and interviewing numerous staff members, the researcher found strong evidence on the barriers to implementing this approach including what factors influenced staff behavior. This study corroborated some of the challenges that have been found in the mental health policy and program implementation research.

Another study exploring mental health program implementation focuses on a program originating in Ohio that has seen great implementation success and has rapidly been disseminated across the United States (Munetz, Morrison, Krake, Young, & Woody, 2006). The study describes the Crisis Intervention Team (CIT) program, which is a partnership between law enforcement, the mental health system, consumers of mental health services, and their families, in which police officers are trained to deal with crisis situations involving people with mental illnesses. One of the challenges found in implementing this program is that it involves the

collaboration of complex systems and various stakeholders (Munetz et al., 2006). This challenge also presented itself in the analysis of ‘Rising to the Challenge’; as described earlier, it is clear that Manitoba’s mental health system and the groups involved are numerous and complex. The Ohio Department of Mental Health utilized a synthesis implementation approach to address this to combine unplanned and spontaneous program diffusion with directed dissemination of the program. The program was developed together with the different stakeholder groups and included training CIT teams, identifying a CIT coordinator for different implementation organizations, the development of resources, technical assistance, and consultation, while consistently adopting new ideas found during implementation at the service delivery level and maintaining core elements of the program (Munetz et al., 2006). Leadership and collaboration were identified as key elements for this program’s implementation success.

An issue that may occur as this program gains more success and grows to other states is the creation of a national protocol, which may lead to it becoming managed in a top-down manner (Munetz et al., 2006); this deviates from the program’s original intention of adopting a synthesis approach to its implementation. The study also assumes that resources, partnerships, and collaborative systems are possible which may not be consistent in all mental health systems. However, Manitoba may benefit from Ohio’s example in implementing something like the CIT program because both Manitoba and Ohio have decentralized mental health systems and Ohio has exemplified how to maintain continuity in this evidence based practice across communities, while still adjusting for differences in local needs.

Another mental health program implementation example is noteworthy because of the implementation success it has had internationally. Developed in Australia, the Triple P – Positive Parenting Program has been implemented in 14 different countries, including Canada; it is a

parent and family support program aimed at reducing parenting difficulties and the development of behavioral and emotional problems in children, and has been praised for its carefully planned implementation strategy (Turner & Sanders, 2006). The program's implementation approach is characterized by professional training, workplace support, and quality maintenance (Turner & Sanders, 2006). The recommendations that were proposed in this descriptive report can certainly be considered in implementing policy, especially at the service delivery level. Recommendations included program/resource development, such as implementation manuals, detailed procedural guidelines, and practical tools to support service provision; quality training; promotion of practitioner self-efficacy by incorporating self-regulation implementation practice, accreditation, and a network for resources, updates, and problem solving; workplace support by providing information about program benefits and costs with ongoing consultation; and supervision for maintaining program fidelity, peer support, and mentoring (Turner & Sanders, 2006). Since this program has been transferable internationally, all the way to Winnipeg (Healthy Child Manitoba, 2015), it provides a good model for implementation that could be considered for other areas of mental health found in *Rising to the Challenge*.

Another study worth mentioning came from Montreal and examined the planning of a mental health and homelessness pilot project called At Home/Chez Soi (Fleury, Grenier, Vallee, Hurtubise, & Levesque, 2014). At Home/Chez Soi, sponsored by the Mental Health Commission of Canada, was a two-year, five city randomized controlled trial of the Housing First Model for chronically homeless people with mental illnesses (MacLeod, Worton, & Nelson, 2017). This study is particularly interesting because it utilizes components of the ACF in studying this policy stage. Eighteen interviews and a discussion group of seven key actors from both public and community organizations in both the mental health and homelessness sectors were conducted,

along with participant observations of project meetings and a document analysis of meeting minutes and correspondence (Fleury et al., 2014). The topics discussed in the interviews and discussion group included the project planning context, key policy actors, the project's vision, consumer participation, governance structures, organizational contexts, resources, and defining events (Fleury et al., 2014). The planning stage was broken down into three phases in which advocacy coalitions were defined. The first period was defined as having a state of general concord, except for some doubts expressed near the end of the phase which led to the categorization of three coalitions; one coalition was composed of policy makers who instigated the project, another was composed of researchers and clinicians in the field, and the third was composed of actors most concerned with incorporating the Housing First model and the rights of consumers (Fleury et al., 2014).

Each of these advocacy coalitions held strongly different policy beliefs. The second phase was characterized by a significant amount of conflict between these coalitions and their beliefs, which led to the identification of policy brokers who attempted to mediate these conflicts (Fleury et al., 2014). This led to a third stage of acceptance and commitment where agreements were made among coalitions (Fleury et al., 2014). This study provided an example of how the ACF can be applied in the mental health field. The identification of advocacy coalitions was helpful in understanding how their various policy beliefs eventually lead to the development of policy decisions and outputs. The role of policy brokers in seeing this process through was also made clear. However, it is important to note that the ACF was applied to the planning phase of this project, rather than through the implementation of the project. That being said, it does still show some applicability of the ACF to mental health programs.

These studies provide evidence for some of the similar experience in implementing both mental health programs and policies. However, these studies and the models that they present are often too singular for examining broad mental health policies, like the one under study. There are a wide variety of objectives and strategic actions that cannot be covered by program implementation models. Sometimes policies will require programs to be developed or changed, at which point, one of these models may become useful and relevant for understanding the overall policy process under which the specific program is operating. With that being said, we will now turn to the case studies that look specifically at implementing mental health policy.

Policy Case Studies.

The first policy study helps to examine policy implementation processes at the service delivery level. The study examines an attempt at implementing recovery-oriented principles and policies in six public sector mental health service organizations from four Australian states (Deane, Crowe, King, Kavanagh, & Oades, 2006). Like the Triple P – Positive Parenting Program, this policy had a planned implementation approach. The implementation methods included a training program of 2 days with 6 and 12 month booster sessions, manuals that included communications of the guiding principles and clinical skills training, goal and homework planning forms, team meetings to review goal plans and progress, and a great deal of staff support (Deane et al., 2006). The study required that the service organizations recruit interested staff who would then participate in the training process and their responses to the trainings were obtained; while the responses at the management and service delivery level were positive, the methods were lacking in describing how these responses were measured or recorded. The study also does not explore the fact that there may have been a significant number of staff who did not participate in the training and this may have had an effect on the overall

organizational adoption of this policy. However, the feedback received from the participants in the study may provide some insight for Manitoba's mental health policy makers. This policy implementation approach unfortunately did not yield the kind of success found in the Triple P program and many of the challenges described in the research on program implementation were encountered. The researchers' experiences led them to propose ideas for what would have improved the process. These improvements included determining consistent and specific roles for various staff members, reviewing fidelity of the implementation plan, applying workshop training immediately into practice so trainees would not forget it, and increasing practitioner process management (Deane et al., 2006). This study helps exemplify the challenges associated with implementing policy into practice.

The following case study is an example of a much broader mental health policy aimed at mental health system change. The study examines the implementation of a mental health policy for Ghana, which was developed as a result of not having one at all in the country prior to 2000 (Awenva et al., 2010). Developing a mental health policy nearly from scratch enabled planners to easily identify implementation barriers. Researchers used a mixed methods approach to gather data from five of the ten regions in Ghana. For quantitative data, they used the World Health Organization's checklist to assess the content and process of policy; the checklist includes a series of interrelated modules that are designed to address the needs and priorities in policy development and service planning (World Health Organization, 2015).

For qualitative data, the researchers conducted focus groups and 122 semi-structured interviews with key members from different levels of the implementation process for an understanding of the context and implementation process. The respondents included mental health professionals, policy makers, academics, administrators, health researchers, the media,

religious leaders, traditional and faith leaders, and service users. Their data identified the following barriers to mental health policy implementation: the low priority of mental health at the government level, dwindling human resource capacity, no commitment to funding the policy, insufficient consultation prior to policy formulation, limited awareness of mental health among the people implementing the policy, and the lack of evidence based policy formulation (Awenva et al., 2010). Three main strategies were suggested by respondents to overcome these barriers: revising mental health policy and legislation, training and human resource capacity development, and greater collaboration in developing mental health policy (Awenva et al., 2010). The methods chosen for this study were quite comprehensive and have created one of the few policy implementation studies in this review that used a mixed methods approach. One area that the study did not report on was any difference found between regions, which could help in better understanding the contextual concerns in implementation. This study sheds light on the challenges that occur with system wide mental health policies. The recommendations found may be appropriate for Manitoba to learn from and due to the similarities in implementing broad, system-wide target objectives.

Also worth mentioning is a study coming out of the United States. Philadelphia has been undergoing a mental health system transformation in response to a move to increase evidence-based and recovery-oriented treatments; as a result, behavioral health policies and initiatives began to emerge, which provided the researchers of this study an opportunity to examine their implementation process (Beidas et al., 2016). Similar to the use of the ACF in this study, the Philadelphia study is using a conceptual model to study implementation. The study used the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework to assess variables such as outer context change, inner context variables, intervention specific variables, and how all

of these factors can facilitate implementation (Beidas et al., 2016). Data from 7 treatment developers, 33 agency administrators, and 16 system leaders were collected through semi-structured interviews (Beidas et al., 2016). The interviews highlighted the barriers and facilitators for implementation and three themes emerged from these findings, which included outer context, inner context, and intervention characteristics (Beidas et al., 2016). The outer context barriers included system demands, returns on investment, and workforce issues; the inner context barriers included organizational sustainability, resources, and time constraints; and an intervention barrier was found to be the fit of the intervention with the client population (Beidas et al., 2016). The study also found a number of facilitating factors for implementation. These factors included collaboration, financial support, agency buy-in, and administrators with clinical backgrounds (Beidas et al., 2016).

The sources of data encompassed the different contextual factors of the implementation process in this case. The results of this study provide a significant amount of information about policy implementation and the planning of such processes. Manitoba's system can learn from the results of this study, especially from this study's examination of intervention specific barriers and facilitators. While this study describes similar processes that were also found in the implementation of Rising to the Challenge, this study likely would have benefited from interviewing more stakeholder groups, such as front line workers.

A Canadian study coming out of Quebec is also being proposed to study how mental health policy can be implemented in ways that are specific to the diversity of stakeholders involved in the mental health system (Park et al., 2014). This study is specifically examining implementing recovery oriented principles in a Department of Psychiatry. This study is unique because it is using a participatory research approach where data will be collected from service

providers and service users about their experiential knowledge of recovery-oriented services; data will be collected through participant observation, focus groups and semi-structured interviews (Park et al., 2014). This information will be used to develop and implement 'Recovery in Action' initiatives. These efforts will then be evaluated to determine the success of the tailored implementation by examining the changes in attitudes and practices among service providers and users (Park et al., 2014). The proposed outcomes of this study are to gain an understanding of how new mental health treatments are understood and adopted within a healthcare organization and to provide strategies for how to accelerate adoption of these practices within an organization (Park et al., 2014). This study highlights the idea of participatory research for tailoring mental health policy implementation to specific local contexts. The results of this study will provide useful information for a mental health system, like Canada's, that operates in many different local and regional environments. Since the Government of Manitoba used participatory research in developing the policy by consulting with service users, it could also take from this study's participatory research approach in evaluating its policy.

Mental health policy implementation is also represented in another international example. In the United Kingdom, an organization named the National Mental Health Development Unit (NMH DU) operated from 2009 to 2011 to improve mental health services and policy (McPherson, 2011). The organization made many achievements with its initiatives, which included translating national policies into practical deliverables and coordinating national, regional, and local implementation. The closure of the NMH DU highlighted some of the barriers that exist in mental health policy implementation and also what was needed in this case to maintain ongoing implementation. Its closure was due to financial pressures and reorganization

with the NMH DU's function to be transferred to a different governing board (McPherson, 2011). As was mentioned earlier with the various challenges for mental health policy implementation, political support is needed to implement a policy so that the appropriate funding and resources can be provided. With a change to the governing body responsible for taking over the NMH DU's function, it was unclear whether mental health would remain on its agenda (McPherson, 2011). The financial pressures experienced by this organization also highlight the need for sufficient resources in implementing mental health policy. The outgoing chief executive of the NMH DU expressed that without national support the pressure to maintain the work that was done in improving mental health will fall back on the mental health community; the commitment of these organizations to continue implementing mental health policy was noted as needed to maintain their momentum (McPherson, 2011). This directly relates to the challenges expressed earlier that highlight the need for implementers to be committed to their roles and for the existence of an organizational culture of support for a given policy. This article provided another example for Manitoba in considering factors, such as how finances are managed, organizational politics, and collaboration among stakeholders.

Another international example of examining mental health policy implementation comes from a 1988 study from Italy. The study examined a national psychiatric reform policy that aimed towards deinstitutionalization and creating community based services for those with mental illnesses, ten years after its inception (Bollini, Reich, & Muscettola, 1988). The law set out national guidelines but did not specify how to implement the reform so that regional governments could take the responsibility of creating their own implementation plans that fit local needs (Bollini et al., 1988). This was also seen in Canada with the MHCC national policy's flexible guidelines as mentioned earlier in the discussion of Canada's mental health system. This

study was initiated because after 10 years of this policy being in place, certain achievements and drawbacks were noted, along with significant differences between the North-Central and South Italian regions (Bollini et al., 1988). In order to study these differences, researchers conducted a cross-sectional survey with 435 patients from general hospitals, 1037 patients from community mental health centers, 434 patients from public mental hospitals, and 102 patients from private mental hospitals (Bollini et al., 1988). The methods chosen for this study were comprehensive in the sense that it studied the effects of context well by examining implementation across geographical areas, institutions, and organizations. This was the only study in this review that used survey as its primary data collection tool, however, other sources of quantitative data were clearly not accessible at the time based on the lack of an information system. The study might have been strengthened by conducting interviews to gather more in-depth data on what occurred during the implementation of the mental health reform policy. The results of their study provided significant evidence for implementing national policy and revising policy.

First, the lack of an information system hindered the policymakers' ability to track and evaluate implementation so a better system would need to be put in place; second, the role and activities of the private sector were not adequately analyzed so its role in the health care system needs to be determined; third, the regional differences that were evident in the implementation review need to be addressed in policy revisions; and finally, many chronically ill patients were found to still be institutionalized and new strategies were needed in policy revisions to create community care options for them (Bollini et al., 1988). This study is a helpful resource for mental health policy implementation studies as the researchers were able to review implementation outcomes ten years after the policy was put in place. The implementation failures that were found can be seen as lessons for policy makers in Manitoba, like having an

adequate information system, clarifying the roles of the organizations involved, and addressing the differences that occur in different contexts. This study was able to review this implementation with a ten-year time frame, which according to the ACF, will lead to better-informed judgments about and more time to identify and develop solutions to implementation problems.

More evidence can be seen in the work that is being done in Europe to improve mental health policy. In 2010, the Federation of the European Academies of Medicine (FEAM) found that mental health was neglected in European health policies as a result of misunderstandings of mental health issues, treatments, and stigma, and that there is much need to improve policy-maker and public awareness on these issues (Fears & Höschl, 2011). FEAM attempted to address this in a meeting conducted by the European Parliament on how to capitalize on scientific advances and improve mental health services through the European Union. The multi-disciplinary parties in attendance mutually agreed on the following in regards to what was needed to make these improvements: developing health research through funding increases, awareness raising of the importance of this research, and training the next generation of scientists; the development of therapies which requires research and a partnership between academia and industry to increase pharmaceutical investment in the mental health therapeutic area; increasing research capacity which has been reduced as a result of regulatory bureaucracy and costs in psychiatric research; and an increase in policy partnerships and coordination between health and social care departments (Fears & Höschl, 2011). This example highlights many of the recommendations that were brought up in this review. All of these can provide the Government of Manitoba with a stronger understanding of how other jurisdictions, which are trying to implement mental health policies are attempting to proceed with this task.

Another case study provided an example of mental health policy implementation with an application of the Advocacy Coalition Framework. This study examined the introduction of Community Treatment Orders (CTOs) to treat those with serious mental illnesses in Ontario (Swigger & Heinmiller, 2014). CTOs were seen as somewhat controversial because some people would be compelled to receive treatment against their will; this controversy made the researchers' application of the ACF useful as they were able to identify two different coalitions based on their distinct beliefs and the power resources held by each coalition (Swigger & Heinmiller, 2014). The data used by the researchers included 63 transcripts from stakeholder testimony during a hearing for the Bill that introduced CTOs; they conducted a content analysis to determine beliefs held by stakeholders and to determine what coalition they fell into (Swigger & Heinmiller, 2014).

Aside from the researchers identifying a pro-CTO coalition and an anti-CTO coalition, their analysis also enabled them to determine how their resources and strategies contributed to policy implementation. The anti-CTO coalition was composed of service users and advocates who believed in patients' right to self-determination; they were seen as having less power because they had fewer resources at their disposal and they were negatively impacted by public opinion, which because of tragic events at that time where the media aligned mental illness with violence, led to the domination of stigmatic views (Swigger & Heinmiller, 2014). The pro-CTO coalition was made up of medical professionals who believed in community safety; their power was greater because their profession was dominant in the mental health system, their opinions were respected, they had financial and informational resources at their disposal, and they had the support of the public and politicians (Swigger & Heinmiller, 2014). This study provides a good example of how the ACF can be applied to mental health policy. The methods used provided a

useful avenue for obtaining data about beliefs and for defining coalitions. It was also a useful example of how resources and strategies contribute to the competition between coalitions and how coalitions' policy interests can prevail over one another to form policy decisions.

A recent case study from the United States adds some important findings to the mental health policy implementation literature. This study addressed the implementation gap experienced by medical professionals and researchers lacking the knowledge and training for how to implement public policy; the researchers asserted that a reason why public policies take so long to reach patients is because practitioners lack knowledge and training in policy advocacy (Culyba & Patton, 2016). It not only discusses problems in implementation, but offers suggestions for how practitioners and researchers can become active in implementation. The study discusses the ethical obligations for mental health practitioners to engage in public policy and advocacy efforts in the United States, it offers strategies for how practitioners and researchers can participate, and it highlights a legislative case study in which some of these strategies were utilized (Culyba & Patton, 2016). Three suggestions were given to develop implementation participation. The suggestions included training psychiatrists during their residencies and fellowships in public policy advocacy, post-graduate training and mentoring in public policy advocacy for mental health professionals outside of psychiatry, and enhancing the status and credit of public policy advocacy within mental health academia (Culyba & Patton, 2016).

The case study that was discussed highlighted how mental health research could be used to influence public policy debates. In terms of research methods, this was a participator case study that included a legislative analysis of a bill that would allow the public and press access to child delinquency courts, remove child protective discretion of the judge, and place this burden

on the child (Culyba & Patton, 2016). One of the study's researchers then reviewed and introduced evidence-based research into the public committee hearing debate for this bill. He provided information on poly-victimization, someone experiencing numerous victimizations regardless of duration or frequency, and how this bill would psychologically harm the many poly-victimized youth who go through these court proceedings (Culyba & Patton, 2016). This public policy advocacy added an important perspective to this case and the committee decided not to pass the bill. This study provides important implications for public policy advocacy and an example of how this was done successfully. The research suggests that advocating for a policy that will benefit clients will help practitioners assist in ensuring the success of the policy's implementation. The suggestions for how practitioners and researchers can engage in these debates would be important for better implementation planning. It could also contribute to better informing the psychiatric profession on recovery-oriented policy efforts.

Summary.

This literature review included various international empirical studies of mental health policy and program implementation along with some descriptive studies of successfully implemented mental health programs and policies. While the mental health systems will vary internationally, there were many similarities found in methodologies, the barriers identified, and the facilitating factors for implementation. Four studies used a mixed methods approach where semi-structured interviews were used alongside other methods, such as focus groups, policy checklists, self-reports, scales, questionnaires, administrative data, observation, and documentation; one from the United States, one from Ghana, one from England, and another from Canada (Awenva et al., 2010; Beidas et al., 2013; Fleury et al., 2014; Green, 2000). The remainder, and majority, of the studies used qualitative research to study mental health policy

and program implementation in the United States, Canada, Australia, England, Puerto Rico, and Italy. Most studies made use of semi-structured interviews (Beidas et al., 2013; Elrod et al., 2006; Park et al., 2014; Proctor et al., 2007), while other qualitative methods that were utilized included observation (Park, 2014), focus groups (Awenva et al., 2010; Park et al., 2014), survey (Bollini et al., 1988; Lloyd-Evans et al., 2017; Smith et al., 2017), informal feedback (Deane et al., 2006), and legislative analysis (Culyba & Patton, 2016; Swigger & Heinmiller, 2014). Most of the participants in these studies were directors of mental health agencies, with fewer studies focusing on practitioners, and even fewer studies obtaining data from all of the stakeholders involved in policy implementation processes. This shows that qualitative data has primarily been used to study mental health policy implementation and that most data come from those in administrative roles. This leaves potential for quantitative data and data from various stakeholders involved in a given policy process to strengthen the literature on mental health policy and program implementation.

Many barriers and facilitating factors for mental health policy implementation were highlighted in the preceding literature. The barriers that were identified can be organized into five core areas: policy specific barriers, political barriers, system barriers, organizational barriers, and technical barriers. Policy specific barriers included challenges such as policies not being applicable in real world settings, insufficient consultation of various stakeholders prior to policy formation, and a lack of evidence based policy formation. Political barriers included that mental health is of low priority to government, limiting commitment for funding the policy, and if there is a reorganization of governance. System barriers included the reorganization of governance within the mental health system, confusion regarding agency roles, difficulties in establishing multi-agency relationships, limitations in the collaboration of complex systems and various

stakeholders, a lack of mental health awareness among implementers, absence of decision making protocols, inadequate designation of resources and supplies, and not adequately addressing regional differences in implementation processes. Organizational barriers included not having an agency infrastructure that supports implementation, staff resistance to learning new methods, staff shortages and workload pressures, confusion regarding staff roles, lack of access to information on policy implementation protocols for staff, lack of financial and tangible resources, and insufficient time to experience the policy working in practice. The primary technical barrier was not having an effective information system for tracking implementation.

The facilitating factors for implementation that were identified in the literature were numerous and some directly complement the barriers that have just been mentioned. The facilitators can also be organized into a similar five core areas: policy, political, system, organizational, and technical facilitators. The policy specific facilitators found in the literature included adopting new ideas from ground level while maintaining core elements of policy and undertaking ongoing revision of mental health policies. In regard to political facilitators for implementation there was a general consensus among the studies that having political support is a significant factor in facilitating the implementation process. The system specific facilitators included functioning as a multidisciplinary team, providing consultation to organizations, collaboration, reviewing the fidelity of the implementation plan, and developing health research through awareness of its importance and funding. The organizational facilitators included training staff and applying learning immediately for increased retention, leadership, time, human resource capacity development, supervision, a culture of support, having people with implementation experience on board, identifying a policy coordinator in each implementing agency, and determining roles for all those involved. The technical facilitators included having

access to multiple sources to obtain information regarding the policy and related activities, and the development of and access to resources.

Aside from the preceding studies reviewed, the non-empirical literature on mental health policy implementation also includes many recommendations for effectively implementing mental health policy. The following discussion will summarize the recommendations found in this literature. Seven recommendations will be presented that were common in the literature. Some directly address the challenges that have been found in mental health policy implementation and others take a broader focus.

One recommendation found in the literature for improving policy implementation in the mental health field is to increase mental health awareness and education. As was related in the discussion about the stigma and definitional ambiguity of mental health, there are still widespread misunderstandings about mental health. In order to carry through a major policy to affect social change, a strategy to inform and educate the public to gain its support would be required (McCollam, 1999). It would also be beneficial to direct education and awareness campaigns towards policy makers and professionals in the field so that any misconceptions or negative attitudes can be addressed among those developing and implementing these policies.

Another recommendation for improving mental health policy implementation is to increase resources. The lack of appropriate resources was found to be a significant challenge in implementation at various levels. Adequate resources need to be allocated and planned for if there is any chance for the policy to succeed (Lund, Caldas de Almeida, Whiteford, & Mahoney, 2014). One suggested way to do this, by the Standing Senate Committee on Social Affairs & Science in Canada (Canada. Parliament. Senate of Canada. Standing Committee on Social Affairs, Science and Technology., 2004), was to shift the resources from the institutional sector

to the community with a mental health transition fund to cover transition costs to invest more in community based services (Shera & Ramon, 2013a). This would certainly be helpful for policies whose objectives reflect changes at the community level or policies better suited for bottom-up approaches to implementation. The general impression from this area of the literature is that resources are essential to this process and need to be planned out in detail in policy development and implementation.

Strong leadership is another recommendation that has been found to be effective in implementing mental health policy. Some regard this as mattering most in translating plans into actions and that leadership capacity needs to be developed from the macro level of policy to local levels of implementation (Barry, 2007; Lund et al., 2014). Strong leadership provides direction, accountability, and policy advocacy (Ward et al., 2017), which is important within a system comprised of so many different organizations and stakeholders.

The next recommendation found to be common directly relates to a challenge found in the literature. With so many different stakeholders involved in this process, roles and responsibilities are recommended to be emphasized in planning. Policy players need to clearly define the roles and responsibilities of key stakeholders in implementing the policy and how the capacity for this will be built (Lund et al., 2014). Clear roles and responsibilities also contribute to increasing direction and accountability in implementation.

Another recommendation for improving the implementation of mental health policies is enhancing monitoring and evaluation procedures. It has been noted that arrangements need to be in place to monitor the implementation of a policy and on a joint interdepartmental basis instead of in a fragmentary way, which is most often the case (McCollam, 1999). There are often challenges in measuring goal achievement as goals and outcomes can be difficult to attribute

directly to outputs and implementation activities (Nilsen et al., 2013). To ensure effective monitoring arrangements, policy plans must include clear sets of objectives and indicators in order to assess the extent to which the policy is implemented (Lund et al., 2014). Objectives and indicators can be turned into a sort of checklist to track progress, and, if appropriate, general policy evaluation tools can be used to assess progress. The World Health Organization provides an evaluation plan on its website that can be used to assess the planning and implementation of mental health policies; it assesses the content and process of policy and includes various modules that have been developed to address the needs and priorities in policy development and service planning (World Health Organization, 2015). Regardless of what methods are used, monitoring and evaluation plans are seen as integral to the effective implementation of mental health policy.

Capacity building was also a common recommendation in the literature. On one level, it is needed to build the capacity of the workforce to develop the skills that support the implementation of policy initiatives (Barry, 2007). Capacity building is also needed at the government level. It has been noted that there are important weaknesses in most national, regional, and local levels of government to design, implement, monitor, and evaluate mental health policies and that this capacity needs to be strengthened (Barry, 2007). The literature also provided strategies for how to increase capacity. Capacity can be built through teaching programs aimed at developing the mental health knowledge of those involved with the policy development, through providing ongoing support and supervision to those responsible for the implementation, and through developing networks for mental health policy where people can share their experiences and promote new projects (Lund et al., 2014).

The final recommendation found in the literature goes beyond the scope of mental health policy. It suggests addressing the social determinants of mental health. Mental health is regarded

as being the product of a number of social determinants, which suggest a need for a multi-disciplinary approach to policy development and implementation; one which focuses on public policies that favor mental health and address the social determinants such as employment policies, poverty reduction policies, criminal justice policies, and education policies (Mantoura, 2014). With all of the challenges in implementing mental health policy, this approach provides an indirect path for improving mental health concerns.

Rising to the Challenge.

It should also be noted that *Rising to the Challenge* has been referenced in the mental health literature since it was created. A number of articles describe the shifts that mental health and education systems are making to become more recovery-oriented, inclusive, and to include integrated service delivery. One article regarding the recovery model in Canada looks at the evolution of this model since its origins and how it has been implemented in national and provincial mental health policies (Piat & Sabetti, 2012). Manitoba was seen as a province which has widely accepted the concept of recovery as a catalyst for system change, which includes recovery champions in its leadership efforts, which is committed to and funds peer-support, and which links recovery to social inclusion (Piat & Sabetti, 2012). As the evidence in this study shows, Manitoba certainly has adopted the recovery model into its strategy, has a recovery champions team in operation, and makes links between recovery and social inclusion; however, there was no evidence that showed that peer support was funded, despite the strategy voicing a commitment in this area. This article appears to base its perception of Manitoba's adoption of the recovery oriented model on the existence of the strategy document, but as this thesis shows, the reality of Manitoba's commitment to recovery was not as strong in implementation.

Another article that made note of Rising to the Challenge discussed social inclusion in Canadian schools and innovative programs that have been put in place to promote it across the country. The article makes note of the high prevalence of mental health issues in children and uses Manitoba as an example of a province which has put plans in place to address those issues (Sokal & Katz, 2015). The only citation that is used for this is the Rising to the Challenge document. It infers that Manitoba is responding to child mental health by having the strategy, however this refers more to the plan than it does to its implementation and its actual impacts for child mental health.

A chapter of a book about parental psychiatric disorder that looked at policy context and change for families with a parent experiencing a mental illness described case examples from Canada, including Manitoba. It refers to Rising to the Challenge in commending Manitoba for making broad policy efforts for improving outcomes for children and encouraging family support; however, the mental health strategy is critiqued for not specifically discussing strategies to improve outcomes for children who grow up with mental illness in their family (Nicholson et al., 2015). While the strategy has accomplished the development of broad policy goals, and the lack of clear and specific goals may contribute to a barrier for the implementation affecting each child experiencing more specific issues.

The last article that mentions Rising to the Challenge comes from the United States. It discusses provisions in the Affordable Care Act and how psychiatrists can play important roles in integrating mental health care services to focus more on illness prevention and health promotion (Shim et al., 2012). The authors refer to Manitoba as achieving province-wide success in prevention and promotion by focusing on childhood interventions and by strengthening integrated mental health care services (Shim et al., 2012). While the results of this study show

evidence of strengthening childhood interventions, the evidence did not show increased activities to strengthen integrated care models. While integrated care and child mental health interventions certainly exist in Manitoba, the results of this study would suggest that they have not reached the province-wide success implied in this article.

Gaps.

This thesis fills a number of gaps in the mental health policy implementation literature. As mentioned earlier, mental health strategies are relatively new both across the provinces and nationally in Canada. *Rising to the Challenge* is the first strategy that Manitoba has seen since the province's mental health reform in the late 1980s and 1990s and a period of mental health renewal in the early 2000s (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). *Changing Directions, Changing Lives* is the first mental health strategy for Canada (Mental Health Commission of Canada, 2012). By examining and describing the implementation of *Rising to the Challenge*, this study provides insights for mental health strategic planning in Manitoba and Canada, two systems that have not currently generated much literature on this subject.

This study also contributes to the mental health policy implementation literature in terms of its methodology. While some of the aforementioned literature gathered data from different stakeholders involved in particular policy implementation processes, most studies focused on one level of implementation, like administrators or practitioners. This study gathers data from various actors in the implementation process, which fills a gap in understanding any differences or similarities in how the implementation of mental health policies is understood and facilitated among different levels. There also appears to be a lack of use of documents as a data collection tool in the literature. By analyzing implementation related documents, this study is able to

describe factors related to organization and information tracking that other studies have not. This is an important addition to the literature since many studies noted how important information systems are for evaluating the implementation of mental health policies.

This study also fills in some gaps in the literature for the ACF. This framework has been used to study policy in a wide variety of areas including air pollution, drug, watershed, pharmacy, marine, nuclear energy, climate, transportation, pension, offshore oil and gas, health, social, and economic policy (Jenkins-Smith et al., 2014; Weible et al., 2009). However, the ACF has rarely been applied specifically to mental health policy. This provides an opportunity to determine how congruent the ACF is with Manitoba's mental health policy subsystems along with the political environment that they operate within. In summary, this study fills gaps in the mental health policy implementation literature by adding a Canadian and Manitoban example of mental health strategic planning, by gathering data from a wide variety of implementation actors, by gathering data from documents, and by applying to the ACF to mental health policy.

Chapter III: Methodology

This research was designed in a way that allowed for an in-depth analysis of *Rising to the Challenge* and the unique dynamic of implementing policy in the mental health field. This section will begin with the primary research question along with relevant sub questions that were explored in this study. Following these is a look at the case study method as it was chosen in order to provide a comprehensive example of a particular policy's implementation process in detail. The synthesis approach and Advocacy Coalition Framework are then discussed as the theoretical foundation of this research, along with the rationale for their use in this study. An introduction to *Rising to the Challenge* will also be provided. Concluding this section is an explanation of how document and interview data were gathered and analyzed. The combination of theory and methods chosen here has guided the research on the implementation of this particular mental health policy.

List of Research Questions

Primary Question:

What are the factors, processes, challenges, and successes that affect the implementation of *Rising to the Challenge: A Strategic Plan for the Mental Health and Well-being of Manitobans*?

Sub Questions:

- Has an implementation plan been put in place by the Government of Manitoba in the planning of this policy instrument?
- Has an implementation model or theory been put in place by the Government of Manitoba in the planning of this policy document?
- How did the design of the policy affect the implementation process?

- Was the policy design realistic or symbolic?
- Are the goals, objectives, and strategic actions specific enough to support implementation?
- If the policy is being implemented well, what can we learn from this?
- What, if any, conflicts or complications have emerged in the implementation process? What seems to have contributed to their emergence?
- How have the policy processes (goals, objectives, and strategic actions) changed as they were implemented? Has the experience gained in implementation resulted in any alterations? What has been adapted and how has it been adapted?
- How are the outcome variables, established by the policy makers, being measured?
- Were outcome indicators developed as part of the implementation process? If so, what are they? How do implementers think they are related to goals?
- Who is the network of actors who have been made aware of this policy and how are they implementing it? Why is it so low profile? What efforts are being made to implement this policy? How were any changes to implementation communicated to actors?
- What are the effects of policy implementation on front line staff?
- What is the extent to which goals/implementation plans are shared across implementing organizations? Does there seem to be variation in how goals and implementation plans are valued? Are there incompatible implementation goals among implementers?

Case Study

The case study methodology was utilized in order to describe the implementation of the Government of Manitoba's mental health strategic plan. A case study can be described as the in depth study of the particularity and complexity of a single case while coming to an

understanding of how it operates within important circumstances and contexts (Stake, 1995). In order to achieve an in depth understanding of such complexities, the case study method allows for a variety of data to be collected. This kind of inquiry works both with results that rely on multiple sources of evidence, with data converging through triangulation, and with results that rely on theoretical propositions to guide the data collection and analysis (Yin, 2014). These multiple sources of evidence are all of a qualitative nature. Qualitative data are the most valuable source of data when trying to interpret the particularity of how something works and to come to a deeper experiential understanding of a particular case (Stake, 2010) The case study method has also been noted as valuable for implementation research by helping to illustrate the real-world challenges and successes in moving from research and policy to practice (Brownson, Colditz, & Proctor, 2012). The relevance to implementation research also applies because of the case study focus on the interaction within and across entities that help in recognizing the case as an integrated system (Stake, 2006). Viewing this case a system stems from the theoretical perspective underlying this research.

Synthesis Approach - Advocacy Coalition Framework

The policy implementation in this case study is described using the synthesis model of policy implementation (Sabatier, 1986) with elements of the Advocacy Coalition Framework (ACF) (Sabatier, 1988). Early theories of policy implementation were categorized as top down approaches, which focus on the goals and strategies as structured by the statutes and policy makers, and bottom up approaches, which focused on starting at the lowest levels of the implementation system and moving upward to determine where implementation is more or less successful (Birkland, 2011). Following these approaches were the developments of synthesized approaches that have been adopted for the purpose of this study. The synthesis approach adopts

from the bottom-up approach by utilizing the concerns and strategies of a variety of public and private actors involved with a policy problem and combines this with the top-down focus on how socio-economic conditions and legal instruments constrain behavior (Sabatier, 1986). *Rising to the Challenge* is most congruent with this approach because it was initiated by government officials, but has also acknowledged a variety of different actors in its development and implementation (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a).

An important element of the synthesis approach is its emphasis on time frames for analyzing policy change. Rather than looking at policy implementation over a period of five years, which may lead to premature judgments about effectiveness, the synthesis approach focuses on policy change over a period of a decade or more. In order to manage this longer time frame and the countless individual policy actors that could be involved in implementation, actors need to be aggregated into advocacy coalitions, based on a set of shared beliefs, which seek to achieve their policy goals over time (Sabatier, 1986). The features of the synthesis approach were used to develop the Advocacy Coalition Framework; a framework for how policy change can be viewed within various contextual factors over a longer time frame. A diagram of the ACF can be found in Appendix A. By applying this framework to the case study, the implementation of this policy response is described in terms of the policy subsystem that encompasses it, the contextual factors that impact it, the various actors that are involved in its implementation along with the resources, strategies, and beliefs that they bring with them, how conflicts and revisions are dealt with, and the extent of policy-oriented learning over time.

The five-year strategy was announced in 2011 and has since produced a summary of achievements for the first two years. The ACF adopts a much longer time frame than was used for this strategy and is considered, by this author, as the ideal time-frame for implementing

policy and creating policy change. The differences found between this ideal situation and the results found within the exploration of *Rising to the Challenge* may show that not all policy learning will have emerged within the five-year time frame. However, the evidence that is found through the data will help in understanding the implications for policy-oriented learning within different time frames.

Defining the Case

The primary unit of analysis for this case study is the Government of Manitoba's mental health strategic plan "Rising to the Challenge". In 2011, the provincial government developed this as a response to mental illnesses and mental health problems, along with responding to calls for improvements needed in the provincial mental health system. It is a five-year plan that aims to strengthen the way that people with mental health issues are supported. The strategy outlines six goals, which each have its own objectives and specific actions to be taken. The objectives address the different factors that make mental health issues a social problem in Manitoba. The plan states that: "improving the mental health and well being of Manitobans will occur by implementing the following six goals and their corresponding objectives and strategic actions" (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a).

While *Rising to the Challenge* aims to see improvements in the entire province of Manitoba, this study will be bounded by the implementation processes that are occurring in the City of Winnipeg. This case study has an embedded research design as it contains multiple units of analysis adding various factors that will enhance the insights into the single case (Yin, 2014). The subunits are defined as the different implementation levels (policy makers, organizational administrators, street-level bureaucrats). The policy-making subunit includes the provincial Cabinet, relevant Cabinet Ministers, the Mental Health and Spiritual Health Care branch within

the department of Health, Healthy Living and Seniors, Manitoba Health, and the Winnipeg Regional Health Authority. The organizational administration subunit includes management from mental health departments in different hospitals and different community organizations. The street-level bureaucrat subunit includes social workers and other mental health professionals from these same organizations.

A critical analysis of the strategy document itself is presented and includes a section on how the definition of policy used in this study relates to the term, strategy, along with what implications may flow from the level of importance a strategy has in comparison to other types of policy. This section also includes a discussion about the problems, goals, and instruments that are described in the strategy and how well they are articulated and connected. The second component of this critical analysis includes an examination of the specifications of the Canada Health Act (Canada Health Act, 1985 c. C-6) and the jurisdictional powers of the federal and provincial governments and how these affect this particular policy. This helps describe what actions are in and out of the scope of this policy. The third component of this critical analysis utilizes the three conceptual models used in the Canadian Mental Health Association's Framework for Support (Canadian Mental Health Association, 2004) that include changing the way communities provide services and supports to people with mental illnesses, re-examining how mental illnesses are thought about and understood, and understanding how consumers can direct their own recovery process (Canadian Mental Health Association, 2004). These models are compared and contrasted with the goals and strategies of the Government of Manitoba's mental health strategic plan.

Data Collection

The data collection process began by contacting representatives from the Department of Health, Healthy Living and Seniors. It was intended that by making this contact, arrangements would be made to identify key informants and sources for particular data. It was hoped that with the help of department representatives, a network of the key informants, expert working groups, and the various implementing actors would be identified. It would also have been determined if advocacy coalitions were intentionally at work involved in the implementation of this policy response.

The Department of Health, Healthy Living and Seniors was not forthcoming with the information at their disposal. I was not able to access much of the information that I requested, which is described further in the sections below. The representatives from the department were able to connect me with some key informants by forwarding the interview recruitment letter in Appendix B to some of their contacts. Since it was determined that advocacy coalitions were not intentionally at work, for the purpose of this study the various actors were organized into groups of key informants based on shared beliefs, likely coinciding with the different levels of the implementation chain (e.g. policy maker vs. front line social worker).

The review of the literature on mental health policy implementation identified a number of barriers and facilitating factors for the implementation process. These were highlighted during the collection of data as sensitizing concepts; since they are known to be significant for policy implementation. Sensitizing concepts provide direction by raising consciousness about a particular concept in a particular context (Patton, 2011). The barriers and facilitating factors described in the literature review served as a guide in extracting documents related to these

concepts, influencing probing questions during interviews, and they were highlighted on the observational form that was developed.

Interviews.

After the implementation network was identified, interviews were arranged with willing implementers in order to obtain their descriptions and interpretations of the implementation of this policy response. A purposive sample was developed to include people in different coalitions or different levels of the implementation system. These interviews included policy makers, administrators, social workers, and other street-level bureaucrats. Interviews conducted at the policy making level aimed to seek out information regarding the policy instruments and resources at their disposal, the causal theory behind the policy's objectives, and other policy design features that affected the implementation process. Interviews at all levels of the implementation system sought out information about the various contexts in which implementers work, the strategies employed by various actors to meet their goals, and their interpretations of the extent of policy-oriented learning that took place. Information that could not be found in the documentation was inquired about during interviews along with clarifications regarding the content and use of the documents. All participants noted not having any relevant document sources in their possession.

The intended sample size was to have 9 key informant interviews. This was planned so that there would be three interviews at each level of the implementation chain; the policy making level, the organizational administrator level, and the street level bureaucrat level. An attempt was also made to include respondents from the private sector, the public sector, the recovery-oriented system, the bio-medical system, and self-help organizations. The study ended up including 10 key informant interviews in order to have representation from different sectors, organizations,

and implementation levels. Some of the respondents ended up having numerous roles in their position and did not necessarily fit into one of the implementation level categories; four respondents identified as being both policy makers and administrators, one respondent identified as being both an administrator and front line worker, two respondents identified as policy makers, and three identified as front line workers. The sample size was intended to be relatively small in order to gain an in-depth understanding of each person's experience in the implementation process. The intention for having three people from each level was so that any themes that represent similarities or differences in experience could be uncovered both within and between implementation levels; this was still accomplished despite the distribution of positions being different than originally expected.

Many similar concepts were inquired about during the interviews with different policy implementers. Since there were efforts to learn about similarities and differences in regards to these concepts across implementing levels, a semi-structured interview format was developed for this purpose (Stake, 2010). This allowed for clarification and probing questions to be tailored to the individual in order to gain an understanding of each individual's unique experience with these implementation concepts. After the initial questions were asked, the interview took on a conversational nature, which is appropriate for seeking out unique interpretations (Stake, 2010). Appendix C provides the interview guide that was used to cover important concepts in the policy implementation process. Generally, the same questions were asked in all interviews in order to assess similarities and differences.

Documents.

It was originally intended that permission for access to document sources would be arranged starting with the Department of Health, Healthy Living and Seniors before moving on

to the Winnipeg Regional Health Authority (WRHA), Manitoba Health, and community organizations identified as being involved. Sources of government data that were requested included an organizational chart of the implementing actors involved in this policy response, any documents with statistical indicators that indicate change related to implementation, documents regarding the policy instruments and resources available to the policy makers and implementers, implementation meeting agendas and minutes, implementation proposals, progress reports, and evaluations. In my attempts to communicate with the department about what documentation they could make available, I was informed that they did not have a record of document data aside from what was published on their website. Notes were said to have been taken by working group members, but that these people had since changed positions and the department did not have access to their notes. Out of the network of actors that I was put in contact with, one was a working group member who still had a record of the documentation that was kept for that working group's progress; I was granted access to these documents.

It was originally intended that once the network of key informants and relevant implementing organizations had been identified, similar documentation as listed above would be sought from these organizations. Contact was to be made with the heads of these organizations and meetings set up to determine the level of access they would allow to their documentation regarding the implementation of this policy. It was determined that this kind of documentation for the strategy did not exist within these organizations and that the responsibility for keeping records of such documents would have been vested with the department. Aside from the documents obtained from one of the working groups, other documents from these organizations were obtained online and included provincial annual reports for the Department of Health,

Healthy Living and Seniors and for WRHA, Manitoba Health annual statistics, and the Summary Reports of Achievements.

Sources of documentation outside of the government and non-governmental organizations were obtained as well. In the past few years there have been news reports about successes and issues within the mental health system in Manitoba.

A search was conducted through the Winnipeg Free Press Archives using the search terms 'Rising to the Challenge' and 'mental health strategy'. The results were narrowed by searching a year preceding and extending past the years that the strategy's timeline was in operation, from 2010-2017. The news articles that were obtained provide insight on the implementation process of this policy. Finally, documentation that paints a picture of the exogenous factors included in the (Sabatier, 1986) ACF (basic attributes of the problem area, basic distribution of natural resources, fundamental socio-cultural values and social structure, basic constitutional structure, changes in socio-economic conditions, changes in public opinion, changes in systemic governing coalition, policy decisions and impacts) were included. Documentation regarding these exogenous factors came from organizational documents, reports, news articles, and relevant scholarly literature.

Based on my previous knowledge of mental health policy implementation from conducting the literature review and examining the policy under study, the documents mentioned here served as a starting point and a guide for collecting more documents. I then engaged in a process of theoretical sampling to collect more documents that I may not have considered during the thesis proposal stage. This process involves jointly collecting, coding, and analyzing the documents and deciding which documents to collect next and where to find them (Breckenridge & Jones, 2009). Additional documents that emerged from this process included government

press releases, Hansard records, journal articles, economic forecasts from the Conference Board of Canada, and various news articles. In order to organize these documents and track the decisions and justifications for obtaining additional documents, a document abstracting form will be used. A copy of this form can be found in Appendix D.

Observation.

According to the “Rising to the Challenge” document, work plans for the various goals were created by “expert” working groups to guide the implementation of the strategic plan (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). During the data collection phase of this research, access was requested to attend any meetings of the working groups, so that observational data could be obtained on how the implementation plans were progressing. An observational form was developed for gathering data during an implementation meetings and was designed to incorporate the original research questions, what the strategic plan proposed in measuring the implementation and accomplishments of the plan, and essential factors for policy implementation according to the Advocacy Coalition Framework. Unfortunately through my consultations with the Department of Health, Healthy Living and Seniors I was informed that the working groups had completed their time-limited, preparatory work on the moving the strategy forward, were no longer in operation, and so I was not able to collect observational data.

Data Analysis

The two sources of data gathered for this study were directly interpreted by the researcher throughout the entire data collection phase. This was done to produce more opportunities for identifying patterns and themes among the documents and interviews (Stake, 1995). As more data accumulated, a more refined method of coding was used to organize and analyze the data. In

the process of initial coding data were sorted into categories based on formulated meanings of the interview content; a process of focused coding followed where the most significant and frequent codes were conceptually defined and assessed (Thornberg & Charmaz, 2014). Specific methods for analyzing each source of data are presented below.

Interviews.

To analyze the interviews in this study, a narrative influence was used to conduct a thematic analysis. With a narrative analysis, the focus is on representing findings in terms of the individual's unique story, which can be used in conjunction with thematic presentations of data (Roulston, 2014). Pseudonyms were used for each of the narratives. Analysis began by transcribing each interview and reading each transcription as a whole to begin to uncover themes emerging from the data. The data were reduced by editing the individuals' stories to represent the central ideas discussed, which was followed by a process of making connections between ideas, allowing the researcher to make assertions and more specific themes regarding the phenomenon (Roulston, 2014). Thematic representations found in these data were also compared and contrasted with thematic representations found in the document data. Finally, vignettes that illustrate the implementation process were developed and presented in the thesis.

Documents.

To analyze the documents in this study, the researcher conducted a thematic analysis of the data. This strategy included coding the data in terms of their content meaning to identify themes to generate patterns and assertions (Coffey, 2014). Based on the theoretical sampling approach that I used to collect the documents, I began by analyzing a few documents and used the codes and themes that were emerging to search for further documents for analysis. The

analysis included an ongoing comparison of codes, which created a preliminary set of conceptual categories, from which point new categories emerged and new documents were fitted and re-fitted into existing categories (Breckenridge & Jones, 2009). This helped to reduce and organize the documentation sources into categories, which assisted in gaining an understanding of the implementation process. The generated themes are also helpful for defining the factors that are most relevant for implementing policy in the mental health field. Based on the issues that were raised throughout the data and the sensitizing concepts used, the themes that emerged from the document analysis were congruent with the themes emerging from the interview data.

By using multiple sources of data, I was able to utilize methodological triangulation. By using different methods, such as documents and interviews, I was able to develop a more comprehensive account of the case (Stake, 1995). The accumulation of these different sources of data resulted in a discussion of the factors, challenges, and successes associated with implementing policy in the mental health field. It was also originally intended to include a logic model that illustrated the implementation process of “Rising to the Challenge”. Logic models have become increasingly useful in doing case study evaluations and studying theories of change by operationalizing a complex chain of occurrence over an extended period of time (Yin, 2014). This was intended because it directly relates to the theoretical foundations of the synthesis approach to policy implementation and the Advocacy Coalition Framework that this study is based on. The occurrences or events are staged in cause-effect patterns (Yin, 2014), which could speak to the causal theory behind the implementation plan and its use of objectives and outcomes. However, due to the number of barriers in the planning and implementation of this response, outcomes were not clearly defined, outputs were not well connected, impacts were not

measured, and a chain of occurrence did not emerge. For these reasons, a logic model was not included in this thesis.

Chapter IV: Findings

The following chapter describes the findings that emerged through the analysis of the data in this study. It begins with a critical analysis of the *Rising to the Challenge* document, which also includes a discussion of the strategy's scope within provincial and federal jurisdictions and a discussion of how the document relates to the Canadian Mental Health Association's Framework for Support (Trainor, Pomeroy, & Pape, 2004). This is followed by the narrative analysis of each of the ten interviews that were conducted and a cross-narrative analysis that describes the themes emerging from the narratives in detail. The analysis of the documents that were gathered for this study is then discussed. The chapter concludes with a discussion of how all of these findings combine to answer this study's research questions.

Strategy Document Critical Analysis

Strategy Document.

The Government of Manitoba's *Rising to the Challenge* (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a) document is referred to as a strategy, or a strategic plan, for the mental health and well-being of Manitobans. In the literature review definition of terms section, the terms strategy and policy are defined and related to one another in order to explain how *Rising to the Challenge* has been defined by this writer as a policy response and to explain how policy implementation theory can be applied to this strategy. While for the purpose of this thesis the strategy is defined as a policy response, it is important to recognize that different types of policies are capable of producing different outcomes and may be assigned different value by those who are involved in implementing them. These differences can be illustrated by describing a legislative act, policy and strategy relevant to this study.

The Mental Health Act is an example of legislation in Manitoba. It sets out in law specific criteria and requirements for admitting and treating patients in psychiatric facilities, those on leave from a facility, as well as those under Orders of Committeeship in the community (Mental Health Act, 1998, c. M110). The criteria and requirements outlined in the Mental Health Act are provincial law, which illustrates how this level of policy must be followed and enforced by those responsible for the admission and treatment of patients who are in psychiatric facilities. Laws are more powerful policy instruments than policies or strategies created by mental health organizations because they are created by an accepted legal authority, recognized by the courts, have wide legal effect, and are highly binding in that they generally will impose sanctions for noncompliance (L. Pal, 2003). While this specific Act does not include penalties for non-compliance, there is a quasi-judicial accountability structure built into this through the Mental Health Review Board, which hears appeals on admission, treatment, and competency issues (Government of Manitoba, 2016b). This Review Board ensures that the provisions of the Mental Health Act are enforced properly by allowing Review Board members to make orders to take immediate effect that can reverse a physician's decision or order a physician to comply with a patient's wishes (Mental Health Act, 1998, c. M110).

The Mental Health and Spiritual Health Care Branch of Manitoba Health has developed a policy document called 'Consumer Participation in Mental Health Services, Planning, Implementation and Evaluation (Manitoba Health, 2003). This is an example of what Manitoba Health would refer to as a policy. The policy includes a statement describing consumer rights to participation, the policy's purpose, the policy's values, and specific standards, procedures, and guidelines for the organizations, which were identified as being required to implement this policy (Manitoba Health, 2003). This kind of policy specifies exactly what the implementers need to do,

which includes evaluation and reporting back to Manitoba Health. While this kind of policy includes direct implementation and reporting guidelines, it has less power as a policy instrument than legislation which may limit its implementation, because policies are created by administrative rather legal authorities, and generally have no binding legal effect that describes what actions are taken if the policy is not implemented. While policies like this may lack legal power they are often chosen for their flexibility in that their rules can be changed much more quickly and easily (L. Pal, 2003).

Strategies on the other hand can take on a different policy meaning. As noted earlier, strategic planning has been increasingly used in the past two decades in human service organizations to launch new initiatives (McKenzie & Wharf, 2010). Campbell refers to strategic planning as a process for defining organizational objectives, implementing strategies to achieve those objectives, and measuring the effectiveness of those strategies (Campbell, 1993). Strategies like *Rising to the Challenge* differ from legislation and policies like the ones noted above by not having clear defined roles for who is responsible for what specific actions and lacking the specificity required for implementing a new initiative (McKenzie & Wharf, 2010). Strategies can be a way for governments to more easily achieve their objectives by avoiding the legislative process (Paun & Hazell, 2010) or to make it seem like something is being done without having to invest a lot of resources. This may make their objectives and planning easier to initiate, however, there is less assurance than with legislation and policy documents that a strategy will be followed through and successfully implemented. Governments can also use strategies as a symbolic policy response in which they state the importance of the issue at hand and may appoint a task force or steering committee as a substitute for real action which further limits the likelihood that objectives would be met (McKenzie & Wharf, 2010). Although there are not strict guidelines for

its implementation, Rising to the Challenge is referred to as a strategy intended for implementation. There are a number of instances in the document that refer to how the objectives and goals included will be achieved through the implementation of the strategy over the next five years (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). The way that the strategy document was designed has important implications for how well it can be implemented.

In order to examine the design of this document a description of the strategy is discussed based on what it includes as well as how articulate and connected the problems, goals, and instruments are. The document is introduced with its intent, how the policy was developed, how success can occur, and the 6-points of the strategic plan that aim to improve mental health in Manitoba (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). The document then describes the problems that the strategy aims to address. The definition of policy problems indicates what the problem or issue is and the causal factors that contribute to the problem (Pal, 2006). The problems described include how mental health problems affect all Manitobans, that one in four Manitobans experienced a mental illness within a five year time span used prior to the strategy starting, that mental health problems affect 20% of children and 20-25% of seniors, that there are higher rates of mental illness and suicide among Manitoba's Indigenous population, that there are specific mental health vulnerabilities for immigrants and refugees, and that there is an upward trend in the diagnosis of depression (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). This section also describes how a whole population approach to mental health promotion and early intervention strategies have been determined to be the best preventative measures (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). The strategy goes on to identify its vision and mission statements prior to describing the six key pillars that the strategy is based on.

The six key pillars serve as the philosophical basis of the strategy. They are described as the lenses that each strategic action needs to be viewed through in order to be accountable to the directions of this plan (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). They are the policy values that drive the implementation of the strategy. The six pillars outlined in the strategy are mental health promotion, which refers to promoting positive mental health and well-being across the entire population; recovery, which refers to building a recovery based system that values the self-determination, meaning, and empowerment of someone through their experience with mental health problems or illnesses; inclusion, which refers to processes of reducing stigma and social prejudice and ensuring that people can actively participate in society, shared responsibility, which refers to how community members, relevant departments and sectors can work together to increase their knowledge to support individuals with mental health problems or illnesses and to strengthen policy programs and practice; leading and promising practices, which refer to making mental health care decisions based on experiential knowledge and the best available leading practices; and cultural safety which refers to providing culturally appropriate services and addressing power imbalances and institutional discrimination existing in the mental health system (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). Following the descriptions of each of the pillars are the goals, objectives, and strategic actions of Rising to the Challenge. A policy's goals can be referred to as the objectives to be achieved by the policy (L. A. Pal, 2006). There are six goals outlined in Rising to the Challenge which are listed below:

- 1) Mental health and well being of the population are promoted and mental health problems and illnesses are prevented wherever possible.
- 2) Access to a range of recovery-oriented services is available as close to home as possible.

- 3) Innovation and research are strengthened, promoted and supported.
- 4) Social inclusion of people living with mental health problems and illnesses in communities and systems is promoted and supported.
- 5) Family participation is supported so that family members and natural supports can foster recovery and wellbeing.
- 6) Workforce development strengthens the policy environment and practice guidelines needed to promote mental health, well being and recovery.

(Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a)

Each goal has corresponding objectives and more specific strategic actions intended to meet those objectives. While the objectives and strategic actions are intended to create more specific actions to meet the strategy's goals, the goals themselves are not specific enough to evaluate whether the objectives and actions taken to meet the goals were successful. The goals are written with vague language and lack specific targets, which can lead people to interpret these goals differently. Consider goal 2, "Access to a range of recovery oriented services is available as close to home as possible." The language used does not include any scale of improvement, in that if nothing was implemented in regards to this goal, that goal statement could still be interpreted as having been achieved. Perhaps the services were not made more accessible and closer to home, but they would still be as close to home as the currently are, which could be considered as close to home as possible. It would be challenging to evaluate the success of this strategy without clearly stated goals.

It was clear throughout the review of this section of the document that the pillars of the strategy are well reflected through the goals and objectives. It was also found that each of the problems listed earlier in the document was addressed through the proposed strategic actions.

The whole population approach and early intervention strategies that were determined as effective approaches in the strategy were also evident in the strategic actions. The connection between the problems identified and the goals, objectives, and strategic actions to address those problems as well as their alignment with the policy values outlined in the six pillars are strengths of this strategic plan. However, the theory that connects each of the goals to the problems they are meant to address is not articulated in the strategy. As described in the literature review, policy implementation theorists determined specific factors that were necessary in order for effective implementation to occur and these included basing policy on valid theory and ensuring causal connections between policy theory and policy goals (Hogwood & Gunn, 1984; Sabatier & Mazmanian, 1981; Sabatier, 1986). Describing a theoretical basis for the goals would help determine what is meant to happen to the problem if the goals are achieved. For example, this would help describe whether mental health promotion and suicide prevention activities would completely prevent suicides from occurring or reduce the rates of suicide in Manitoba.

Another strength of this strategy is in the way it was developed. The document was informed by the work of the World Health Organization, other national mental health strategies, the work of the Mental Health Commission of Canada, and through consultations with people affected by mental health problems and illnesses, their family members, regional health authorities, mental health organizations, and cross-departmental representatives (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). This approach to developing the strategy is also reflective of some of the pillars used to guide the strategy, such as inclusion, shared responsibility, leading and promising practices, and cultural safety. The approach is also congruent with the synthesis approach of policy implementation by using the resources and knowledge of people in the top policy and administrative positions along with the strategies and

knowledge of the people and workers who are closest to the problems described in the strategy. However, there is no evidence that service providers, such as family physicians, psychiatrists, clinical psychologists, registered psychiatric nurses, registered nurses, social workers, or occupational therapists, were consulted in the development of this strategy.

While there are clear strengths in how this strategy was developed and how well its concepts are connected there are some limitations with how clear pieces of the document are. There is a lack of clarity in the purpose of the strategy. It is clear that overall this is meant to improve the mental health and well-being of Manitobans; however, components of the document describing what the strategy is meant for are not strongly connected to each other. For example, in the preamble of the document, the intent of the strategy is described as providing high-level direction to planning in mental health and well-being in Manitoba over the five-year time frame (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). In the conclusion of the background section of the document, the strategy is referred to as being a guide for moving Manitoba's mental health system forward. The document then notes the strategy's mission statement, which is, "to develop, implement and maintain an integrated and coordinated model of mental health promotion, prevention, support and treatment for Manitobans" (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). This statement is much more specific and refers to implementable actions. As the strategy begins to describe the goals, objectives, and strategic actions it starts to portray the strategy as a more specific task oriented policy document. The lack of clarity comes with the language describing whether or not this strategy is a guiding document to help make further plans or a plan in itself to implement specific actions to lead to improved mental health outcomes. The purpose of this document seems to be caught between the portrayals of strategy and policy as described earlier.

Another limitation that relates to the more specific components of this strategy is in the clarity and measurability of the strategic actions set out for the objectives related to implementing the goals. Most of the strategic actions are quite vague and lack clarity on how they would be achieved. Examples like “identify and maximize opportunities to strengthen service navigation across the mental health system,” and “work collaboratively to prevent suicide, with a focus on First Nations, Metis and Inuit populations” use very positive sounding language but are not clear on what maximizing opportunities, strengthening navigation, or preventing suicide will really mean in the implementation of this strategy. While a majority of the strategic actions use language like this, some of them appear to be more specific, for example, “develop and implement a provincial action plan for mental health promotion as well as mental illness prevention for adults, recognizing the diverse needs of Manitobans,” and “continue re-development of Selkirk Mental Health Centre.” These examples are more clear in what they intend to accomplish in that the work would result in an output. With these output related activities we are able to anticipate progress with the processes facilitated through the strategy. It can be more difficult to determine achievement of specific outcomes and impacts achieved through these actions when there are no measurable targets articulated, such as reducing suicide rates by 10%. While these examples propose clear outputs, they do not identify who is responsible for the action, like the provincial policy document did, nor does it describe many specific policy instruments that will be used during implementation. Policy instruments are referred to as a means chosen for how to address the policy problem and achieve its goals (L. A. Pal, 2006). The only instruments that can be derived from the policy document itself are information-based instruments in the strategic actions that refer to developing and using different provincial action plans. Unfortunately information-based instruments have been referred to as the

least effective type of policy instrument since there is no obligation to act on the information (L. A. Pal, 2006). The lack of clarity on the strategic actions and the instruments used to achieve them begs the question of how the implementation of this strategy can be measured.

Following the section of the document that outlines the goals, objectives, and strategic actions is a section dedicated to how accomplishments will be measured. It starts by explaining how working groups will be developed for each of the six goals in order to create work plans to set specific, valid, and measurable outputs and outcomes based on the strategic action (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). This makes it clearer why the strategic actions are not very specific. It would appear that the strategic actions that the mission statement says will be implemented are not at the stage of being thought of as real actions to be taken. It is then noted that the working group plans will be accountable to a departmental steering committee (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). This implies that action will be taken and progress will be reported to the department responsible for this strategy. The document concludes this section by explaining that an evaluation plan will be developed; yet it is also not entirely clear what its purpose is. At one point it notes that “the evaluation plan will help translate the strategic plan into measurable actions and will demonstrate accountability and values for the actions undertaken,” but also states that “an evaluation plan will measure the strategic plan’s successes on practice, program, organizational, and policy levels” (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). The first statement sounds like just another step in turning the strategic actions into actual measurable actions, which should be completed as the strategic actions are determined. Yet the second statement implies that they are talking about a real evaluation that will measure the strategy’s success in improving mental

health outcomes. This again speaks to the lack of clarity as to whether this strategy is an exercise in directional planning or intended to create change through specific measurable outcomes.

It seems that a lot of effort has been put into the planning for this. It began with the policy values of the six pillars, from those six goals were developed, and then objectives were developed to meet those goals. In order to meet those objectives strategic actions were formulated, and in order to define the strategic actions, working plans were described. In order to translate the working plans an evaluation plan would be made. There are a lot of steps in this process that seem to serve the purpose of further refining the plan without clearly identifying a point at which implementation would occur. It seems like these steps could have been reduced and time and resources could have been saved if intentional and measurable actions were developed earlier on in the process if implementation of this strategy was meant to occur.

Federal and Provincial Jurisdictional Specifications.

The following section of this critical analysis includes an examination of the specifications of the Canada Health Act and the jurisdictional powers of the federal and provincial governments and how these affect this particular policy in order to describe what actions are in and out of the scope of this policy. As mentioned in the literature review, the Government of Canada's main role is to provide money to provinces and territories, which leaves the regulation and operation of mental health services a provincial/territorial responsibility (Jackman, 2000). Since the activities in the strategy only affect the regulation and operation of Manitoba's mental health services, not a lot of coordination with the federal government would be required for this strategy. The only coordination would be that Manitoba satisfies the criteria required to receive the federal cash contributions to help continue financing provincial mental health programs. In order to receive the Canada Health Transfer, Manitoba is required to meet

the criteria in the Canada Health Act. In order to qualify for this cash contribution, Manitoba's health care insurance plan must be administered by a public authority, insure comprehensive health services, insure universal coverage, be portable for insured residents, and provide reasonable access by insured persons. While the strategy deals with trying to improve access to services it does not deal with the full range of measures in this Act and would not have a significant impact on the criteria met by the provinces health care insurance plan to receive the health transfer.

It is also important to recognize that the Canada Health Act deals with insured services, which are largely restricted to care delivered in hospitals or by physicians, and that the definition of hospital does not include a hospital or institution that primarily operates for the treatment of the mentally disordered (Canada Health Act, 1985 c. C-6). Also important to note is that the Act also excludes uninsured health and social programming. With the shift from institutional care to community and recovery oriented care, some of the initiatives in the strategy would be categorized as uninsured and social programming and would not fall under the funding for the Health Transfer aside from care provided in hospitals. The Canada Social Transfer, on the other hand, provides provinces and territories support for post-secondary education, social assistance, social services, early childhood development, early learning, and childcare as defined by the Federal-Provincial Fiscal Arrangements Act (Department of Finance Canada, 2011b; Federal-Provincial Fiscal Arrangements Act, R.S.C, 1985, c. F-8). This is the source of support for many of the community mental health programs in Manitoba, which would fall under the social services definition. This particular transfer finances social programs in a way that provides provinces and territories flexibility in how the funds are spent (Department of Finance Canada, 2011b) which allows this provincial strategy the freedom to take whatever actions needed to

provide support to Manitoba's residents without having to meet specific criteria in order to receive the Canada Social Transfer.

As mentioned earlier, the Canadian government has jurisdiction over the control of activities that put human health at risk, regulating matters of national health and welfare, including health services for members of the Canadian armed forces and veterans, members of the Royal Canadian Mounted Police, immigrants and refugees, and for inmates in federal penitentiaries, and providing health resources to First Nations communities included under the federal Indian Act (Indian Act, 1985; Jackman, 2000). The areas where Manitoba's strategy could have coordinated with the federal government are when mental health issues become issues of national concern. This includes if mental health issues were related to an epidemic, like issues of depression and suicide. Coordination could also have happened in regards to providing mental health services to Indigenous communities given that the strategy might overlap with federal jurisdiction in its attempts to adopt cultural safety measures and to address mental health concerns in Indigenous communities. Another area of coordination would be for the mental health treatment of people who are on parole. As one of the narrators in this study describes, changes to federal funding models or changes in federal jurisdictions, such as First Nations Health and federal penitentiaries, could alter the province's ability to implement this strategy. This study did not find direct evidence of coordination between the strategy's developers and the groups that fall under federal jurisdiction, however, the strategy describes intentions of working on areas that can fall under federal jurisdiction, such as First Nations communities, immigration, and criminal justice issues, which may include people who are on parole. The inclusion of these areas in the strategy may indicate that coordination with stakeholders working in these areas may have occurred in the development of the strategy.

In terms of coordination between the Government of Manitoba and the Government of Canada, the strategy document provides evidence that some level of coordination was achieved. The document notes that the Mental Health Commission of Canada provided leadership and guidance during the development of the strategy, and one of the strategic actions under the access to recovery oriented services goal included enhancing the structures, policies, and processes between government jurisdictions (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). However, the extent to which this coordination was achieved with the federal government is unclear. With that being said, most of the activities and goals of the strategic plan do fall under the jurisdiction of provinces and territories, which include the establishment and management of public hospitals, authority over the design, management, and delivery of health care services, the protection and promotion of health at the local level, and the regulation of health records, health insurance, and the training of health professionals (Jackman, 2000). Since the actions taken in *Rising to the Challenge* do fall under this jurisdiction they are in scope of the provincial mental health strategy.

Canadian Mental Health Association Framework for Support.

The final section of this critical analysis includes a discussion of how the three conceptual models utilized in the Canadian Mental Health Association's (CMHA) Framework for Support (Trainor et al., 2004) compare and contrast with the *Rising to the Challenge* strategy. The Framework for Support offers a way to approach policy by re-conceptualizing and improving the way we think about mental illnesses and provide services. The framework is being used because it was recognized by the Federal/Provincial/Territorial Advisory Network on Mental Health in their 1997 Report on Best Practices in Mental Health Reform (Trainor et al.,

2004) as a best practice in mental health policy. Since then it has continued to be utilized to help guide mental health research, practice, and policy.

In a paper examining indicators to assess the achievement of Canadian mental health reform goals, it was found that a major shortcoming was the lack of consumer involvement in the planning and delivery of care; the CMHA framework was used as an example to demonstrate the importance and ability of consumers and families to be involved in these roles (McEwan & Goldner, 2002). In a systematic review of studies examining the relationship between housing and health related variables, the framework was utilized to support the concept of housing being a fundamental right, important social determinant to health, and a precondition to community inclusion (Kyle & Dunn, 2008; Trainor et al., 2004). In a paper discussing the importance of value-based approaches and consumer run organizations for mental health reform, the framework was referenced for having influenced several Canadian provinces to actively include consumers in virtually all areas of mental health care (Nelson, Janzen, Trainor, & Ochocka, 2008).

In another article, the framework was used to support the assertions that supported employment and social enterprise models to improve economic security for mental health service consumers (Morrow, Wasik, Cohen, & Perry, 2009). It was referenced for its person-centered approach, support networks and various knowledge bases. The framework was described as the most progressive articulation of the recovery model in Canada. Another article discussed the implementation of recovery based mental health policies in four countries and highlighted how the elements in the framework document have been very influential and continue to be focused on in provincial and national mental health reform (Ramon, Shera, Healy, Lachman, & Renouf, 2009). The adoption of this framework across many different provinces for its award winning vision in mental health planning has been noted in the psychological literature as well (Nelson &

Lavoie, 2010). In another article that reviewed the evolution of the recovery model in Canada, the framework was praised for its leadership in consumer-involvement promotion and was utilized to support assertions that recognizing social equality for people with mental illnesses is important for mental health policy (Piat & Sabetti, 2012).

Another article examining the implementation of the recovery model in England and Canada emphasized the limited role that formal mental health services play in recovery and used the framework to describe the importance of the community resource base for efforts at mental health reform (Shera & Ramon, 2013a). The framework has also more recently been recognized for its transformative elements for creating fundamental systemic changes in community mental health (Townley & Sylvestre, 2014). Another recent article which examined the methods used to study mental health service use by homeless persons described an exclusive focus on formal services; the framework was referenced to express the importance of self-help and consumer run organizations needed by people with mental illness (Kerman, Sylvestre, & Polillo, 2016). The CMHA's Framework for Support has continued to be utilized as a best practice guideline for mental health research, practice, and policy, which speaks to its relevance in current mental health improvement initiatives. Alignment with this framework would help determine if *Rising to the Challenge* can be considered a best practice policy document for mental health.

There are commonalities that are evident in the foundations of the Framework of Support and the strategy. The framework demonstrates that it aligns with trends in health policy, such as mental health promotion, the recovery perspective, and the population approach through identifying social and environmental determinants and best practices (Trainor et al., 2004). These trends are also evident in the strategy's pillars of mental health promotion, recovery, inclusion, shared responsibility, leading and promising practices, and in its recognition of the need to

address the determinants of health (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). The ways in which the strategy aligns with the framework's conceptual models are described below.

The first conceptual model included in the framework is called the Community Resource Base. It refers to how policy should focus on the processes of people's lives, with the individual as the central focus. It also emphasizes how community resources need to include not just mental health services, but also self-help and consumer organizations, family and friends, generic community services, along with having important needs met such as housing, income, work, and education (Trainor et al., 2004). This model has important implications that can be related to the work in *Rising to the Challenge*. The model states that policy and program delivery should be developed by listening to consumers (Trainor et al., 2004). *Rising to the Challenge* aligns with this by including people with lived experience in the development of the strategy and also in the working groups which are responsible for implementation plans. The strategy aims to address consumer involvement through strengthening the use of knowledge derived from lived experience and through expanding the use of peer support in mental health services (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a); however, the strategy does not indicate how knowledge will be gathered or how peer support will expand. The extent of consumer involvement in program delivery in Manitoba's mental health system is also not made clear.

The second implication of this model is that it supports a belief that all of the resources noted in the model need to be utilized in order for someone to experience a fulfilling life (Trainor et al., 2004). This can be seen in the strategy as it recognizes the need to address social determinants, such as income, housing, work, and education by partnering with community organizations in these sectors and relevant government departments. The strategy also utilizes

community resources alongside mental health services as articulated in the framework and uses a person-centered approach by emphasizing social inclusion through stigma reduction initiatives, poverty reduction initiatives, and cultural awareness. This is also done by emphasizing recovery through family participation, recovery oriented workforce development, and improved service navigation (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a).

Closely related is the framework's implication that we need to shift the service paradigm to a community process paradigm. This is reflected in the strategy with the focus on recovery and the background information that is provided which describes the historical mental health reform movements that have shifted from public mental health services acting alone to more involvement of community resources (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). The model also implies that the different sectors form partnerships and recognize each other's importance (Trainor et al., 2004), which again, is seen in the strategy through the collaborative work in formulating the document, the use of cross-departmental and other partnerships, and through the emphasis on family participation (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). The strategy does not speak directly to the balance in these partnerships or how much they value each other; however, the emphasis on a recovery based mental health system would also reflect a shift towards more balanced attitudes. This model also emphasizes the individual's full participation in society and power to make decisions (Trainor et al., 2004), which is reflected in the strategy through the social inclusion and recovery goals.

The model also notes how the representation of consumers in service planning should be improved (Trainor et al., 2004). The strategy does not mention anything about the extent of the representation of consumers in planning and development in the document itself, so it is unclear

whether or not this was taken into consideration. Another implication of the framework is that all sectors need to be considered when developing strategies for change, rather than change being focused only on the service system (Trainor et al., 2004). While the strategy does mention various partnerships, it does not mention specific strategic actions that target change in the community resource sectors other than family participation.

The final implication of this model is that resources need to be more balanced across all of the sectors to work effectively (Trainor et al., 2004). As mentioned earlier in the analysis, the identification of resources was lacking in the strategy, especially financial resources. It is unclear through reading the document how resources have been distributed. Overall, *Rising to the Challenge* is strongly congruent with the Community Resource Base model of the framework by aligning with a majority of the characteristics it articulated. However, the ways that the document could be improved based on the framework would be to ensure a high representation of consumers in policy and program planning, to determine how their knowledge will be gathered and used, to determine how peer support services would be expanded, to target more strategies towards generic services and community organizations, and to include a plan that describes what resources will be used and how they will be distributed to ensure balance across sectors.

The second conceptual model included in the framework is called the Knowledge Resource Base. It refers to how we need to improve our understanding of mental illness by going beyond clinical expertise and identifying all the sources of knowledge that people utilize. The sources of knowledge include medial/clinical knowledge, social science knowledge, experiential knowledge, customary and traditional knowledge, which will be facilitated by a foundation of social acceptance and inclusion, a recognition of diversity, mental health literacy, and an

enriched range of services and supports (Trainor et al., 2004). This model also has important implications that can be related to the Rising to the Challenge document.

This model implies that these components build a strong base of experience and knowledge and can contribute to a more comprehensive understanding of mental illness (Trainor et al., 2004). It is clear that the mental health strategy recognizes this. Experiential knowledge is included through consumer and family participation; customary/traditional knowledge is recognized and challenged by promoting social inclusion, a whole population approach to mental health promotion, and by working to reduce stigma; social science knowledge is recognized by seeking to address the social determinants of health and by working cross-departmentally with government agencies that work on addressing these specific concerns; and medical/clinical knowledge continues to be utilized and expanded on as recovery oriented services become paramount. As mentioned earlier, the strategy is lacking in clarity in specifying its strategic actions so it does not describe specific mechanisms to gather these different kinds of knowledge to improve mental health policy and practice. However, the integration of these types of knowledge in the strategy's goals and pillars shows at least that they are valued.

The model also states that each component has strengths and weaknesses and should be subjected to critical analysis (Trainor et al., 2004). The strengths of each source of knowledge are apparent in the strategic document, but there is not an emphasis on the weaknesses that may be associated with them. The strategy does refer to strengthening the use of different kinds of knowledge, but it is not clear to what that is referring (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). The last implication of this model is the need for better communication as various perspectives are integrated (Trainor et al., 2004). The expectation for the level of communication and dialogue in the strategy is unclear; however, the desired

utilization of these different components is clear, as are the desired partnerships, which shows that some level of communication is understood to be required. Rising to the Challenge has demonstrated congruence with the Knowledge Resource Base model of the framework by aligning with nearly all of its components and implications. The only area where this framework might suggest improvement is on how the strategy intends to critically analyze its sources of knowledge.

The third conceptual model of the framework is called the Personal Resource Base. It takes a strengths based perspective for shifting how consumers see themselves and are seen by others by balancing the challenges of their illness with the personal resources that are needed to live a fulfilling life. The categories of the Personal Resource Base include a practical understanding of the illness and the reactions it elicits from others, developing a positive sense of self that is separate from their illness, developing a sense of purpose and meaning, and experiencing inclusion and belonging (Trainor et al., 2004). The implications of this model compare with Rising to the Challenge, as well. This model implies that policy should recognize the personal resources that are needed for everyone's mental health (Trainor et al., 2004). This is reflected in the strategy through the use of a whole population approach to mental health promotion and through its recognition of the components used in the Personal Resource Base.

The second implication is that policy reflect the importance of a consumer's sense of control in decision making for issues like service options, workplace issues, and interpersonal relationships (Trainor et al., 2004), which is also reflected in the strategy's recovery pillar as it refers to the importance of having control and input in one's life (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). The third implication reflects the importance of portraying how the various personal resources are put in place to strengthen the person at the

center of the model. Each component aligns with the strategy's emphasis on consumer and family participation, social inclusion, and the recovery approach. The only component of the model that is not as strongly connected to the strategy is due to the lack of clarity in the strategy on how consumers can become more educated and understand their experience with mental illness fully.

The final implication of this model is that policy should take into account the timing of an illness and the time of life the illness occurs for consumers (Trainor et al., 2004). The strategy does not specifically refer to goals or strategic actions that address different challenges that occur during different times or stages of a mental illness; however, the actions taken to promote recovery oriented services and increase peer support services may help to address this. The strategy does acknowledge the time of life through its use of early intervention approaches and separate foci on youth, adult, and senior mental health needs (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). The strategy is strongly congruent with the Personal Resource Base model of this framework. The only places it might improve is by clarifying how people can become more educated on their experiences with mental illness and by being more clear on specific interventions and the choices of service options for the different stages of a mental illness.

While there were some aspects of the three conceptual models used in the Framework for Support that were not strongly emphasized in the Rising to the Challenge document, there was not anything strongly deviating from it. Most components were congruent with the strategy and the only ones that were not, mainly, lacked clarity in how these components would be included, which means it is possible that they were considered in the making of the strategy. So overall, the strategy strongly aligns with a framework for best practices in mental health policy. The

document itself is strong in how it was developed and what it aims to achieve. Where it falls short is clarity on what specific actions need to be taken to achieve its goals and how it will be implemented, which is also reflective of the lack of specific implementation and accountability planning for both CMHA's Framework for Support and Canada's nation mental health strategy (Trainor et al., 2004; Mental Health Commission of Canada, 2012). The narrative accounts of people involved in its implementation will shed light on the realities of this strategy's implementation process.

Narrative Analysis

Narrative One.

The first narrative that will be described comes from Anna, who identified as having roles as both a policy maker and a mental health organization administrator. Anna played a role in developing the Rising to the Challenge strategy and was brought on to do so as a result of her vast experience working with various mental health agencies over the years. Her knowledge and experience in this field provide her with expertise with regard to mental health services, advocacy, legislation, policy and in the implementation of Manitoba's mental health strategic plan.

Theme: Policy Design

Organizational Structure in the Development of the Policy as a Facilitating Factor

Anna's involvement in the planning of this policy response began when a group was formed to develop and write the strategy. Then working groups, composed of a range of stakeholders, were established around each of the goals articulated in the strategy in order to create more detail about what could happen in the next five years. Anna admitted to not having a direct role in disseminating the strategy within Manitoba's mental health system. The intent was

that Manitoba Health's Mental Health and Spiritual Health Care Branch would work with the Regional Health Authorities, the self-help groups, and the rest of the system to get the message out. Anna highlighted this plan as a facilitating factor in implementing a strategy like this:

“they’re (the mental health branch) the ones who spearheaded this and worked with you know, the health authorities to, to really make this happen, right? And then other people, so yeah, you need an organizational structure that’s going to focus on something.”

Theme: Mental Health System Complexity

Mental Health System Complexity as a Barrier

While Anna regarded organizational structure as an important element for an organization to implement a policy response, she saw challenges that come with this task as well. She viewed Manitoba's mental health system as very complex as it includes a formal system, a semi-formal system, an informal system, as well as a variety of private practitioners who would all need access to the strategy:

The services within um, for example Winnipeg in the hospital and the formal community based system, there’s a way to do that. All of the agencies, whether it’s Canadian Mental Health Association or Klinik or, you know, those, there’s a way to get information out to them. But there’s also a whole bunch of agencies that aren’t really formally part of the mental health system, so you know you think of like Ma Mawi and Salvation Army and those, so how, you know, getting information out to those is a little more complicated.

Theme: Policy Role

A Value Based Directional Planning Document

The complexity of this system affected Anna's views on the strategy as a policy response for improving mental health in Manitoba. Her perception of this policy was that it was a valuable

first step in steering the direction that the mental health system should go and in embedding the overall values, principles and philosophy of what a system should be. Anna described the strategy as:

A directional blueprint for where the Manitoba mental health system should go. So it's a combination I think of trying to look at, you know, a philosophical orientation but then also, you know, talking about what are the key areas you know that, uh that need to be addressed

Anna viewed this policy as being effective as a philosophical document, but with a lack of having “*any other teeth to it*” in terms of improving the key areas that needed to be addressed. She also knew that while this was Manitoba’s first mental health strategy, the concepts included in it were not new concepts; the strategy was mainly a tool to bring together the best thinking in an official document and to provide direction on how to continue to move the mental health system forward.

Theme: Mental Health System Complexity

Mental Health System Complexity Perpetuates Various Dichotomies and Mental Health Definitional Ambiguity

Anna’s perception of the policy’s value may not have been shared among other members of the mental health system. Anna highlighted a challenge in that many mental health systems, including Manitoba’s, have a lot of stratification in them and that there is not necessarily consensus among everyone involved. “*In the mental health system there is a lot of dichotomies and it’s difficult to find middle ground sometimes.*” In her work, she came across various dilemmas experienced by different stakeholders, such as individual rights versus protection, what treatment means for different people, and the differences between the medical oriented approach

and the recovery oriented approach to mental health. Anna expressed that while there may have been disagreement on how to achieve the goals in the strategy, there was not a lot of disagreement that these were important things for the system to address among the people involved in developing the strategy.

Theme: Policy Design

Stakeholder engagement in Policy Development

Anna saw value in the policy process of determining who would be involved in developing the strategy. It engaged a wide variety of stakeholders that included not just people in the formal mental health system, but also people from self-help organizations, First Nations groups, different government departments, and people with lived experience. The intention of this was to gather a cross-section of ideas and to have conversations around what were the most critical goal areas for improving mental health.

Theme: Cross Departmental Approach

Cross-Departmental Collaboration Needed

In Anna's experience, the mental health field had a good track record for engaging various stakeholders in this manner, but she also thought that more effort needed to be made to recognize the impacts of mental health cross-departmentally:

The uh, silo'd approach, right, to developing policy in isolation of what that impact will mean on another part of your department, another department, um, you know that cross governmental kind of lens uh, didn't really happen the way it should.

It seemed that collaborating with other departments could have important impacts for addressing the social determinants of mental health. Anna identified that one of the major issues in the system is the lack of housing supports for people with mental health issues and she found that

there was not enough of an emphasis on this in the strategy. Her point was that it is beneficial to deal with issues like housing, poverty, and mental health together due to their interconnected nature, rather than addressing each of these issues separately.

Theme: Policy Role

Lack of Goal Clarity as a Barrier

When it came to implementing the strategy's goals, objectives, and strategic actions, Anna had doubts regarding how this could be achieved. She felt that there was a lack of clarity in the goals, language used, and targets. For her, words and phrases like "*strengthen the capacity,*" and "*identify or maximize opportunities*" would not really resonate with people. She also related how the vague language takes away from any concrete meaning in the strategic actions:

What are you going to do? What does that actually mean? Um you know, identify and maximize opportunities to enhance equitable access? But I mean, good strategic direction, but what is it actually, what is that actually going to mean in terms of concreteness?

It was not clear to Anna what the overall target for the projected five years of the strategy was nor was there a trajectory explaining what would happen over the course of that time and what the outcomes would be to determine if the strategy, or pieces of it, were successful: "*if you, if you ended up with um, you know you created um, I don't know you created um you know some kind of a small little program in five years, would that meet that strategic action?*" While the lack of clarity in the strategy was a barrier to implementation for Anna, she recognized that concrete actions leading to outcomes were not intended for this document.

Theme: Policy Role

Policy Intended as Directional Planning for Working Groups to Operationalize

In Anna's mind, the document was intended for setting the direction that the working groups would then use to identify clear actions that would meet the strategic direction. When Anna began working within one of the strategy's working groups, the group members were expected to figure out what was meant by the strategic actions and created 'wish lists' for what they wanted to change in the mental health system. The wish lists that were created ended up being too lengthy and broad for them to realistically achieve, *"it was hard to pull people back to quit asking for the moon. You know, because asking for the moon, not going to get you anywhere, right?"* In hindsight, Anna would have preferred a more strategic approach to this by identifying the top five things that needed to happen to make the working group's actions more attainable. But this did not happen and Anna saw this as the stage that the strategy, *"fell off the table."* Work had started in the working groups but had not come to completion; she was not sure what happened with them or if there was documentation related to this.

Theme: Evaluation

Evaluation Challenged by Summary of Achievement Reports

Eventually documentation surfaced in the form of summary of achievement reports that were created after years one and two. After reading them Anna regarded these reports as long lists of achievements that were not linked to the goals of the strategy, making it difficult to actually attach any success to the strategy. *"Some of the activities that are in that shopping list were things that, that were happening that had nothing to do with this document being developed."* An example for her was the opening of the Crisis Response Centre since it was a project that had been worked on for years prior to the strategy, *"It just happened to open just*

after this report came out. But this report didn't drive the Crisis Response Centre. It's a little bit of a misnomer."

Theme: Financial Resources

Collaboration and Financial Resources for Tangible Activities as Facilitating Factors

Despite some of these inconsistencies, Anna did end up seeing some progress occurring as a result of the strategy. She saw a fair amount of work occur on promoting recovery as an underlying force in the delivery of mental health services. She recalled tangible activities that included having a conference on recovery oriented services, developing recovery lead positions in each of the regions, and becoming involved in a recovery oriented services document through the Mental Health Commission of Canada. For Anna, the success that she saw with these activities was a result of the collaborative work of the people involved in these recovery efforts and the funding that was provided for activities and positions like the recovery leads.

Theme: Financial Resources

Lack of Funding as a Barrier to Implementation

While Anna knew that funding was a facilitating factor for those recovery related activities as well as for a web based navigation tool for youth that was made, she also recognized how under-resourced the mental health system has been and how the lack of funding was a barrier to this strategy's implementation. During her time in the working group, there was a process for obtaining financial support for the activities in the strategy; the working group would develop some ideas, bring them to the government, and see if government would decide whether or not it would fund those activities, rather than having concrete funding attached to the strategy from the beginning. While she was aware that there would be some funding for the strategy, it was not clear how much and for what it would be used.

A document like this without any um, tangible funding attached to it, you know, is a little difficult because it doesn't um, it talks about strategically where you want to go, but it doesn't give you any um concrete pieces of uh substance to move forward.

Anna experienced how the lack of funding in mental health slowed the implementation of strategies like this because administrators either have to wait for new funding, which is limited, or reinvest what they already have. One of the tactics in Manitoba to move towards the directions set in the *Rising to the Challenge* strategy has been to allocate any new funds to community based services rather than hospital based services. *“Trying to make that shift, you have to bridge the funding for a while so that you can create more community based services and then decrease your reliance on hospital based services, but that takes time.”* Anna had not seen a significant shift in this in the past 30 years, and saw the growth needed to fund the activities in this five year strategy as limited.

Theme: Public and Political Support

Political Commitment is Needed

Anna related these funding challenges to the political challenges in implementing this strategy. She regarded political support of the strategy as necessary to attain the funding needed to implement it. *“The political will involves not just the policy ideas but the actual resources to actually make some of these changes happen.”* Based on her knowledge, the Government of Manitoba spends less than 5%¹ of its health budget on mental health as opposed to other

¹ Based on a 2010 report (Jacobs et al., 2010), Manitoba spent \$471 million on mental health, which would calculate as 3.7% of the 2010 provincial budget. Total per capita expenditures were not calculated because of the differentiation of services provided in each province. The per capita costs of these different services highlight inequitable provincial trends in mental health spending. For example, Manitoba spent \$88.49 per capita on general inpatient hospital care while the Canadian average for general inpatient hospital care per capita costs was \$51.7. Manitoba had the second highest level of spending on general inpatient hospital care

governments that spend up to 12%² outside of Canada. While Anna described Manitoba Health's Mental Health Branch as being committed to this strategy in trying to make it a "*cornerstone of health policy*", she recognized that increasing the funding for mental health would take a substantial commitment from the provincial government. She knew that this kind of commitment comes with its challenges as well. In reference to the strategy:

This gets put in with the myriad of what needs to happen in health, but then, in the entire province, you know, from fighting floods to, you know, this and that, where does it get placed on the priority list?

It became clear that the people trying to implement this strategy have to compete for funding against all of the departments that require funding for their services and try to advocate for making this more of a political priority.

Theme: Time Constraints

Time Allotted Was Not Enough

By the end of the five-year timeline, Anna learned a lot from her experience with the implementation of this strategy. She felt that the strategy was far too grandiose for a five year plan and that what was needed to make policy become practice is to follow through with concrete strategic plans. "*I think that's the learning, you know, you can have policy but if you haven't got a way to make it practical, it just sits there on the shelf.*"

compared to the other provinces. In terms of community mental health services, Manitoba spent \$36.42 per capita whereby the Canadian average was \$53.50. Manitoba spent the second least amount on community mental health services compared to the seven provinces that had reported per capita costs for these services. There has not been more recent data as comprehensive as this breakdown of provincial mental health spending since this report.

² Research identified that a number of high-income countries outside of Canada spends 10% or

Theme: Evaluation

Evaluation Needed to Move Policy Forward

Anna felt that there were areas that could be improved on when creating policies like this in the future. Aside from creating a compendium document that describes what the goals, objectives and actions of the strategy mean, Anna thought it would be important to do an analysis on the impacts that the strategy had and where it would take us from here:

Here's where we got in five years, now for the next five years I'd like to see them be more concrete about what is it that they are going to try to achieve, with some targets and trajectories and you know some much more concrete substance to it.

Anna also saw importance in the policy makers being critically honest with themselves in this analysis and not including outcomes on the summary of achievements that did not result from the strategy. *"I think they should, they should be honest with themselves, that's the, that's the way to move forward."*

Summary

Anna provided a knowledgeable perspective on the implementation of Rising to the Challenge from her roles as a policy maker involved in this strategy and as a mental health organization administrator. She highlighted the strengths she found in the document as a philosophical direction indicating where Manitoba's mental health system needs to go, in the process of collaborating with various stakeholders to develop the strategy, and in the progress seen in promoting recovery oriented services. She also provided important information about the challenges that occurred with the lack of clarity in the document, the follow through needed in the implementation plans of the working groups, the dichotomies evident in the mental health system, the lack of resources and the absence of strong political support.

Narrative Two.

The next narrative describes Lillian's experience with Rising to the Challenge. Lillian identified as a policy maker involved in the development of the strategy and in overseeing its progress. While she admittedly was not directly involved in the implementation process, her years of experience in mental health policy and advocacy provided her with expertise on the various factors that impact mental health policy. She explores how these factors impacted Manitoba's mental health strategy from its development to where it took us five years later.

Theme: Public and Political Support

Political Influences in Policy Development

Lillian felt that the selection of the group to develop the policy was important. This was because the first step of determining who would be on the steering committee that developed the strategy document had important political implications. Since this is a government led strategy, she regarded the government as having the power to choose who it wants developing the document and so it would choose people who most closely align with its political values and beliefs.

Theme: Policy Design

Collaboration in Policy Development

A variety of different people in the mental health field were recruited in the development and implementation of this strategy that included people with lived experience rather than solely relying on clinical expertise. These decisions were highlighted as a strength of this strategy for Lillian.

We did absolutely rely on people with a lot of letters behind their names and, you know, the occasional white coat wearer (laughs) for sure, uh but, but there was a lot of

conversation with people who live everyday with mental illness and talk about what that means for them, in terms of their ability to survive functionally in a family setting, to uh get and maintain a job and to flourish in that job, and to get the healthcare that they need when they're in crisis.

Lillian found it useful to partner with non-governmental organizations, which could provide very useful, unbiased oversight. She found strength in collaborating with a large group of partners on the strategy's development.

Theme: Financial Resources

Financial Resources as a Facilitating Factor for Evidence in Summary of Achievement Reports

Through the implementation of this strategy Lillian was able to identify areas of success and areas with little progress. In terms of areas of success, Lillian saw an investment that was made into trauma centered care the day the strategy was announced, the opening of the Crisis Response Centre, supports put in place for community housing, the development of a campus mental health strategy for the University of Manitoba, and Manitoba leading a national summit on mental health. She tied the successes of the document to the strategy's summary of achievement reports:

I could give you the list of, of the checkboxes of things that got accomplished and so, I believe that these things would not have been accomplished if we didn't develop the strategy and we didn't um, have a focus and a plan to get certain things done.

Theme: Cross Departmental Approach

Social Determinants of Mental Health Not Addressed Adequately

Lillian also thought that mental health service access for Indigenous people and addressing the social determinants of health were areas that lacked significant progress. As

mentioned earlier, this may be due to issues in coordinating First Nations health issues between federal and provincial jurisdictions. In passionately reflecting on the suicide epidemics in First Nations communities, Lillian illustrated complexities of the social determinants of mental health:

Not everybody that's endeavoring to commit suicide there has a profound and diagnosed mental illness. But they don't have a house! And they're not going to school! And they don't have friends! You know, like there are so, such a multi-pronged approach there, let's, how about clean water people? Let's try to do that and then we'll, then we'll have no mold in the homes, and then we'll, you know, and then we'll actually maybe be able to drill down and find out that, you know, Mary actually is Bipolar.

So what happened in the implementation to make some activities of the strategy successful and some not? Lillian came across many major factors that affected this strategy and also affected other policy responses that she encountered within the mental health field.

Theme: Financial Resources

Dedicated Financial Resources as a Facilitating Factor

Resources were a major, if not the primary, implementation factor in Lillian's experience. She regarded financial support as a facilitating factor in pushing forward the strategy and was sure that "*there would have been dedicated resources for it.*" She used the investment that was made to fund trauma centered care as an example of some of the funding that was available.

Theme: Financial Resources

Financial Resources Lacking for Mental Health

While it was clear to her that financial resources aid in mental health policy implementation, there were challenges that presented themselves in obtaining this funding. She

attributed problems with this strategy's implementation to this challenge; *"the implementation of it, also not perfect. And I think that that wasn't because of the document, it was because of the dough."* She also experienced mental health funding being impacted during the tougher economic periods in the province, *"the economy tanked, things got tough, everybody had to pinch in somewhere, you know, mental health is always the area where things got to give"*.

Theme: Public and Political Support

Stigma as Negatively Impacting Political Support

Lillian also found a lack political support for the strategy, which she tied closely to how much financial support the strategy would have. It seemed to her that the more political support you have for something, the more funding that is put behind it; it was inferred that mental health has historically not been very high on the political agenda. In reference to budget cuts in mental health Lillian added, *"Because mental illness isn't an obvious javelin in the chest or a cardiac arrest or a cancerous tumor, right? And it's the easiest thing to go."* Lillian also regarded political support as challenging because it is also impacted by stigma. She described the differences in advocating for mental health and physical health resources:

So it wasn't different for me, but I could feel it being different for the people from whom I wanted things. So that meant that I had to change my approach and sometimes be more patient and sometimes be more, um, persistent. Yeah it was never ever, ever a hard sell to talk about 'let's fund this chemotherapy drug'. It was harder to say 'here's a really expensive drug that's going to help people, you know, with schizophrenia.' You know, people hesitated.

It seemed that the limited resources for mental health created a significant barrier for the strategy and was a major reason for why many of the proposed activities were not able to be implemented.

Theme: Leadership

Leadership as Needed

Lillian reflected on the work that is needed in mental health policy to mitigate this funding challenge and what was done for this strategy despite a challenging economic climate. One of the most important things for her was having someone in a leadership role with political will and awareness of the health budget to not only advocate for more resources for implementing the strategy but to also know how to spend the money they do have in a better way.

I think being able to have somebody in a decision making role that can um, look at that budget in a dynamic way and move money to where its really working and have an over expenditure on this line because its really cooking and, you know, let this one wither on the vine if necessary.

Theme: Financial Resources

Financial Resource Reallocation as a Facilitating Factor

An example that stood out for her of the process of reallocating funds was bed closures at the Grace Hospital. As she remembered, the services were deemed to be not cost effective or positively impacting patients' lives so a difficult decision was made to take funding away and spend it in a more promising area: *“Huge chunk of change that, um, was not new but it was going to be used in a new way to hopefully provide a path forward for these families that were just spinning their wheels.”* This example highlighted for me not only the challenges of having little

new money to spend on the strategy, but the challenges in making decisions on how to best spend the limited money that the system already is using.

Theme: Financial Resources

Human Resource Capacity in the Mental Health System Limited

Lillian spoke about the need for human resource development. I would relate this to how some of the strategic directions, like increasing access to services, would require more professionals to make this happen. Lillian seemed to see this as an oversight with this strategy:

In many respects this document did require us to like just add water and stir and we're going to have psychiatrists and psychologists and mental health professionals and outreach workers and, it actually doesn't work that way. Yeah there is no elixir where you can instantly create these professionals.

In her experience with this strategy the process of filling these positions was really tough and also, “making sure that we had culturally appropriate people in the right place at the right time for the right people; really, really tough”. She found it to be a complex challenge as it includes the education of mental health professionals, educating professionals outside of the mental health field about mental health issues and could mean financial commitments for publicly funded mental health professionals which ties in the additional challenge of limited funding in mental health. Aside from professional development, Lillian also felt that it is so important to nurture good advocates. For her, people need to go beyond caring about mental health and experiencing it to knowing how to advocate and use the resources available to them to do so.

Theme: Public and Political Support

Stigma Negatively Impacts Public Opinions of Mental Health Policy

Lillian felt that there were even more challenges that needed to be dealt with prior to being able to obtain these resources, to achieve the strategy's goals, and to obtain the political support needed to ensure those financial resources. An important challenge that Lillian brought up as the next major factor that she felt impacted the implementation of the mental health strategy was public opinion. She experienced the public's support of an issue to be paramount in the amount of political support it would get and saw this issue as still having a lack of public support because of the stigma associated with mental illness. Lillian expressed that a lot of these attitudes come from tragic events that are seen in the news. She highlighted a couple of high profile crimes that were committed by people suffering from mental illnesses, which reinforced very negative attitudes in the general public about people with mental illnesses. She saw how professionals would easily interpret these events as a call for prevention; but people who are not as aware of the clinical complexities of mental health issues would not have the attitude of spending money on an illness that caused someone to commit a serious crime against someone. *"How do you convey that we need to make investments in post-partum care and not be seen to be, you know, sympathizing with the devil?"* In relation to Rising to the Challenge, Lillian identified as a challenge creating policy that reflects the best practices in mental health and balancing that with the attitudes of the public in order to have its support:

So, you write a strategy and you tell me how you're going to deal with the most extreme and severe uh, cases of mental illness that, that hit the media and so forth, and how you're going to do that in a clinically sound and sensitive way that is not going to completely alienate and piss off the tax payer on things that they cannot understand. So

you've got to give that to me in sensitive, all-encompassing language that is accessible to people

She thought that the best way to gain public support was simply to engage people on a personal level. Lillian knew that so many people have loved ones with mental health problems, so getting past that stigma and engaging them on a personal level is how to garner that support.

Theme: Evaluation

Evaluation as a Facilitating Factor

In thinking about how overall implementation of a strategy like Rising to the Challenge could be ensured, Lillian knew that tracking its progress was needed. In terms of this strategy, she identified that there was a process of feedback involved during the implementation, which included informal feedback from clinicians, service users, people involved in the strategy, and some of the community organizations which were involved in the implementation, and also a formal update presented to the Minister of Health at least once a year. She also saw the importance of measurement in tracking progress, *“measuring, measuring, measuring, you know, making sure that what you said you were going to do is, is happening and, and evaluating those outcomes.”*

Theme: Mental Health System Complexity

The Breadth of Mental health as an Issue Makes it Hard to Address

When Lillian reflected on the strategy's overall effectiveness she put aside the summary of achievement reports, and had this to say:

Today we still have people who are in a mental health crisis and cannot get immediate access to care, which is what families care about. Today, we still do not have enough health care professionals, particularly working in the public system, to give people the

access to care that they need. Today, we have people that are living on the street largely because of an untreated mental illness. Today, we have children in Cross Lake that are thinking about killing themselves. So that means that this didn't work, right?

She made this comment to reflect on the realities that are still occurring for people with mental health issues despite the efforts made in this strategy. But she recognized that mental health is such a broad issue and that the people involved in the strategy knew that there would not be one document to solve all of the issues, which for Lillian was all the more reason to try to figure out some kind of path in that haze and move the system forward to develop elements that would help people. *“So, was it perfect? No. Did we accomplish some, I think, really good things? Absolutely we did. Did we get the job done? Not close.”*

Summary

Lillian's narrative was an informative account from her role as a policy maker and from her experience working closely with mental health policy. She offered an impassioned perspective as someone who appreciates the complexities of mental health problems and illnesses and the complexities of the systems in which these problems are managed. Lillian highlighted the benefits of collaborating with various stakeholders, how stigma affecting the public and the people who make decisions affecting mental health system impacts policy, and was able to describe the interconnectedness of resources with political and public support and the challenges associated with obtaining them. A notable difference that stood out between the first two narratives was how Anna and Lillian saw the effect of the strategy on the list of accomplishments quite differently. Lillian's narrative left us with the reality that there is still a lot of work to be done, however, our conversation left me with hope that positive changes in the

mental health system are happening by dedicated people who are advocating for the improvements that Rising to the Challenge is aiming to achieve.

Narrative Three.

Janine is the presenter of the third narrative. As both a policy maker involved with various mental health policies and as an administrator in different mental health organizations throughout her career, Janine was brought on to help in the development of Rising to the Challenge. She was interested in sharing her expertise in mental health policy as well as her experience with this particular policy response.

Theme: Policy Design

Clear Roles Established for Policy Development and Implementation

Janine worked with a lot of different people in the development and implementation of the mental health strategic plan. They each had important roles and responsibilities in order to make the policy goals a reality in Manitoba. She recalled how the steering group and the working groups played important roles in developing the plan, but not in implementing it. As Janine described, the steering group was there to inform the development of the strategic plan and the working groups were in place to develop the content that fits under the pillars. After the development stage was completed, the Mental Health and Spiritual Health Care Branch of Manitoba Health took over. Janine recalled how they took all of that information and synthesized it into one working document, which is how Rising to the Challenge came to be. When it came to implementing that working document, Janine explained that the responsibility for this sat with the Branch, which is different from other narrators who described this responsibility as lying with the Regional Health Authorities. Due to her role in being part of the steering and working groups, she did not see herself as having a direct role in the implementation stage of this strategy.

Theme: Policy Design

Stakeholders Were Engaged in Policy Development

The work that she did in those groups was a positive experience for Janine. The way that the document was developed highlighted for her what she described as a strength in making this strategy and that was in utilizing the perspectives of a wide variety of stakeholders: “*So I think in terms of a process they did a very nice job of um, engaging a lot of really important perspectives to participate.*” Some of the stakeholders who Janine worked with included the regional health authorities, people with lived experience, and people from different departments such as Labour and Education.

There was definitely high engagement and um, it resonates with lots of different departments, so that’s what’s really great about sort of this place in time, it doesn’t, it’s not a hard sell, right, to say that we need to have a comprehensive strategic plan and it’s not hard to, I don’t believe, my impression is that its not hard to engage other departments either.

It became clear that the people who were involved saw mental health as an important area to improve and that she saw value in addressing cross-departmental concerns. However, Janine’s interpretation of the ease of engaging multiple departments was different than other narrators who interpreted this engagement process as difficult.

Theme: Evaluation

Evaluation Challenged by Summary of Achievement Reports

Even though Janine valued how the strategy was developed, her attitude was not the same in regards to the overall success of the implementation. While Janine was aware of progress that

the strategy had made by providing funding to certain projects, she seemed quite certain that the strategy has not created any substantial change:

I know they have checked off a whole bunch of things that, that have been, you know, funded through this, um, but this is really just the beginning, I don't think we've really made any substantive, um, you know, um dent into this, would be my opinion.

Janine did not seem to view this strategy as having much of an impact, and as the years went on she was made aware of the summary of achievements reports that present lists of activities that were implied to be accomplished as a result of the strategy. Some of the accomplishments listed, like the establishment of a mental health court in Winnipeg, she saw as not a result of the strategy and some actually predated the strategy. She saw this as meaning that some of the things that can be found in the summary reports are not necessarily directly attached to the strategy, but are included simply because they align with the strategy's values. She interpreted the process as being one of selecting projects which were initiated during the strategy's five year time frame and saying that those investments were related to a pillar of the strategy and then the project would show up as an achievement in the report.

Theme: Financial Resources

Ineffective Funding Approach for Policy Activities

There did not seem to be a doubt in her mind as to what caused the lack of success that she described. Aside from a few funded initiatives that she noticed, it was because of the funding approach taken by the government in implementing this strategy. Janine felt strongly about this point, which made clear that this was a major implementation barrier from her experience. She was made aware that the branch responsible for the strategy was only going to attach funding for the implementation of a few key activities; so the implementation became a process of selecting

from the list of activities that the steering and working groups made and figuring out how much funding they could attach to make those happen. Janine explained the problem:

So, what is problematic with that approach is that you're not implementing the strategic plan, you're simply pulling a few activities from each of the categories, each of the pillars to pitch to government to get funding for and then to make that happen. So it's very much a, kind of um, a focus on activities which is different than a strategic plan which is about system transformation.

It was in this comment that it became clear that Janine's expectation of this policy response was as a strategic plan; she was looking for system transformation. "*A strategic plan shouldn't be about activities, it should be about robust investments into, into our system.*" Picking certain activities and making investments here and there was not seen as an effective strategy for Janine. "*This drib drab approach really isn't going to get us anywhere.*" Janine seemed to attach a sense of disappointment because, on one hand, she made clear that the policy document itself was valuable and that the elements were there to make it meaningful, but then on the other hand, the lack of resources prevented the strategy from becoming more transformative and from accomplishing the macro change that the strategy set out to do.

We fall short around implementation and that is reflective of the funding that's available, or the lack of funding and the lack of a comprehensive funding approach, so what we have is just a, you know, a little bit of money thrown at something.

Janine developed some ideas on what she thought would need to be done in these situations, which included knowing how much funding the branch has, knowing what the branch is capable of and then figuring out how to build a system based on what they can afford rather than

developing an entire strategy, and then finding out how the funding will be distributed afterwards. Janine knew that it wasn't that easy to solve this financial problem.

Theme: Financial Resources

Political Appearances Contributing to Ineffective Funding Approach

Janine also came across another factor that made funding even more complicated for a strategy like Rising to the Challenge. What Janine experienced was how political factors tie into this financial barrier to successful implementation. She was under the impression that governments might choose to fund the strategy in a tactical move to have some “*quick wins*” and make a few investments in an area like mental health. The appearance of politicians who are motivated to remain in positions of power was prominent in her description:

They want to be re-elected and so what you see is sort of these, you know, small offerings to kind of, you know, create the appearance of investment but when you look at all of it together you'll see that, maybe not so big after all.

This gave me the impression that while moves like this may have created the appearance to the general public that work was being done on the strategy people who were working in the field to make these improvements happen were struggling to find the resources to do so.

Theme: Financial Resources

Cost-Sharing Cross-Departmentally to Mitigate Financial Strain in Mental Health

As Janine reflected on the problems that she experienced with how the implementation of this strategy rolled out, she began to consider what she thought would be needed to mitigate these challenges. Janine considered the idea of cost-sharing, but even this had additional challenges attached to it. Cost sharing, to her, was a way to unload some of the weight from the

mental health budget onto other departments, which may be working closely with mental health initiatives.

If we have a strategic plan around mental health and well being and this plan, you know, is, includes obviously very much a health focus but its not just health, it really is in many ways touching on a lot of the social determinants of health which fall outside of the health kind of bucket if you will, so you bring those departments around but where do you see departments then investing in some of this, right?

Janine thought of examples of where cost sharing could occur, like with Labour for psychological health in the workplace initiatives, Education and Training for work and school mental health initiatives, and Justice for initiatives like the mental health court. With other departments struggling for funding, as well, this would not be easy to arrange. She was disappointed in the sense that it seemed as if a solution was right in front of them, but the people they needed to collaborate with just are not picking up on it, which is quite different than Lillian's interpretation that it is not hard to engage other departments:

That's I think where the challenge is, making the case for say the department of Justice investing in, you know, services that support, you know, criminally involved or, people interfacing the justice system and addressing mental health issues, but they would say, well it's a health issue. Right? So then there becomes this back and forth around where the funding should come for this

This challenge did not end here in Janine's experience. She also tied in the inequity of having all of the responsibility for funding and implementation of a strategy as broad as Rising to the Challenge lying in the hands of a very small government branch, which, in her impression, had very few staff members. The challenge is not just that mental health funding is low, it's that they

are also taking all the responsibility for paying for things that should be cost-shared with other departments. Janine had reflected on how getting other departments on board was “*not a hard sell*”, but it seems that perhaps collaborating to create the strategy document was a much easier sell than developing a collaborative funding approach.

Theme: Leadership

Advocacy for Mental Health Funding Needed

By the end of the five-year time frame, Janine had learned from her experience and from the challenges that she encountered. She was mostly at a loss as to how to overcome these challenges, but advocacy was something she felt was needed. She wanted to see more advocacy for mental health funding; in particular, for a mental health transfer fund from the federal government that could be used specifically for mental health initiatives. Janine’s point indicates a lack of advocacy for mental health funding, which may be in effect of the absence of advocacy coalitions in the implementation of this strategy.

Theme: Time Constraints

Time Frame Allotted Was Not Enough

For Janine, she was surprised that the five-year timeline point was already coming to an end because she felt like the strategy had just been released. This was reflected with her feeling that they have hardly got started with it. While she saw the content of the document as valuable, she made this comment regarding the timeline attached to it: “*don’t get me wrong, like these are all important things. But, you know maybe, maybe a five-year plan is too short. Maybe we need to be developing ten year plans.*” I interpreted this as part of Janine’s learned experience as a result of being involved in Rising to the Challenge and saw it as a hopeful sign for what she could bring to further attempts at implementing mental health policy responses.

Summary

Janine's narrative was helpful in understanding the perspective of a policy maker and administrator on the elements that needed to be considered for implementing Manitoba's mental health strategic plan. She was able to illustrate specific challenges that were evident in the implementation, which focused mainly on the piecemeal approach to funding that was provided for a limited number of initiatives in the strategy. She also included additional challenges related to political and cross-departmental factors. While Janine did not express seeing much strength in the implementation of this strategy she did find strengths in both the collaborative nature of developing the strategy and the content of the strategy itself. Her narrative left us with the potential for understanding and addressing important barriers that could lead to the mental health system transformation she was hoping to see.

Narrative Four.

The fourth narrative presents the experience that Heather had with the implementation of Rising to the Challenge. Having many years of experience doing policy work in a number of different mental health organizational settings, Heather contributed the perspective of both a policy maker and a mental health organization administrator. Her experience with this strategy led her to be able to talk about the strategy document itself, the activities of the working groups, and certain factors that present themselves that are relevant to mental health policy implementation.

Theme: Policy Design

Policy Development and Implementation Roles were Developed

Heather's involvement with the strategy began when the document and implementation planning were being developed. She recalled how there was a large consultation that took place

which was characterized by focus groups of people with lived experiences and families across the province to inform the document. But when it came to implementing the document, working groups were formed around each of the goals after the strategy was released. *“So the thinking around the working groups that came out of this was that each one was now going to focus on those goal areas and try to come up with some action plans for how they may implement”*. This suggested that the working groups were not a part of the planning of the document, but were in place to put the policy into action.

Theme: Policy Design

Policy was Well-informed by Stakeholders and Research

Heather had a positive perspective on how valuable she regarded Rising to the Challenge as a policy response. She attached the value to the strategy’s consistency with the work of the World Health Organization and the Mental Health Commission of Canada and referred to it as *“a good culmination of the research and the kinds of things that needed to happen.”* Heather also saw great value in the various perspectives that were included in developing the strategy.

People came with very, very different um, kind of viewpoints and you know, looking at the elephant from a different direction um, but I think there, there was a lot of very good and very respectful dialogue that got people to a place of consensus.

This suggested that the combination of having a solid research foundation and the collaboration and stakeholder engagement utilized in the making of the document were essential in shaping the direction as to where they wanted to go.

Theme: Evaluation

Implementation not meeting policy goals

The follow through with implementation was not as positive an experience for Heather as she felt the development of the strategy was. She referred to the strategy as having “*lost its legs*” after it became a paper. In her perspective, the document itself had a lot of promise but that nothing more came of that: “*what you see everywhere is really great seeds of all the right things that we need but nothing going to scale.*” This indicates that in the implementation of the strategy did not nearly meet her expectation of the potential for where this strategy could go.

Theme: Financial Resources

Targeting Funding and Cost-Neutral Activities saw the most success

While she felt that the strategy fell short during the implementation stage, she also recalled some good that came from it. A couple of programs that were started she saw as a result of implementing the wellness goal and the access goal which included the Towards Flourishing³ program and a webpage called Stress Hacks for child and adolescent mental health resources. Heather also noticed other areas that she felt the strategy helped move forward, including the considerable increase in family participation and consumer involvement; as well as in influencing other mental health organizations’ policy documents. The biggest area of the strategy that Heather saw people put their energy into was in recovery and trying to change practice.

While Heather attributed success of the strategy to the two programs listed above because they were given some funding to be implemented, for the areas that she saw the most movement in, like consumer participation, family involvement and recovery, she attributed success to the

³ Towards Flourishing is a federally and provincially funded mental health promotion program for families in Manitoba.

fact that they were cost neutral activities. It sounded like these activities were not necessarily about new programs but about changing the way practitioners and the public think about mental health issues and mental health practice.

Things like social inclusion and family participation don't necessarily need new money, they need a new focus and a new kind of way in which you do your work so, practice change versus enhancement, uh, so some of those can live on their own, um, but you want to talk about things like access, that's going to take investment.

She recalled how goals like the improving access goal included “doable actions” which describe much more specific implementable actions than a change in philosophy. Heather thought the cost-neutral activities were beneficial but not completely hitting the mark of the strategy:

So no new investment, just do your work differently. And that'll get you something for sure. And its, its important, and it needs to happen and if you have no new money it's probably the best thing you can invest in, but its sure not the strategy, it's a side step from the strategy.

Theme: Financial Resources

Lack of Financial Resources as a Barrier

There was a significant lack of funding, which Heather thought was a major barrier and explained why so much more movement happened with the cost neutral activities in this strategy's implementation. While she saw some examples of funding made available to implement programs like Towards Flourishing, there was not nearly enough to accomplish what the strategy set out to do. Heather described how this impeded the implementation process:

The real work of any strategy is actually your ability to action and, um, while you don't always know in advance what you've got to bring to bear on that, it's pretty hard in a system like ours to actually find funding. So that's the crux of the whole thing.

In her experience, she felt that there was hope among the strategy's developers that the document itself would create the critical mass needed to get the funding to do the things that needed to be done, but that this did not happen.

For Heather, and what sounded like the rest of the strategic planners, mental health funding being at a low level was not news to them; however, the degree to which this would impact their work from a systemic level was not known to them when the strategy came out. Heather had discovered more recently just how low mental health funding was in Manitoba. She came across new research that looked at mental health spending in different countries and different provinces in Canada, where the gold standard was determined to be 12% of health care dollars going to mental health. She used the United Kingdom as an example of where this happens. When she learned about Canada she discovered that the average spending across the country is around 7%⁴ of health dollars going to mental health with Manitoba, in particular, spending the lowest proportion on mental health at 5% of the health budget. This new information seemed to really put this barrier into context for Heather:

I think people getting their head around the money aspect is new in Canada. I mean, easy to say we're short on everything and everybody's been saying that forever and that's understood, but to see how far off the mark we actually are for where we should be as a, as a developed nation, um, we're just not, we're not in the game here.

⁴ On average, mental health spending in Canada is 7.2% (Lurie, 2014).

This information seemed to solidify the view she had that new resources and significant investments are essential in moving forward in mental health. The understanding of their dire financial situation was also felt by others in the working groups as Heather describes it:

I think the belief at the time that it was written was that if we all just came together and agreed what it was that needed to happen we could just do it with existing resources, and I think now people are beginning to understand how much unmet need there is and um, how much of an uphill battle it is to actually make a difference to rise to the challenge.

Heather recalled this pressure as being felt by the working groups as they were putting their action plans together, “everybody felt the reins were really pulled back on any actions that they might want to put forward because there was no new money.” Looking back at this stage in the process, Heather thought that it may have been a good idea for each of the groups to put forward the costs required to do their various activities and then decide what they could pay for based on that, however this came with challenges for her as well. Heather used the metaphor of rebuilding a house after a fire to describe the challenges in being able to fund a few activities when the scope of the problem is far bigger than that:

It's kind of like, you know, your house burns down, what do you need? Well we need everything. Well you can't have everything. If you only get to have one or two things, what are you going to have? And now that's where everything kind of breaks apart a bit, because its hard to figure out what those building blocks are and the order in which things would build if there's only a small trickle of funds coming in.

Theme: Financial Resources

Reallocating funds enabled activities to occur

It was clear to me that this was a major barrier and the source of some discouragement; however, Heather was still encouraged by the progress, albeit slow, that did occur. One of the ways she was aware that this can happen was through reallocating funds that the system already has. For example, she described a situation in which if the health authorities were able to get some bridge funding to be able to fund some community programs, there would not be as high a need for inpatient psychiatric beds. With that need reduced, the money going towards it could instead be used to fund a different mental health initiative. In Heather's experience, these reallocation activities were possible, but they did not happen as often and in the ways that they should. She recalled the mental health court as an example of a mental health initiative that saves money for justice by reducing the number of people incarcerated:

So those kind of policy changes really need to be quickly followed with the resource changes to match them and, that's, that's a really hard battle that we do everyday in our work, trying to make the resources catch up to the demand. And the demands are huge, absolutely huge. And so, this money was spent before over here in the criminal justice system; we saved that from the criminal justice system but we don't invest it in the mental health system

Theme: Cross Departmental Approach

Cross-Departmental Collaboration as a Recommendation

Heather saw mental health as having a huge impact on other departments and related this to some of the unique issues that Manitoba has as a province; issues like the high levels of poverty, Indigenous people moving off crown land or off treaty land and trying to make it in

urban settings, and the high number of families in the child welfare system. “*We have some unique issues here, um, and you know, I think those don’t necessarily float to the top of peoples’ thinking and mental health is a key part of it*”; she later added “*these are huge systemic issues and mental health has a piece across all of them.*” This seems to provide evidence that different departments would benefit from collaborating with the mental health branch to reduce some of the impacts that effect their departments. It would also seem to me that significant investment in mental health will help reduce costs in other departments, as well. Based on Heather’s comments I was left with the impression that the financial dilemma in the mental health sector has left these policy makers playing a strategic game of making moves with investing the money they do have, reallocating money as programs change, and collaborating with other departments to figure out who is paying for what and where funds saved can be reinvested.

Theme: Financial Resources

Large Financial Investments Needed

Heather felt that this could all be ameliorated by a large investment overall. It is what she felt was needed to create the changes needed in the mental health system: “*well without new resources, it’s very hard to make a breakthrough in these areas. It’s very hard.*” She left me with the idea of scale, which was brought up earlier as she described Manitoba’s mental health system as having all the right seeds. It left me with the impression that Manitoba has the research, the treatments, and the programs, but that the system is just too small to meet the demand. Large investment seems to be what is needed to create the widespread change that Rising to the Challenge set out to make.

Theme: Public and Political Support

Stigma Negatively Impacting Public Opinion

Heather knew that these large investments that could lead to significant improvements in the mental health system do not just happen overnight and there are other factors that tie into the likelihood of obtaining large investment for mental health services. One of these factors in Heather's experience was public opinion. There were many times when she saw how media and the tragic events highlighted in the news would have a large impact on how the public sees mental health issues. Usually, members of the general public would respond to these stories by wanting people with mental health problems "locked up behind closed doors". She saw families of people with mental illness wanting institutional admission to keep their loved ones safe and people in the general public wanting this to keep the public safe. Heather's views on this were that this kind of thinking reinforces old stigmas and pulls us in the opposite direction to where we would want our mental health system to go:

It's completely in the opposite direction of kind of the human rights and the dignity and where the state of the art treatment would suggest we can do our best work and create the best chances of recovery. It's, it's in the opposite direction of all of those ways of thinking, um, but that's where public opinion tends to take us.

Theme: Public and Political Support

Political Support Negatively Impacted by Stigma and Public Opinion

Heather also noticed how political support was strongly tied into these public views. She saw how politics can pull us in the direction of institutional admission because politicians hear what the public is saying and what the public is demanding. Heather felt that political support was needed for a strategy like this because politicians control the public finances and can determine

whether or not you get that huge investment: *“well at the end of the day, this kind of a plan needs to be endorsed by the leading officials and funds need to support it to implement it. That’s your only chance”*. This suggests that it is extra challenging to obtain political support and the funding for a strategy when politicians choose to support the concerns of the public even if it is not in the public’s best interest.

Theme: Policy Design

Human Resources of Steering Committee Impacted by Turnover

Heather also came across a couple of other barriers that effected the implementation of this policy response during her experience with it. One of these barriers was the human resource capacity of the people responsible for the strategy and its implementation. She knew that there was a low number of staff members in the branch responsible for this strategy and saw this as a challenge in driving a strategy like this forward, along with the number of staff changes in the working groups that impeded the implementation of the strategy; *“the groups that were set up to do this, um, well lots, lots happened; people retired, change in positions, all kind of things happened along the way and the groups kind of fizzled out”*. Heather also recalled that some of these staff changes included government leaders who were supporting the strategy which seemed to be a significant factor for her, *“if you have change in leadership, its pretty hard to get that and I don’t know a strategy anywhere that will sustain itself with those kind of changes, um, pretty hard”*. Based on Heather’s experiences, it seems that the lack of investment in human resources and staffing instability involved made this policy response nearly impossible to fully come to fruition.

Theme: EvaluationLack of Measurement

Heather also noticed a barrier in terms of implementation measurement. As Heather describes the implementation of the working groups, *“I think they did action plans but I don’t think there was any process in place to monitor action plans.”*

Theme: Financial ResourcesTargeted funding approach as a recommendation

Heather felt strongly that there were more actions needed to make the implementation of a strategy like Rising to the Challenge successful. Funding was a major factor she felt was needed to create the changes outlined in the strategy, but she also thought implementation could benefit from targeting funding for preventative measures:

You have to put the upfront money and that’s only one piece of it right, you actually want to get upfront of that and you want to do mental health promotion and you want to keep the youngins healthy and you want to keep them from getting into um, you know the child protection system and years in foster care and years of trauma and you want to stop that process too by getting upfront and um. So those all take front end investments; you can’t be pulling from here and investing over there and thinking I’m not going to have this need now. This need reduces over many years as this stuff gets better.

To me this seemed like a very strategic response for how the policy planners could start using money if the policy planners were to receive a large investment towards mental health, but also how to spend the limited resources they did have.

Theme: Leadership

Advocacy and Leadership Needed Among Stakeholders

Heather also saw room for improvement in terms of who is involved in these policy planning and implementation activities. She felt there was importance in making intra-governmental partnerships and felt that housing, employment, and income assistance were good examples; but she also valued the importance of working with external mental health agencies to be the advocates behind these initiatives: *“that kind of strategy takes an awful lot of push and its very hard for that to happen internal to government, it almost needs to be the external agencies that are pushing that, aligning together and working together”*. It would seem to me that external agencies can provide that extra push by showing the government how important these issues are to the community. This is another example of how the presence of active advocacy coalitions could have facilitated stronger implementation. Heather also saw a necessity for stakeholder involvement in policy planning and implementation. She endorsed the synthesis model of implementation by saying that the approach needed to be *“top-down bottom-up at the same time”* and that it was needed for both sets of actors fully engaged. To Heather, this would include family members whose voices, in her experience, carried the most weight, and also the need for leadership to carry the strategy forward which takes the shape of a policy champion: *“I think one of the biggest things is you need a champion at a very senior level who’s there with you.”* Having a committed policy champion and a team that is maintained overtime was an important recommendation for creating the change this policy aimed to achieve: *“within four to eight years you can change a heck of a lot if you have focused energy and commitment.”* These comments also highlight the needs for a well-led advocacy coalition.

Summary

Heather brought a lot of wisdom to the subject of the implementation of Rising to the Challenge from her experience with the strategy and from her work with other mental health policy initiatives. While she identified positive factors in the development of the strategy and positive outcomes that resulted from small elements of the strategy that were able to obtain funding, she was also able to describe in detail the challenges that she identified as the reasons why this strategy was not as effective as it could have been. Her description of the financial situation that the mental health system in Manitoba finds itself in really brought to light just how much of a systemic barrier this is for improving mental health care. Her description of the public, political, human resource, and evaluation factors that affected this implementation process highlighted how complex implementation processes can be. Her endorsement of the synthesis model of implementation and comments regarding the need for an effective advocacy coalition were included in the recommendations that Heather provided that will be important for future policy makers to consider in Manitoba's mental health system.

Narrative Five.

The fifth narrative that describes the implementation of Rising to the Challenge comes from a man named Phillip. Phillip has lengthy experience of being involved in the mental health system and as a result he has developed an understanding of the shaping and formation of mental health policy in Manitoba and nationally. Phillip explained that due to his experience and skills in leadership and advocacy, he was asked to be involved in the groups that were formed to develop and write the strategy under study.

*Theme: Policy Design*National Strategy Influenced Development of Provincial Strategy

Phillip began his narrative further back in time than the other narrative accounts. The plot begins prior to Canada having its own mental health strategy. In order to change this, the Mental Health Commission of Canada set out to develop a national strategy. Once this was completed, Phillip explained how the provinces and territories in Canada were meant to use this document to guide their own strategic mental health plans: *“so, using it as a reference, as a base, then each province said well then what portions philosophically, strategically can we use from the national mental health strategy and yet contextualize it to the provincial environment and scene”*. Based on his knowledge, Phillip reported being fairly certain that all provinces and territories have since created their own mental health strategies. It seemed clear to me that this national strategy was a major driving force in the development of *Rising to the Challenge*

*Theme: Policy Design*Stakeholder Engagement in Policy Development

The plot then moves into the development of Manitoba’s mental health strategy. It began with the executive director of the Mental Health Branch of Manitoba Health forming a diverse group of urban, rural, northern, regional health authority, mental health organization, and non-profit organization representatives to create the strategy, as Phillip describes.

*Theme: Policy Design*Specified Roles for Implementation

Based on his account, the implementation seemed to begin at the point when five working groups were created because Phillip described their role as including tasks for figuring out how to reach the strategy’s goals. After reviewing literature and background research on

what the best evidence is for a particular goal, he explained how the working groups functioned and he used the recovery goal as an example:

We give our thoughts, we give our viewpoints on what we believe should be essential to let's say recovery oriented mental health services and what recovery oriented mental health services look like and what that is and how do you move towards that, how do you create recovery oriented mental health systems. So similarly with peer support; what is peer support? What's the evidence for it? Um, what are the challenges of embedding mental health peer supports in the mental health system? How many do we need? Um, how do we train mental health service providers to be accepting of peer support workers?

The implementation was then turned over to the regional health authorities to take direction from the strategy and to implement it according to their own context, according to Phillip. This is where things started to get complicated. He explained his understanding as being that the strategy did not become an official policy statement and that it mainly became an expectation that the Regional Health Authorities would attempt to implement it depending on the resources and capacity they had. The plot turned with his identification of the first barrier that limited this strategy's implementation: a lack of resources.

Theme: Financial Resources

Lack of financial resources as a barrier

Phillip was aware of a lack of financial resources pretty early on in this process, both from a national and provincial context. Nationally he was informed that the federal government would not transfer specific funds for areas like mental health and that it would be up to the provincial governments to determine where money goes. Provincially, when working on this

strategy, he was told to not ask for anything that was going to cost a lot of money because there was “no new money”. For Phillip, this had a lot to do with the provincial budgetary constraints for mental health services:

So you take the total health care budget of Manitoba which is about forty five percent of the government budget, right? Health care is the largest sector. What percentage of that forty five percent is spent on mental health services in Manitoba? Maybe, maybe five percent.

This seemed to shape his view that this lack of financial resources was a major challenge in moving this strategy in the direction they wanted to go in. He goes further to explain the necessity of having this funding and the benefits of investment:

There will need to be some funding enhancements because part of the recovery system, part of the recovery oriented mental health system is also making sure that people with enduring mental illnesses have the sufficient services and supports in the community so as to avoid relapse and re-hospitalization. So you try to make a business case, argument, or model for this; you pay upfront, you spend less on the backside, by less relapse and re-hospitalization.

Phillip’s comments suggested that while there is not enough money being put into mental health by the Manitoba government, it would be beneficial for it to make that investment as the government would save money in the long run.

Theme: EvaluationImplementation was not followed through

Phillip continued his story by airing some frustration in terms of the policy making and implementation process. He referred to a notion, apparently well known in the mental health sector, that the policies that are made are great, but they do not seem to go anywhere:

First of all we do all this wonderful research then we get these people together, expertise or leaders to come up with a document, we make the document, its then uh, endorsed by the government, promoted, its good policy, and then the document sits on the shelf.

The financial barrier seemed to be a significant reason for why these policies were stuck on a shelf which is unfortunate, as Philip seemed to view the strategy as a valuable document overall:

Well assuming that we had the resources and the leadership, funding and leadership. Um it'd be wonderful! Um, it'd, it would be a wonderful working document and that's what it ought to be. It ought to be a working document that acts as a guide and a road map

The idea of a static document sitting on a shelf did not seem to hold a lot of value for Philip. For him, the process of where it could be taken afterwards was much more valuable.

Theme: EvaluationPolicy as an Evolving Process

This idea of a working document was crucial for how valuable he regarded the strategy to be and he also expressed value in evolving the strategy through a learning process, in his next statement:

Does it have everything in it? No. is it perfect? No. um, it's pretty comprehensive but I'm not going to say it's the best mental health strategy I've ever read. I wouldn't even say that about the Mental Health Commission of Canada's national mental health strategy

um, because it has to be an evolving process because we learn new things and we have to unlearn old things

While he did place value on the original document, Phillip recognized the importance of adapting the strategy based on what is learned through the policy process over time, which did not sound like part of his experience.

Theme: Financial Resources

Lack of human resources as a barrier in the mental health field

As Phillip turned back to his story of implementation it was clear that the challenges he had encountered were becoming a part of this learning process. Financial investment, for example, was proving to be essential to see the changes that the working group members had proposed in the working groups. But, as the plot continued, I learned that Phillip's experience was further complicated by new challenges. He described a lack of human resources that were also essential for new mental health programs and initiatives to emerge as a result of the strategy. Phillip identified how the mental health system planners needed to ensure that there would be enough child and adolescent community mental health workers, ensure there would be adequate crisis response services in place. These services would need to work with police regarding engaging with people in crisis. He also described particular shortages in Manitoba of geriatric mental health workers and psychologists.⁵

⁵ Project IN4M is a Canadian Mental Health Association initiative, designed to enhance the adequacy of the supply of mental health human resources. This project is a national effort to identify, develop, and implement a needs-based human resource planning model, and to disseminate and promote this model across Canada (Tholl, 2012).

The challenge in the lack of human resources went beyond having enough workers in place, “*it’s also a question of just training new staff and a new way of doing things*”. He made reference to the shift towards a more recovery-oriented system as an example of something that would have to become practice for workers across Manitoba’s mental health system. But based on Phillip’s experience, this sounded easier said than done. In terms of training new mental health workers, he describes how textbooks are still being printed that do not even mention recovery in them. And, in terms of training current workers, he described how staff just did not have the time:

But the other thing is that leaders and service providers are so busy addressing current concerns of clients and patients, (laughs) where do they have time to do all this stuff, cuz if you’re training your nurses, if you’re training mental health workers, just, just your training, well, how do you do that when they’re supposed to be working with patients and clients?

Theme: Mental Health System Complexity

Mental Health definitional ambiguity as a barrier

Aside from the time constraints of service providers, Philip described how some may not have cared to change their practice and adopt what was included in the strategy. He related how getting psychiatry on board with recovery and with peer support workers is a big challenge: “*and then a lot of psychiatrists say well we already do recovery work, well how do you define recovery? It’s much broader, it’s not just reduction of symptoms*”. This suggests a unique challenge in Manitoba’s mental health system in that the term ‘recovery’ can have different connotations in the bio-medical model than the recovery-model. This seems to have created

some definitional ambiguity that may further complicate implementing something like this strategy.

Theme: Public and Political Support

Lack of political support as a barrier

It became clear that the lack of resources, both financial and human, played a huge role in Phillip's experience of the implementation of the strategy. It was then that he introduced the government to the plot and the role that it plays in determining what resources would be in place for this. As this strategy was led by the provincial government, Phillip referred to how it was up to it to put resources into it. But the level of political support for the strategy depended on a number of factors, "*it depends on what the government priorities are, it depends on what the other priorities are, it depends on the political platforms*".

Theme: Public and Political Support

Public Support and Advocacy Needed for Political Attention

He also went on to explain how political support and resource allocation depend highly on political constituents and in what Manitobans want to see investments, which in his experience, has been in areas other than mental health. In order to combat this, Phillip describes how public support and advocacy would be needed:

So what we have to do is create a social movement. Just like Martin Luther King did with uh, working against segregation and racism, um, why is there, why is there not a social movement? Well let's start at the other end. Why is there not the right kind and the amount of political attention that should be given to this? Well the reason why there's no real political passion is because there's no social outcry. There's not enough sufficient social passion.

Theme: Cross Departmental Approach

Collaborative approach needed across departments and across sectors

Because of a lack of this support overall, Phillip turned to other ways the mental health system could be supported.

Mental health shouldn't be seen and mental illness shouldn't be seen as just something that health deals with, that the health department, health care providers deal with. It's everybody's business. So the corporate sector, the workplace, the small business, the mom and pop shop, schools, the educational system, child and family services, kids in the welfare system, um most of them will develop significant mental health problems and mental illnesses, um, faith communities, spiritual communities.

This speaks to how mental health affects so many areas of peoples' lives and how the responsibility for dealing with mental health issues can be seen as an interdepartmental issue. To me, this adds to the argument found in other narratives of the benefits of an inter-departmental approach in regards to cost-sharing, which would take away some of the weight that the Mental Health Branch is carrying when it is trying to make such big changes without these supports. While earlier Phillip mentioned the collaboration that existed among different stakeholders and departments in the strategy, this seemed to be limited to its development rather than to its implementation.

Theme: Evaluation

Implementation was not followed through

As the story progressed further in time and closer to the end of the strategy's five year time frame, the evidence of whether or not the implementation of Rising to the Challenge saw success became clear. Overall, Phillip reported that not a lot came about as a result of the

strategy. In reference to the extent of the strategy evolving and overcoming the challenges that were experienced during the five years, Phillip expressed: “*Not like I would like to see and um, so much so that I have minimum knowledge about what has transpired since this document came out*”. So the mental health system enhancements that he expected to see, which he earlier referred to as the items that needed financial resources, did not happen.

Theme: Leadership

Leadership as a facilitating factor

Despite these challenges, the implementation of the strategy did not end here for Philip. The challenges he encountered did not affect every component of the strategy. There were a lot of changes that occurred on a philosophical basis in Phillip’s practice. He made a lot of decisions on how he was going to adopt and implement recovery oriented practice which included emphasizing “*the bio, psycho, social, spiritual, communal aspect of personhood in terms of addressing mental health problems and mental illness*”, hiring people with mental illness, increasing peer support workers, and including people with lived experience and family members to be on his organization’s board of directors and committees. There were no requirements from the strategy for Phillip to engage in these tasks, they are a reflection of him figuring out how he could implement aspects of the strategy that did not have a high cost barrier into his own practice. This really speaks to how his leadership skills facilitated the implementation of part of the strategy by Phillip taking the initiative to adopt this piece into his practice.

In terms of the rest of the mental health system, Phillip saw leadership as an essential factor for moving this strategy forward. For him this included having leaders at all levels of the mental health system, meaning people on the boards of the regional health authorities, directors

of mental health services, and service workers who understand the concepts and principles of the strategy. He referred to these leaders as recovery champions and described what their role would be in moving principles, such as recovery, in the strategy, forward:

I would encourage them to have policies uh, around recovery and uh, hire a person who can sort of be the recovery champion and then evaluate your services to how recovery oriented they are and then based on those findings um, choose some goals each year as to how you would move towards being more recovery oriented and deal with fundamental issues.

To me it seemed that designating a policy champion would create the commitment in the follow through that seemed to be missing in the implementation of the strategy. Having a committed policy champion whose role it was to specifically ensure the implementation of these principles seemed to be an important factor in implementation for Phillip.

Summary

As his story came to a close, I remembered a statement Phillip offered that seemed very reflective of his experience implementing this strategy:

So Rising to the Challenge (laughs), what's the challenge? What's the challenge? The challenge is leadership, political advocacy, um, the challenge is resource and capacity, enhancing those, the challenge is economic, the challenge is education wise in terms of reducing stigma.

In these words Philip summarized the challenges that he encountered with this strategy. His words also provide lessons for future policy makers in what issues need to be overcome in order to facilitate the successful implementation of a strategy. Philip's story is important for understanding the connected nature of the challenges that arose, such as financial support,

political support and public support. His story can also serve as an influence on others regarding the strength that comes with leadership and the positive results that can come from this. Despite the challenges he encountered, Philip provided a good example of how policy can be implemented on a direct personal basis with limited resources.

Narrative Six.

The next narrative focuses on the story of Kate. Unlike the previous narratives, Kate had no involvement in the development or implementation planning for Rising to the Challenge. She identified herself as a front-line worker working in the public mental health system. Her experience in this position, spanning over a decade, gave her the opportunity to see how this policy response affected her position prior to and after its emergence. It has also enabled her to speak to her experience and role in implementing this strategy.

Theme: Leadership

Leadership as a facilitating factor

Kate began her story with how she was introduced to the strategy. Not being able to remember exactly who had mentioned it to her, she did remember it being brought up to her in a conversation that piqued her interest and led her to seek the strategy out and become more familiar with it.

Someone mentioned it to me I think in the context of recovery so I went and looked at it and had a read through of it. And then for a course I looked at it and then for another course I looked at it and then I read it a couple more times since then.

The way that she was introduced to the strategy highlights how she took initiative and chose to learn more about it of her own volition prior to later coming across the document for course

study. It also highlights how the policy was not systematically and universally implemented or even disseminated.

Theme: Organizational Culture of Support

Policy not introduced by organization

It also highlights how she was not introduced to the strategy as something she would need to implement through her organization, which she expanded on with this statement: “*there was nothing like that directly you know, no one waved it in front of me and said you must read this and it will change how you work. That never happened*”. It did not seem that there were implementation guidelines set in place at her organization to ensure front-line workers were informed of the strategy or that they were adopting the strategy’s principles and actions and including them in their practice.

Theme: Time Constraints

Time constraints reduce policy’s priority

Kate expressed thinking that the reason why no one specifically asked her to use the document in her practice was because of the expectations of her workload as a front-line worker. In her view, *Rising to the Challenge* was a document that she would have to revisit regularly because the more times she read it, more of the document would sink in; however, revisiting a document again and again was just not something that front-line workers had time for.

Partly I think it’s the level at which I work which is support worker. Um, partly it’s that we’re so busy day to day just doing the work that to sit down and read that and contemplate it and so on just doesn’t happen.

When her workload was high and learning about policy documents and their implication was not high on her priority list, Kate talked about how reading documents like this can be a chore, and

she added, “*you know, and I think sometimes you know, you look at something like this and go for crying out loud (laughs) you want me to do what? In your dreams! In the garbage, you know? (laughs).*” It seemed that Kate’s experience was an exception in that she did find some time to go over the document when she first heard of it, but it sounds like the additional experience of going over the strategy in school provided her with the time outside of work to become more familiar with it.

Theme: Policy Role

Strategy regarded as a vision rather than a policy response

The opportunities that Kate had to review and contemplate the document led her to develop an opinion that the strategy was valuable to her. But, for Kate, it was less valuable as a policy response than it was as a useful vision.

I would put a lot of value in it, in terms of...policy response, I’m not sure. Um, as a visionary response, it’s certainly I think, um, has a lot of, has a lot of value. There, like there’s some strategic goals in that in it, um, that aren’t so specific detailed policy but they, its kind of a strange way of putting it but they kind of give permission for a lot of other things to happen and um, kind of a different way of viewing, um, how we provide services in mental health.

So, rather than the policy specifically outlining what would be implemented, the strategy provided a vision of where the system could go and gave permission for some of the strategic actions to happen. Some of these principles described in the strategy were not new to Kate, so she also described seeing the strategy as something that gave her the permission to do the work she was already doing. The strategy “*kind of validates it a bit*”.

Theme: Leadership

Choosing to adopt strategy into one's own practice

Based on the five years that Kate reflected back on since the strategy was released, it was her view that the strategy had been implemented. She was under the impression that at least three of her co-workers were aware of the strategy and intentional in using it. It was not made clear how these workers were made aware of the strategy. But, what was clear for Kate was that she had a role in implementing this strategy as a front-line worker: *“Part of my role is in changing how I think and broadening my concepts of, um, mental health and well being and that’s part of it”*. She also went on to add: *“So for me the implementation has a lot to do with, you know, changing how I practice”*. Kate took an active role in the implementation of this strategy by learning about the strategy on her own and determining how she would incorporate it into her practice. The practices that she described using to implement the strategy included being careful about how she used language around her clients and remembering to positively reframe situations to make them more hopeful, working more collaboratively with the other professionals in her clients’ lives and modeling positive relationships in those interactions for her clients, and through acknowledging the power differences that exist between her and her clients in their work together. She did not attach any of these practices to specific aspects of the strategy, but these were the actions that she thought moved her practice in a direction that aligned with the strategy’s vision.

Theme: Applicability to Front Line Practice

Lack of applicability to front-line practice

As Kate searched for ways to incorporate the strategy into her practice, she found that it could be a challenging process. The challenge for her came with trying to apply everything in the

strategy to her own position as a front-line worker and in the work that she did with her clients. “*It can sometimes be difficult to see its applicability to your own work and um, sometimes with stuff like this.*” It seemed that without any step-by-step instructions for how people were expected to implement the strategy, workers would be left to their own interpretations of what the principles would mean to them, which could potentially lead to many implementation inconsistencies. Kate thought that it would be helpful to have more guidance in this implementation process to make the strategy directly applicable to front-line workers:

Sometimes with stuff like this, um, it, it would probably be helpful to have it broken down. So for example, if I work at PACT⁶ um, as a support worker I would get um, like it broken down with examples of, you know, two examples let’s say from each goal, this is specifically what you can do, not that you must, but this is specifically what you can do and you know, if you think of other things, great, kind of approach, So that I might get one sort of breakdown, someone else will get another, some other program will get another, you know, that can be helpful and it doesn’t happen.

She saw this suggestion as an opportunity not just to be more direct and universal in implementation, but also to recognize how the implementation of the goals and strategic actions would be different depending on the type of organization and the type of position someone might find themselves in.

Theme: Policy Role

Strategy’s vision set the stage for activities to occur

Aside from finding ways to change her own practice, Kate also saw some changes in the mental health system which was evidence to her that the strategy had been implemented. In

⁶ Program of Assertive Community Treatment

terms of the promotion of mental health and wellbeing and the prevention of mental illness Kate spoke to two ways that this goal was implemented. One was at a get together of community mental health programs where a presentation was made to talk about the Winnipeg Regional Health Authority's Mental Health Promotion Team and also to inform participants of the development of a wellness website that had been created. The second was in terms of suicide prevention in that she had noticed during the five-year time frame of this strategy that there was much more encouragement from her superiors to take suicide prevention training courses. Kate also noticed some changes in relation to the research and innovation goal; however she was not sure if the changes she noticed were as a result of the strategy or not. Programs that emerged, like At Home/Chez Soi⁷ and the Crisis Response Centre were noted as developments that have emerged, but her awareness of the Crisis Response Centre being developed prior to the strategy made her second guess how attached these activities were. She also noticed an increase in assertive community treatment teams in the public mental health system in the past five years. In terms of social inclusion, Kate noticed some work that was done around reducing stigma. Again, not knowing if it was the strategy that directly led to the changes, she did see Rising to the Challenge as having a role in these changes:

You know when I looked through [the strategy] I thought, you know, there's been a lot of change. Is it directly as a result of this? I don't know. But this certainly gives the permission, you know, and the support for a lot of the change.

This related to her idea of how the strategy serves as a vision and gives permission for actions, such as the developments she identified, to occur. Kate's experience of the implementation of

⁷ The At Home/Chez Soi pilot project, sponsored by the Mental Health Commission of Canada, was a two-year, five city randomized controlled trial of the Housing First Model used to help support chronically homeless people with mental illness (MacLeod et al., 2017).

this strategy as a front-line worker never included a direct plan where a supervisor explained how she would be responsible for implementing an action from the strategy. But, it seems, from her experience, that there was some evidence of implementation. Perhaps, this provides evidence that the strategy was implemented, but front-line workers like Kate, may not have been aware at the time that these changes were a result of the implementation process for the strategy.

Theme: Policy Design

National Strategy influencing Provincial Strategy

As the implementation of this strategy progressed over the five year timeline, Kate began to notice different factors that she believed greatly contributed to some of the changes that she was seeing. One factor was the work that the Mental Health Commission of Canada did on the national mental health strategy (Mental Health Commission of Canada, 2012) in moving concepts like recovery into the provincial scope:

I think that the Mental Health Commission of Canada's work has been a really big, um, incentive in a lot of this; their focus on recovery and their um, stuff on, you know like, the incidence of childhood trauma and mental illnesses, and, you know, all of that stuff I think has been a really big kind of push.

It seemed that since the national strategy was used as a guideline for provincial strategies, like Rising to the Challenge, Kate saw the national work as a facilitating factor in moving Manitoba's system in a similar direction.

Theme: Organizational Culture of Support

Organizational Adoption of Strategy's Principles as a Facilitating Factor

Kate also noticed how there was a wider adoption of recovery-oriented practice through Manitoba's public mental health organizations, which, to her, really contributed to the shifts that

she was seeing. It became clear that the organizational support for principles, like recovery, in the document helped promote changes within those organizations. She also described how the whole population approach to mental health promotion was an important factor in changing peoples' views about mental health and mental illness in her experience:

I think that one of the um, important roles of having a general population approach is that it really does reduce stigma. It changes the talk about from not them and us but to everyone. So um, so I think that that's going to be a big factor in reducing stigma.

The principles that were included in Rising to the Challenge, and the adoption of those principles at an organizational level were important factors for Kate, in enabling her to incorporate these changes into her practice.

Theme: Evaluation

Disconnect between strategy's achievements and what is seen in the front lines

While overall Kate saw this as a strategy that had been implemented, there were aspects of it on which she had not seen a lot of movement. One of these aspects had to do with the social inclusion goal. Kate was not on the same page as some of the other narrators in terms of the inclusion of people with lived experience and family members in the development of mental health policies and programs: *“yeah I think, I think that on paper it maybe further ahead than it actually is”*. While recognizing some movement ahead with this, it seemed to Kate like a concept that was talked about more than it was practiced. Kate had a similar view of another aspect that she did not feel had been sufficiently implemented, and this was increasing peer support workers. *“I think the role of peer-support hasn't really been implemented, certainly not at the WRHA level. Um, there, not as employees, right, as integrated into the system”*. This was another area in which she recognized movement, but not nearly enough. Both of her comments reflected her

unique experience in working on the front lines closely with people with lived experience and seeing how aspects of the strategy were truly translated into practice. Highlighting these needs for improvement did not take away from the fact that Kate saw great value in what had been accomplished, especially within the mental health system:

I think it's important to acknowledge what's been done, you know, cuz its, it's easy I think in this line of work because the level of need is so great it's very easy to sort of go gee, not enough's been done, not enough's been done, well no, enough hasn't been done, but a lot has been.

For Kate, a strategy revolving around system transformational goals was such a huge task and it was important for her to recognize the positive steps that were made as a result of the implementation of this strategy.

Theme: Organizational Culture of Support

Organizational culture of support as a recommendation

As Kate looked back on her experience with this strategy and the effect it has had on Manitoba's mental health system in the past five years, she reflected on what could have been done to improve implementation. In her view, the implementation could have been handled differently within her organization. She thought it would have been helpful to have a more team-oriented approach to determining how to go about implementing the strategy:

So bringing it right into like a team meeting and, and starting it off with this is what we're doing really well, this is a gap, can we do anything about the gap, yes or no, if not, ok lets keep doing what we're doing really well. If anyone has any ideas we'll talk about them kind of thing, you know?

She also felt that her organization could have been able to work with the barrier that front-line workers have with time constraints by figuring out an implementation time-line plan that would work for them. For Kate, this meant implementing the strategy piece by piece.

Taking a bite at a time, not the whole damn thing, you know? So we'll, this, for the next two months well let's do this, or for the next year let's, let's tackle this one. It's a five year plan. Let's do goal one and two this year and then another goal each year, you know, those kind of approaches. Something like that, that makes it doable, friendly, not overwhelming.

Theme: Time Constraints

Allowing more time to continue policy progress

While Kate's experience did lead her to identify both positive and negative aspects of the implementation of the strategy, I was reminded of how she referred to the document giving her hope. This sentiment became clear when she began looking towards what she would like to see for the future of mental health in Manitoba: "*Now that this is over? (Laughs) um, I would like to see a policy much the same for the next five years, only maybe moving a lot further*". This could allow for the progress that she was seeing to continue moving in a positive direction and may allow for more time for organizations to learn how to adopt the strategic principles and actions into their specific practices.

Summary

Kate's narrative presented an important perspective on how a front line worker could implement a strategy like Rising to the Challenge. It also was important because it illustrated the process of policy trickling down from the policy makers to the front line workers, which in this case did not happen in a planned way. This is an important consideration for a strategy aiming

for system transformation in that the professionals who are working within that system would need to be aware of these strategic changes in order to ensure they happen in practice. In Kate's case, the implementation was not based on a directive from superiors, which may speak to a disconnect in distributing the document to professionals in the mental health system. However, it could also be that changes were made as a result of the strategy at a more senior level, but that it was not made known to Kate that these were actions based on the strategy. Either way, Kate showed how her leadership skills in taking the initiative to seek out the document, interpret it, and determine ways to apply it into her own work helped implement a strategy that may not have reached her otherwise.

Narrative Seven.

The seventh narrative account centers on a front-line worker named Rebecca. In line with the other front-line worker narrative accounts, Rebecca was not directly involved in the planning of this policy response, but had a role in implementing it through her position as a front-line worker in the public mental health system. She has worked in the mental health system through different programs and was able to speak to what she experienced with Rising to the Challenge in its most recent years of implementation.

Theme: Organizational Culture of Support

Organizational communication and support as a facilitating factor

Rebecca's story begins at a forum that she attended where she was first introduced to Manitoba's mental health strategic plan. She attended a forum on a bi-annual basis that included different staff members and organizations that work in the mental health field and provided officials Rebecca referred to as upper management the opportunity to communicate with different staff members about initiatives like Rising to the Challenge. The forum that she

attended regarding this strategy occurred within the last two years of the five year time line and she saw it as an opportunity *“for upper management to get feedback from frontline staff on how these strategies are, are working and sort of direction where, where we need to go.”* It was helpful for Rebecca to have her organization promote the strategy so that she could understand what it was about. After learning about it, she viewed the strategy as something that could provide some structure to the mental health system. Rebecca appreciated the communication that occurred from the upper level management to front line workers: *“I do like that upper management is interested in having some level of communication with front line staff and getting some direction. They impose some direction but they uh, they also want some feedback.”* This differed from the last narrative account in that there was not an intentional organizational introduction to the strategy. It was at this forum that the implementation process began for Rebecca. She described a task that she and a group of her colleagues were asked to undertake in relation to the strategy, *“basically we were asked individually to sort of write down what we thought our, you know um, to prioritize our direction”*. She explained how she and her colleagues shared their answers and then present them back to the larger group.

Theme: Time Constraints

Time constraints as a barrier for front-line workers

While she seemed to find some value in this process she reported feeling that there could have been more time for discussion on these issues. But there was no time, and this was not a new concept for Rebecca. As a front-line worker, Rebecca explained how she and her colleagues are so busy, and this was an impeding factor in this strategy’s implementation into their work. Aside from the work of adopting the strategy into their practice, Rebecca explained how even taking the time to go to the forum and learn about the strategy was a challenge: *“Even to go to a*

forum requires a huge accommodation. Extra staff have to be brought in just to do the med drops, never mind you don't get to see your people that morning, and then there's catch up."

Rebecca was left with the impression that people would just forget about the strategy after the forum because of the busy nature of front-line work; she referred to how they would all just have to go straight back to work and would not have time to really think about the strategy again or how it would change their work. Rebecca also started to notice in herself and her colleagues how their high demand, busy caseloads impacted their own mental health. She saw this as an important consideration for the strategy to take into account:

I mean, there's the population that you serve, but there's also the human beings that also work in the field whose mental health can also very quickly suffer and that should be part of the whole picture, to have healthy front line workers. Need to acknowledge them as part, part of the strategy too.

Theme: Organizational Culture of Support

Organizational adoption of policy principles as a facilitating factor

Even though the stress and time constraints that Rebecca and her colleagues were under left her with the impression that everyone forgot about the strategy, the implementation did not completely fall short in her eyes. After learning about the strategy she started to notice how parts of it applied to her work. Rebecca noticed how recovery oriented her organization was. She saw all the work that she did as being based in the recovery approach, including finding people housing, helping people build skills, helping people complete education, and helping people develop routines. She saw this as evidence of implementation in her organization, but realized that it had not translated to the rest of the mental health system. She reported limited capacity to meet the goal of increasing access to recovery oriented services in that there were not enough

recovery oriented programs out there. I interpreted this as meaning that some movement has been evident, but staff were not achieving this goal to scale.

Rebecca noticed how other parts of the strategy had been implemented. She reflected on how strategic actions around reducing stigma related to her work and this was something she incorporated into her practice:

Stigma reduction um, for instance, uh, I mean just personal one on one work, like acknowledging, you know, when someone is experiencing, you know, discomfort because they're feeling stigmatized, acknowledging that with um, if that is what it is, being, listening, you know, to people, maybe connecting them with, you know, other groups, resources in the mental health field, like peer oriented stuff, uh, where they can get some support, um, maybe start working towards, you know, improving that.

Rebecca also started to notice changes in her organization around suicide prevention.

What has changed, uh, the practice is that we're much more thorough when it comes to um, suicide prevention and risk assessment. They've really improved the policy, the forms, we have new forms now that we're using and uh, they're much more, yeah, thorough. So that's really helpful.

It was becoming clear how certain aspects of Rising to the Challenge were starting to become practice in her organization.

Theme: Applicability to Front Line Practice

Lack of applicability to front line work

Even though Rebecca started identifying instances of implementation, the implementation process of this strategy became challenging to her. At another forum that she

attended, a program that was implemented as a result of this strategy was presented. She expressed feeling infuriated because the program was not applicable to her work:

To bring people who work in the area of mental health and are dealing with very specific severe persistent mental illness, very specific, you know, heavy needs and to introduce a document like that which was just something really general for, really a general population that kind of presumes that peoples' mental health and everything is pretty stable and all we need to do is maybe just take care of ourselves, take a three minute breather, breathing exercise, you know.

Her comments seemed to reflect that the needs for her clients were much higher and she was going to need an approach that was much more intensive than what she was being offered. For Rebecca, this experience seemed to be more about upper management's goals than the goals that she had for her clients: "*cuz it just felt like we were kind of uh, what's the word, entertaining upper management with something, with a tool that was completely useless for us*".

Theme: Mental Health System Complexity

Definitional ambiguity of mental health concepts as a barrier

As she continued on with her work she also began to see other challenges in implementing certain aspects of the strategy. She found, through her experience, that the work that was being done to increase consumer and family participation was very limited and under-developed. She described some inconsistencies in its implementation:

There's something uh, bizarre about how we talk about the uh, we want the involvement, the consumer involvement but at the same time then we individualize it, right? So people end up thinking staff, you know, people on the front lines end up thinking of it solely in

terms of individual participation in their own care rather than participation in say, like a community advisory committee.

Both kinds of participation that she noted are important. This could also be interpreted to reflect limits on a front-line worker's ability to implement this action any further than with a consumer's own care because she or he may not have access to the kinds of advisory committees in which consumers may be able to participate. But there was another area that Rebecca came across where she encountered definitional ambiguity of some of the strategy's concepts as a challenge. An important part of her practice was to address the power imbalances that her clients face. For Rebecca, this took on a more structural perspective of how inequalities like poverty are perpetuated in society and how these structures affect her clients' lives. But Rebecca started to see different ideas among other front-line workers who adhered to a more cultural perspective to power imbalances.

But that's not the same as having an analysis of how, you know, society is structured, how, how it works. So that piece around understanding power imbalances like its limited to, its cultural power imbalances so I think it's the sense that we're going to be more open to, you know, immigrants and refugees and Aboriginal people and their cultural views. But its, its, yeah, for me I think doing more work with staff who work on the front lines to understand that structure.

The definitional ambiguity in power imbalances was another challenge that Rebecca experienced as she attempted to implement this concept into her practice. The only description of power imbalances in the strategy refers to the importance of analyzing power imbalances and institutional discrimination in order to be sensitive to the values and practices of different cultural groups in mental health treatment. It seemed to Rebecca that it would be much more

effective if there was a clearer definition that included the structural elements that she valued for front-line workers to implement this consistently.

Theme: Cross Departmental Approach

Inter-departmental collaboration to address social determinants of mental health needed

Rebecca began to look forward at the mental health system and aspects that could have been improved with this policy response. A major consideration for her was the impoverished conditions that her clients lived in, and this was something she thought needed a lot of recognition and development in the mental health field: “*when it comes to the economic deprivation that these people live in constantly, everyday, its not well understood how that contributes or undermines mental health*”. She tied this to the need to improve other social determinants, as well. She recognized how this was promoted through the strategy, but through her experience on the front lines she felt that most staff did not have an understanding of these factors. Rebecca wanted to see some improvements in this area and communicating about social determinants of mental health with front line workers was one way to do this according to her. She also suggested that other policy changes outside of mental health should happen, such as increasing social assistance rates and increasing minimum wage. She saw these as being “*massively helpful*” for improving her clients’ mental health. Rebecca was skeptical that the government would be favorable to making these significant changes in policy. She also added how she thought the government would need to take an inter-departmental approach and require departments to collaborate with each other to create these changes rather than working independently from each other.

Summary

Rebecca's narrative provided an important perspective that highlighted a more intentional implementation process from an organization than what we have seen in the previous narratives. It provides an example of the strategy being introduced to front line workers and included an exercise for them to think about how they could use it in their work, which, for Rebecca, included a strong recovery orientation, one on one work with clients to help reduce stigma, and her organization's improvement in suicide prevention tools. Despite this more intentional implementation approach, Rebecca still encountered many challenges with this strategy's implementation including a lack of applicability of certain aspects of the strategy to her work, inconsistencies in implementation due to the definitional ambiguity of concepts like consumer/family participation and power imbalances, and a lack of understanding and work towards addressing the social determinants of mental health. These challenges that Rebecca experienced provide important examples for policy makers to consider when determining how a policy will be implemented into practice at the front-lines.

Narrative Eight.

The next narrative comes from a woman named Maria. Maria categorized herself as a policy maker, but unlike the other policy makers involved in this study, she was not involved in developing Rising to the Challenge. Her work relates to developing policy within the public mental health system. Her experience working in this system led her to develop an understanding of how Rising to the Challenge is used by people in her position and those with whom she works closely.

Theme: Policy Role

Policy viewed as a directional planning document not intended to be directly implemented

Maria first heard about the strategy from colleagues who were involved in its development, so she was aware that a strategy was coming prior to its release. She was officially introduced to it through an e-mail that was circulated throughout her organization from the executives in her organization. Our conversation about the implementation of Rising to the Challenge started with what it meant to her. When I asked her what she thought of the policy, she stopped me immediately and corrected me to say, “*well it’s not a policy*”. She was very firm in differentiating between policy and strategy and did not see Rising to the Challenge as a policy response.

A policy is pretty directive, right? And so then you have to find a way to concretely operationalize exactly what a policy says. This is a strategic document so its, its, it’s not about directly implementing, you know, the, the exact actions here.

Her definitions of policy and strategy strongly influenced her perception of implementation and how it relates to a strategy. This differs from definitions of strategy included in the literature, such as a strategy being referred to as the means an organization chooses to move from where it is today to a desired state sometime in the future through a set of organizational processes, decision guidelines, and a means to measure the effectiveness of those strategies (Campbell, 1993; Duncan et al., 1995). Components like organizational processes, decision guidelines, and measurement tools could certainly be regarded as operational elements relating to direct implementation. However, for Maria, the role of the strategy was about relating the material in the strategy to the work that is going on in different organizations.

You're going to take an objective from the goals and then how does that relate to your agency, your organization, your particular service or the unit in the hospital and then what are you going to do to implement that at that level, but you can't take this plan and apply it in all of those places.

She went on to describe how the strategic actions cannot be consistently implemented across the mental health system because of how different the organizations within it are. “*Well and I mean you can't expect something to be implemented on a forensic unit in the same way it's going to be implemented in a self-help organization*”. This suggests that implementing a strategy includes efforts to localize the values and goals to individual organizations.

Theme: Policy Role

Policy connects the directions of organizations across the province

While Maria referred to the strategy as not something one directly implements, this did not detract from the value she found in it. She found that Rising to the Challenge played a significant role in connecting the organizations that she worked with:

Its one document of many, but its our one provincial document that when we get together with other regions um, its, its kind of one of the things that talks about what we're all doing in common and what we're all working together, how it, how it gets operationalized in each service, in each region, um within each organization is, is unique to the culture of the organization but it's the kind of, hopefully, the guiding principles that guide mental health service delivery.

For Maria, it seemed to be a way to guide the mental health system towards the goals outlined in the strategy, even given the different operations seen in various organizations in different regions of Manitoba.

Theme: Policy Design

Policy well informed by research

She also seemed to find value in the document itself in terms of the research on which it was based:

This is pretty congruent with what is happening around the world and not, not just in Western countries, I mean you can look at, you know, we've looked at translations of strategic plans and guiding documents for mental health that come from Asian countries and African countries and I mean this is based on work of the World Health Organization.

For Maria, it appeared that the comprehensive nature of the review of what has been found to be effective in other countries led to her valuing the strategy as something that could be used to guide the work done in Manitoba.

Theme: Policy Role

Document serves as a guide that informs other policies

The concept of using the strategy as a guide was important to Maria. When I began to inquire about how she implemented the strategy into her work, she stopped me again to make a correction, *“the question wouldn't be about how are you implementing the document, like the strategic plan, its how are you using the strategic plan to implement other things that are ongoing within what you're developing”*. Once her idea of how this strategy and implementation relate to one another was clarified, she related it to her experience using Rising to the challenge to guide her work.

Theme: Policy Role

Document often used to inform other policies

Maria found the strategy to be a useful document in her work, “well I use, I’ve been using it in my work since it came out so”. As she developed policy documents for her organization, she used the strategy to guide how she developed these documents.

So there has to be like a number of documents that guide how you develop those things and where you get your values and your guiding principles from so, certainly Rising to the Challenge has been a reference for everyone, one of those pieces of work since it came out, uh, along with you know, things from the Mental Health Commission of Canada um, other um, Manitoba Health policies. But the strategic plan has been a reference document used to guide the development of, of all of the other core documents.

Rather than implementing specific strategic actions from the strategy, Maria made sure that the work she was producing was in line with the values and goals found in the strategy. Maria also experienced how the policy was used to guide program development in her organization.

Whenever we have big all staff meetings where we’re talking about new programs or we’re talking about um, updates on what’s happening in the program, we usually start with a presentation that goes, you know, this is what’s happening internationally, this is what’s happening nationally, provincially, and then within our own region and we talk about the documents and how they all line up and these are the, the goals and the priorities

Maria’s experience seemed to reflect how any new outputs related to policy or program development that occurred since the announcement of the mental health strategic plan in her organization would need to reflect the values and priorities of the provincial strategic plan. She

also saw this in the program proposals that were developed for government in the cases where funding was made available: *“I mean when the government says that these are our strategic directions and then there’s possibility of funding, certainly the proposals that RHAs⁸ and other services would put forward would be to meet the goals of the strategic plan”*. This further reiterated how any new developments in Manitoba’s mental health system during the strategy’s timeline would be expected to be in line with the strategic direction of Rising to the Challenge. While Maria’s experience was not about directly implementing strategic actions, she began to see parts of the mental health system moving forward based on the strategic priorities of the strategy.

Theme: Policy Role

Progress evident in mental health promotion

One of the values/goals she saw reflected through changes in the mental health system was the promotion of mental health and wellbeing. While she described mental health promotion as something that was already taking place prior to the strategy, so as not to portray it as being in existence as a result of the strategy, there were some changes she noticed since the strategy was announced. She noticed that there had been a *“huge expansion of, of services, of services that we offer or that we partner with other organizations around mental health promotion and mental wellbeing”*. One of the ways she noticed this was through staff increases and partnerships with various public health programs, school boards, post-secondary institutions, and workplaces. Maria saw these changes as being effective in promoting mental health; but also uncovered a challenge that came along with this:

⁸ Regional Health Authorities

Progress has been made around promoting mental wellness, people now are much more aware of what is mental health and what is non mental health, what is flourishing and non-flourishing and when people feel that they're not doing well they want services (laughs), right? So that's the increased demand for services that we're all feeling. But part of that is because we've made people more aware of how things should be for them in their lives when they're mentally healthy and mentally well.

While Maria seemed to value more people understanding their mental health and wellbeing, an increased demand in services occurred as a result. This increased demand puts additional weight on another one of the strategy's goals, to increase access to recovery based mental health services.

Theme: Policy Role

Document supported initiatives that improved access to services

Based on Maria's experience, it seemed that Manitoba's mental health system might not be able to meet this increased demand despite some improvements that she saw during the strategy's timeline. "Access to services, yeah there's been, there's been advancement on that, um, could we do better? For sure." Maria went on to use the example of the Crisis Response Centre as an initiative that helped increase access for people.

We've opened the Crisis Response Centre which identified an entirely new target group of people who have never, who had never accessed mental health services in the past, um and made access easier for people twenty four hours a day seven days a week without an appointment.

While Maria seemed to find great value in this initiative she also recognized that this was another example of something that predated the strategy, so she did not see this as a direct result of the

strategy. For Maria, what the document did was, it “*supported their (the Mental Health Branch) ability to continue the work and expand so it’s not necessarily a result of*”. Maria described the Crisis Response Centre as a good resource to increase access for people. While she did not see it as developing from the strategy; she saw its continued development as being in line with the strategic priorities.

Theme: Policy Role

Recovery activities directly occurring as a result of the strategy

As much as Maria viewed the strategic plan as a guiding document for continuing work, she also came across evidence of changes that occurred as a direct result of the strategy under the recovery pillar. She recalled the development of a provincial recovery champions group that included various stakeholders who came together to further elaborate on issues such as what recovery means and what recovery oriented service within Manitoba would look like. The group put a document together that outlined what the indicators were for a recovery oriented system in Manitoba, turned them into ten system priorities, and worked towards moving those priorities forward. Maria also recalled the group working on other recovery guidelines for the Mental Health Commission of Canada and assisting Brandon University’s Nursing program in redeveloping its curriculum to become recovery-oriented. Through this experience, Maria saw examples of activities that came directly from Rising to the Challenge.

Theme: Financial Resources

Limited financial resources need to align with strategies priorities

While Maria’s story highlights many examples of how the strategy was used well to guide work in the mental health system and to create movement towards a recovery oriented

system, she also came across some challenges that made the strategy not as easy to implement. One challenge she noticed was the lack of financial support for mental health services.

Mental health is severely underfunded and severely underfunded in this province in particular compared to other provinces across the country and Canada is underfunded compared to national so, yeah, but when funds do become available um, it's important to match it, match what you ask for to what the government says is its strategic priorities.

The narrator saw the funds to make changes in the mental health system as very limited, so for her, making sure her work and any program development in which she participated was in line with the strategy in order to obtain what little funding she could, was a priority.

Theme: Applicability to Front Line Practice

Challenge in strategy's applicability to front line practice

Maria also saw some challenges in translating this strategy into practice at the front-line level. Although she is not a front-line worker herself, part of her role as a policy maker in her organization is to ensure that the policies, procedures, and guidelines of the organization are reaching all staff members, including front-line workers. Because of this she was able to offer some insight on how the strategy affected front-line workers. As Rising to the Challenge was rolling out, she saw conflicts between the strategy and the work that many front line workers have to do to follow Manitoba's Mental Health Act when someone has to be involuntarily admitted:

In some cases you're not going to be recovery oriented, you're going to take peoples' civil liberties away from them. And so you're constantly managing that kind of work and that's probably more what front line stuff kind of feel the tension between is yeah its nice, we've got these things that guide us but I still have to be the one who has to go and form

one of my clients to have them hospitalized. So how recovery oriented is that, right?

Those are, those are the tensions and the kind of reactions you get from front line staff versus the philosophical drivings of leadership and planners.

For Maria, this highlighted the disconnect that can occur between the policy making level and the front-line level. While she did describe a process where the policy makers consulted with front-line staff for how to operationalize some of the goals, this seemed to be an unexpected conflict that arose during the implementation phase.

Theme: Time Constraints

Time Constraints of front line workers challenges awareness of strategy

Even beyond this conflict, Maria did not see front-line workers as having much awareness about the strategy and how it affects them. She referred to how some front line workers might interest themselves in reading the strategy, but most people do not because of the day to day demands of their work:

If you have to make a choice between reading a document like this or finding immediate housing for somebody who is about to be evicted in our, you know our province, our city especially somebody whose on income assistance and they're being evicted, this doesn't matter. It's like, who can I get on the phone, who has an in with a place for my client to live, right? They're not thinking about this stuff.

Theme: Organizational Culture of Support

Managerial guidance as a recommendation for implementation

Despite this challenge that Maria identified, she did not think that front-line staff needed to directly be aware of the strategy and how it should change their work. For her, it was up to

clinical supervisors to ensure that all of their staff understand the strategy's values in the same way through training programs, protocols, and consultation:

If you're talking about front line staff I think its, its more important, you know, in, in clinical supervision, in consultation when you're doing that with the front line staff to talk about the values that guide the work we do and, and not so much this strategic plan, but to talk about, you know, the pillars

For Maria, it did not matter if front-line workers knew that this work was coming from the Rising to the Challenge document, as long as their work reflected the pillars and the goals of the strategy.

Theme: Evaluation

Evaluation as a facilitating factor for improving implementation

In reflecting on the five years since the strategy was announced, Maria began to look towards its future. Evaluation was important to her in moving the strategy forward and improving on the changes that have already happened. She recalled how the Crisis Response Centre (CRC) continues to improve through a feedback process.

So since it's opened, there's been multiple changes based on evaluation based on feedback from individuals using the service, service providers referring to it, family members, so it's constantly changing to continue to improve access to services, right? So there's a lot of different quality improvement initiatives going on related to, to access, and I mean CRC is just one example

She also thought that having a proposed timeline is helpful in evaluating a strategic plan like Rising to the Challenge:

You want to have something that kind of says this is our focus for five years and hopefully we've moved not to the end but we've moved further along and then we'll be in a better chance to say for the next five years what should we be focusing on? Do we need to continue to focus on these same things? Or are there other slightly different things we can focus on to move us further again?

This process seemed to be important to Maria in understanding where the strategy was able to move the system, how effective it has been, and what kind of changes need to be made to continue to move the mental health system towards the vision of Rising to the Challenge.

Summary

Maria's experience working in the public mental health system as a policy maker created an implementation perspective different than those described above. Her interpretation of this process was heavily influenced by her differentiation of the strategy as a "plan", a guiding document, rather than an implementable policy document. But, in that strategic guidance flowing from Rising to the Challenge, the change and progress is seen as a result of considering the strategy's values and utilizing those values in the programs that the mental health system decision makers choose to implement. Maria saw the system move towards the values of the strategy through initiatives in mental health promotion, recovery and increased access to services. She also noted challenges with underfunding and involving front-line workers. But overall, Maria saw a lot of value in Rising to the Challenge and saw potential for continuing to move its priorities forward with evaluation and learning what we can to improve it.

Narrative Nine.

The ninth narrative account comes from a man named Peter. Peter's experience with the implementation of Rising to the Challenge was different than was heard in many of the other

narrative accounts, and there are three reasons for this. First, Peter works in the private mental health system, which affects his relationship with government policy differently than the public system. Second, his role in his organization covers policy making, administration, supervision of front line workers, and front line work. Third, prior to our interview, Peter had never heard of *Rising to the Challenge*. Peter's experience of the strategy, or lack thereof, enabled him to speak to the role of private mental health agencies in Manitoba's mental health system and the relationships they have with government. This narrative highlights how the fragmentation of the mental health system and the lack of communication between government and various sectors creates a barrier to the private sector knowing about and implementing the strategy. This also has important implications for patients, since the private mental health sector plays a significant role in the mental health system by treating many people across the province.

Theme: Mental Health System Complexity

Lack of Communication among fragmented system entities as a challenge

Peter's narrative begins in 2011 when the strategy came out, a time, which held no particular significance for him having not heard that a mental health strategy was announced. Through his work, Peter collaborated with many government agencies that would contract the services of his organization. These agencies served as an information source for program and policy changes occurring in government. Regardless of his regular contact with these agencies, he had never heard about the strategy: "*nobody's ever commented; nobody seems to be working from this model.*" In Peter's experience working in the mental health field, there was a clear lack of communication among government, non-profit, and for profit mental health agencies. He found partnerships between these organizations to share information, like the existence of a provincial mental health strategy, atypical.

And that's one of the challenges, right? I mean that there's a, I mean there's a huge level of service delivery that occurs by uh, nonprofit you know, social service agencies and by for-profit private practices and mental health uh, providers, and often times there's a real disconnect between sort of government and government services, versus um, uh non-governmental services, which is unfortunate.

This lack of communication in the fragmentation of the mental health system was a major barrier for the implementation of this strategy in Peter's practice. *"If we're not aware of these kinds of initiatives then it has no impact on our practice."* The government's intent to instill particular values and initiatives into Manitoba's mental health system went unseen with this organization and virtually disabled its ability to assist in implementing the government's goals and strategies.

For Peter and his organization, it was not necessary to know about the strategy to conduct their work. Being in private practice gave them a certain flexibility in determining their practice philosophies and the models that they work by: *"that's one of the benefits I think, and advantages of working in a private practice is that when we see a need we respond to that need and we develop the resource to meet that need."* In his experience, this flexibility saved them time and saved them from dealing with the bureaucratic barriers that often occur when making policy decisions in government. For Peter, if someone in his organization had an idea to incorporate into their practice, that practitioner would provide their input on the idea, shape it, mold it, and implement it.

The organization already had its own practice philosophy and practice guidelines that they found to be effective. In order to inform its guidelines and philosophy the organization used clinical training and experience for developing a perspective on what works, understanding the literature in the area in which it practices, and by obtaining feedback from clients and from the

organizations that contract its services. So, while the organization does not rely on government policy to operate its practice it does want to know what government organizations value and what they think makes a difference.

Theme: Evaluation

Lack of compliance requirements as a challenge to implementation

There were times that government policies were brought to Peter at his practice. To a certain extent, he was able to choose whether or not, and how, to adopt them. When he found that these policies had useful content in them, he would adopt them, but would not necessarily do so if there was content that did not agree with the practice:

And there were things in there that we didn't agree with and we thought didn't make any sense, um, and again, because we're a private practice we weren't bound by needing to uh comply with them in the direct manner that they were spelled out in the documents.

This did not mean that there was no accountability for his practice with these government policies. He had to consider government policies of business partnerships and public payment for their clients to receive services.

There was still some compliance requirement because we're doing business with them and they're saying you need to do business under these, this umbrella of the way that we want the program to be done um, but there's still flexibility in terms of what that looks like from an implementation perspective. So we're able to both uh honor some of the tenets of the program model but provide the implementation of those tenets in a way that we thought was more meaningful.

In Peter's experience, government agencies would at times present their policies to his practice but it was not typical or common for him and did not occur with the Rising to the Challenge strategy.

Theme: Cross Departmental Approach

Strategy impacted by other departmental and jurisdictional policies

Despite being unaware of Rising to the Challenge, Peter still had an awareness of what was changing in the mental health system over that time and what was not over that five year period of time. One of the changes he noticed was in access to mental health services. From Peter's perspective this had reduced significantly. But, rather than this being associated with the provincial mental health strategy, this change came from federal policy decisions. Peter noticed that, particularly for mental health treatment in the criminal justice system, access was reduced because of federal "tough on crime" policies that shifted integral resources from a rehabilitation focus to a detention focus. So, as more money was going to increase space in prisons, money was being taken away from programs that helped people with their mental health concerns in the community.

So, there we saw a huge shift in access because there was no more support for intervention for high risk, high needs individuals coming into the community. And they moved from having a very comprehensive treatment experience with us to having almost no treatment and being managed through. When somebody was acting out they would just send them back to jail.

Peter's experience reflects a unique challenge in that federal government policies and provincial policies can have very different visions and the decisions made at the federal level can impact the

work that is being done on a provincial level. It also speaks to how different government departments impact one another.

Theme: Evaluation

Evidence predating the strategy

Other elements of the strategy, like the focus on addressing the social determinants of mental health and the use of a recovery model were evident in Peter's practice. However, for him, these were elements that already existed in his organization based on what organizational staff knew to be best-practices for mental health treatment, rather than being a result of the strategy.

Theme: Mental Health System Complexity

Strategy interpreted differently across departments as a challenge to implementation

There were also practices that the strategy sought to improve that were not changed in Peter's eyes. Especially in considering his clients with histories of criminal involvement, areas like stigma reduction and family participation are not as easy to improve. These clients have to deal with the co-occurring stigma of struggling with mental health issues and of having histories of criminal involvement. Family participation was also a complicated matter to include in Peter's treatment with these clients. Many of these clients had cut ties with families, or did not want their families to be involved in their treatment plan because of the sensitive and confidential nature of what was discussed between the clients and the mental health professionals at this organization. This also speaks to the importance of considering how strategies like Rising to the Challenge will apply to people with different backgrounds and the impacts the strategies may have on various departments and organizations from which clients may also be receiving services.

Theme: Evaluation

Challenge in measuring what contributes to outcome

The changes that Peter noticed over the five years he did not attribute to the provincial mental health strategy. For Peter, this did not mean that the strategy was not successful, but he saw a lot of challenges in measuring these sorts of changes and figuring out what led to any improvements he might be seeing. “*And at the end of the day it’s so hard to understand, you know, like what contributes to outcome.*” For example, if his clients were doing well, is it because of a shift in the mental health system that happened because of the mental health strategy? Is it because they had good psychological services? Is it because they had supports teaching them life skills? Is it because they just found a place to live? Is it because they had something to eat that day?

It’s a big soup, and, and uh, you know, how to start evaluating each of those separate components um is, yeah its hard to wrap your brain around how you, how you do that, and then what accounts for the greatest percentage of the variance in terms of, of change.

Peter highlighted a challenge in measuring outcomes for his clients that also relates to the challenges in measuring outcomes for this strategy.

Theme: Cross Departmental Approach

Lack of collaboration across sectors in mental health system in policy design

In a reflection of his experience Peter identified a lack of collaboration among different sectors of Manitoba’s mental health system as the reason why this strategy did not have an impact on his practice. For Peter, it had less to do with the implementation process and more to do with who was consulted in developing the strategy.

If we're going to develop a strategy who do we talk to? Are you talking about, with consumers? Do consumers have an input? Uh do uh mental health workers have input? Do social workers have input? Do docs have input? Um, are you looking at one government department? Are you looking at multiple government departments in terms of what their needs are and how justice's mental health needs are different then perhaps, you know, family services mental health needs? Are you including anybody from a university? Are you including uh, you know, uh non profits like Klinik? Are you talking to private practice psychologists or are you talking to Aboriginal uh healing programs? So that's the start. Its not about the implementation its about, you know, whose going to help develop it, and what's the process for that going to look like?

Including all of these different stakeholders into the development of mental health policies was seen by Peter as an important consideration in the development of impactful mental health policies.

Summary

Peter's narrative presented an important perspective on public policy implementation in the private sector. His experience sheds light on some of the issues with the disconnection of our mental health system between public and private mental health. This is an important consideration because a province-wide policy would need to reach all mental health organizations within and outside of the public mental health system, including insured private practice medicine. Peter highlighted important issues, including how different departments and levels of a government impact provincial policy, the challenges in measuring mental health outcomes, and the importance of collaboration in policy development. These issues are important

for public policy makers to consider if they want their policies reaching private sector organizations as well as related government departments.

Narrative Ten.

Michael is the focus of the final narrative. His story sheds light on an area of Manitoba's mental health system that was not represented by the other narrators. Michael is a front line worker who works in the public mental health system in a hospital based setting. Working in a setting that has historically been based heavily in the bio-medical approach to mental health treatment, Michael was able to speak to the challenges in implementing a strategy like Rising to the Challenge into that setting. Like Peter, he had also never heard of Rising to the Challenge prior to our interview.

Theme: Organizational Culture of Support

Lack of Organization support as a barrier

Michael's lack of awareness of this strategy was not a rare occurrence in his role as a social worker. He saw himself as being regarded differently by other professionals working within the hospital setting. Michael saw a very distinct hierarchy from his experiences working among these professionals: *"First place a medical doctor, the psychiatrists, second place a nurse practitioner a physician, third place the nurses, ok? Fourth place, the unit assistants and occupational therapists, last place social workers."* Feeling regarded as less valued connected to why Michael was not always informed about organizational policy actions. In his experience, policy actions like the strategy were often a part of presentations that are made to staff and can be attended as a part of the staff's required professional development hours. But Michael had not been encouraged by his superiors, nor was he expected to attend these presentations. *"From my agency's standpoint, from my organizational expectation for me, is what I do to see people get*

through with their discharge plans, ok? They don't care whether I have attended, you know, this, this, this you know, presentation." Michael also experienced other mental health professionals being encouraged and expected to attend presentations like this and saw this as a result of the lack of respect that his profession had in this system. This also related to an experience he had regarding Applied Suicide Intervention Skills Training and his role in doing this work. *"My boss basically doesn't like question me whether I know suicide prevention, ok, or whether I do suicide prevention on patients; those are things that are expected more from nursing staff"*.

He also noticed this in how professionals within this hierarchy collaborated with one another. While he worked within teams of mental health professionals, it most often was not very collaborative due to some people being valued more than others. Michael reflected on times when he needed important information about patients in order to complete referrals and he was met with resistance from his colleagues:

Many times I need to know that because I am doing referrals to important placements like Selkirk Mental Health Centre, which are like quite, you know, are quite the referrals, whether it is to the geriatric program, whether it is to the rehab program, whether it is to the acquired brain injury program, I need to know those. [Researcher: so why can't you, why is it not appropriate for you to ask?] Because a lot of people like to know why do I need to know.

Michael's experience reflects a lack of collaboration and lack of support from his colleagues. In his eyes, he was seen a certain way by his colleagues. He was not expected to know things about particular clients they were working with and he was not expected to attend professional development training where he may have learned about strategies like Rising to the Challenge.

Theme: Time Constraints

Time constraints affect ability to consider the strategy's priorities

For Michael, it was not his job to be familiar with these kinds of strategies; it was his job to do casework with his clients. His priorities were based on the kind of client care he could give his clients with the pressures of his high caseload, rather than being based on priorities that the Mental Health and Spiritual Health Care Branch saw as important in its strategy. Other than the professional development presentations that Michael rarely attended, he thought that it may have been possible that a document like *Rising to the Challenge* could have been distributed to staff through e-mail. But due to the pressures of his caseload, it was unlikely that he would have the time to consider it. *"Maybe they might have sent it as an email attachment; here's the thing in eight hours of my work, how much time do I have (Laughs) to see it and go through, contemplate about each attachment?"* So it also seemed that time constraints factored in to Michael's inability to implement the strategy. For Michael, he simply did not see himself as having a role in implementing *Rising to the Challenge*.

Theme: Applicability to Front Line Practice

Lack of applicability to front line work in the bio-medical mental health system

Working within a bio-medical model of mental health treatment seemed to be a challenge in itself in implementing a recovery based mental health strategy. Michael did not see the medical system as being recovery oriented in the way that it is defined in *Rising to the Challenge* and despite efforts to incorporate methodologies like this, it was not realistic to do so. Colleagues of his discussed incorporating decolonizing methodologies into their practice, however Michael saw it simply as rhetoric and theory, *"but the work resembles something different."* Turning that

rhetoric into practice was not something that he saw as a reality in his practice. There were a few reasons for this.

One was because of the hierarchy that was evident in his experience. I was left with the impression that due to the psychiatrist being at the top, they have the most decision making power for a client's treatment. Due to their training in medicine and the bio-medical model, they would choose a medication regime and would be less likely to think about the recovery oriented services that might also help a client.

Michael had doubts that community mental health workers would even follow the recovery approach based on their tasks regarding assessments and discharge. He reflected on how these workers are primarily trained to conduct risk assessments for incoming patients. They assess a patient's risk by essentially determining at what level of risk they present, which to Michael, does not complement the recovery oriented approach. In terms of their role in discharge, the social workers would play a role in finding housing and social assistance supports but would not be utilized for their potential role in determining a recovery oriented plan for patients. Michael described a process where many patients come back to the hospital after being discharged and experienced repeated admissions.

So again, when there is repeated admissions, that is when it completely comes to the attention of the physician that maybe this time we need to have a better discharge, ok, maybe this time we need to have a better plan in place

Using a recovery oriented approach sounded like a last resort option. These challenges that Michael found in his experience seemed to make working in the bio-medical system a major barrier to moving towards a recovery oriented system, "So the biomedical model is still existent

and I don't see it changing in the next ten years" His story seemed to reflect attempts at creating system transformation within a system resistant to change.

Theme: Applicability to Front Line Practice

Policy seen more as rhetoric than practical

Because of his recognition of this challenge, Michael did not put much value into this strategy. He found that when people started talking about recovery or decolonizing methodologies, it was just that – talk. There did not seem to be any evidence for him of seeing these principles and methodologies being adopted into practice, *“so a lot of these things, these recovery oriented whatever principles are great to hear; that's not exactly how it works.”*

Theme: Mental Health System Complexity

The concept of recovery's definitional ambiguity as a challenge

Michael noticed how the term recovery was used in the hospital setting. He had heard different interpretations of what the term recovery means, *“recovery in many ways can be defined as when people are not at risk to themselves (laughs); some people may define recovery in that sense as well.”* He was under the impression that doctors could define recovery in various ways and that doctors may be saying they are using a recovery approach but they may not be in a way that is reflective of Rising to the Challenge's definition.

Mental Health System Complexity

Concepts interpreted differently in bio-medical system reveals lack of implementation evidence

Aside from the challenges that Michael found in implementing this strategy, he did not see much evidence rising from this strategy. From his perspective, he did not see an improvement for access to services. In reflecting on the strategy over the past five years, he had

seen five new beds brought in to create more spaces for patients, which was not nearly enough to meet the demand for services that he saw.

He also did not see much evidence of family participation improving. But he did see this in a different way, similar to Peter. While Michael was involved in working with families to provide psycho-education to help them support their family member living with a mental illness, it was also not always appropriate or possible to do this, “*the biggest problem with a lot of our clients are, they have broken bridges with family, so family focus in a majority of our patients is not there.*” Based on these conflicts and the foundation of his work being in a biomedical system, Michael did not see this as a strategy with a lot of influence.

Summary

Michael’s story highlights some important issues in implementing mental health policy within a bio-medical system as a front line worker. Aside from being unaware of Rising to the Challenge because of a lack of time and lack of support from his superiors to attend training sessions, he was able to describe a variety of barriers in implementing something like this. The hierarchy that he experienced in his work prevented his role from being valued and prevented his ability to implement recovery oriented principles into his work. Working in a system that defines recovery in various ways also impedes this process. Overall, Michael highlighted an area where a policy is trying to create change in a system resistant to change; he did not see evidence of change in his experience and did not have much hope for seeing change in the future. These challenges highlight important implications for policy makers and implementers to consider when planning system change within the biomedical model.

Cross-Narrative Thematic Analysis

Eleven themes emerged from the analysis of the ten interviews conducted for this study. Table 1 provides a visual representation of each of the themes and includes a definition for each of them. In the following section, each theme is described in detail to explain the relevance of each to the implementation of Rising to the Challenge; as well as the commonalities and differences in the expression of these themes across all of the interviews. After each theme is described there is a discussion of how the theme relates to the mental health policy implementation literature; as well as how it relates to Sabatier's (Sabatier, 1986) synthesis theory of implementation and the Advocacy Coalition Framework. Following this discussion, Table 2 provides a visual representation of how each theme was distributed across the narratives.

Table 1: Themes emerging from the narratives

Theme	Definition
1. Policy Design	The extent to which policies are designed to support implementation, depending on the levels of research and consultation, the clarity of goals, the choice of policy instruments, as well as the extent of formal implementation, funding, and accountability planning.
2. Cross Department/Sector Approach	An implementation approach that utilizes the resources and strategies of all departments, sectors, and organizations related to the mental health field.
3. Mental Health System Complexity	The complex composition of the organizations and stakeholders that exist within the mental health system

	and how the fragmentation of this system can impact implementation.
4. Applicability to Front Line Practice	The extent to which policies are applicable in real-world settings by ensuring that there is a connection between policy goals and the realities of front line practice.
5. Time Constraints	The extent to which both policy and practice related time limitations can impact efforts at implementation.
6. Organizational Culture of Support	The extent to which organizations value a policy and provide support, guidance, and accountability for their staff in implementation efforts.
7. Policy Role	The perceptions of implementation actors regarding what the purpose of a policy is and how it is intended to be used.
8. Evaluation	The process put in place to measure mental health outcomes, to monitor progress throughout the implementation process, and to determine what achievements have been made.
9. Financial Resources	The extent to which a policy is provided financial support and the determination of how these resources will be allocated for implementation in all organizations involved.
10. Public and Political Support	The support needed from public and political realms to

	facilitate policy change and higher levels of financial resources from government.
11. Leadership	The ability and willingness of policy actors at all implementation levels to advocate for and lead implementation efforts within the mental health system.

Theme 1: Policy Design.

A theme that emerged across policy makers, mental health organization administrators, and front line workers was policy design in implementation. This refers to how policies can be designed in a way that will either hinder or facilitate their implementation.

Across all implementation levels, Rising to the Challenge was seen to be designed in a way that made it a well-informed document. There was a significant amount of stakeholder engagement and collaboration in its design, which was seen as a strength among interview participants.

However, a couple of policy makers had opposing perspectives on the ease of this collaborative process. One policy maker noted that it is not a hard sell to engage other departments on a comprehensive mental health plan, while another policy maker saw that engaging different departments and sectors was very difficult due to stigma and limited resources, especially in terms of advocating for increased mental health funding.

This difference could be attributed to different views of the particular stakeholders with whom these policy makers were dealing, and could be due to different requests for involvement. It may be easier for a department to support a mental health strategy with supplemental information than it is for it to provide human or financial resources for a policy's development or implementation. Similar data were found among other narrators in terms of there being a lack of implementation collaboration among sectors and departments. Most respondents saw this as

something that was missing with this strategy and that it would be needed for effective implementation. This is discussed in greater detail in the Cross Departmental theme following this one. Aside from the collaborative nature of this policy's design, Rising to the Challenge was also seen by all implementation levels to be well informed by research, both from what other countries are finding to be effective in mental health system transformation, and from Canada's national mental health strategy.

An important factor that was evident in the design of this policy is that there was an organizational structure attached to it. The policy makers and administrators who were involved all stated that there were clear roles set for those who were involved in the policy's design and implementation, which was seen as a strength during this process. There was a consensus among these policy makers and administrators that the steering group members had the role of designing the policy document itself. However, the roles for implementation were not reported similarly across these participants and the implementation plans were unclear. There was a general consensus that the working groups were the next stage in moving the policy forward towards implementation, but some referred to their role as developing content that fit under the strategy's key pillars, to create more detail about what could happen in the next 5 years, to create action plans for how to implement each of the strategy's goals, to create wish lists on what members of the working groups wanted to change in the mental health system, and to determine how to make the strategy's goals happen. While each narrator thought that there were clear roles for these groups, it seems that they had different ideas about whether these groups were working with the strategy's pillars rather than its goals, and whether they were meant to create more content or specific action plans.

There was also a lack of clarity in terms of where these participants thought the next stage of implementation would go. One policy maker/administrator reported that after the working groups' work was completed the Mental Health and Spiritual Health Care Branch would work with the RHAs and self help groups to get the message out to the implementation actors. However, another reported that the Mental Health and Spiritual Health Care Branch would take over after this, but did not refer to what actions it would take, and an administrator reported that the implementation was turned over to the RHAs to take direction from the strategy and implement it in their own context. So, while the narrators all thought that there was an intended implementation process for the organizations, which were involved, they were not clear on which organizations or policy actors would fill which implementation roles.

It was also noted by a policy maker/administrator that while there was a clear organizational structure it was also impacted by human resources turnover. Because some staff involved in this organizational structure retired and changed positions the working groups "fizzled out," making it unclear how far the working groups got in their tasks and whether or not the implementation continued over further stages and/or reached out to additional implementation actors.

Theme's relationship to theory.

The elements of this policy's design that were described by the different implementation actors is reflective of some elements of Sabatier's (1986) synthesis approach to policy implementation. Through the stakeholder engagement and collaborative approach used in the design of the strategy, we are seeing the use of the various actors and strategies involved in the policy problem from a bottom up perspective. We also see how a structure was provided by the

organization and policy makers responsible for this strategy in terms of identifying the actors involved, their roles, and the stages of implementation stemming from the top down perspective.

The collaborative approach taken in the policy design is also reflective of Sabatier's focus on policy subsystems. The stakeholders who were brought in to inform this strategy were treated as important representatives of Manitoba's mental health policy subsystems by being engaged in coordinating this policy over time.

In the advocacy coalition framework, external events can create changes to the environment that can contribute to revisions needing to be made over time to the policy in order to address those changes in the environment. The human resource turnover that was described is an example of an external event as it created constraints and affected the short-term resources available for implementation and it became a barrier to implementing this policy. By addressing the human resources concern by hiring new staff or reassigning roles and tasks, the policy may have been able to move forward.

Theme 2: Cross Department/Sector Approach.

Another theme that emerged from the experience of the policy makers, administrators, and front line workers in this study was the need for an implementation approach that utilized all departments and sectors related to the mental health field. This refers to various government departments such as housing, justice, or child welfare and different mental health sectors that include public services, private services, self-help groups, and non-profit organizations.

There was a general consensus that this kind of approach was lacking with this strategy and that it was certainly needed. While one policy maker/administrator reported that the mental health system had a good record in collaborating with various stakeholders, she thought that more effort was needed to work past the usual approach of different departments and sectors

developing and implementing policies in silos. An administrator expressed how mental health is “everybody’s business”, which makes working in silos ineffective when we are dealing with a problem that affects each of those silos. The respondent from the private mental health system also felt that this approach was lacking and attributed this as the reason why the strategy did not have an impact on his practice. If the strategy was intended to reach the entire mental health system, including the private system, those leading implementation would have to identify policy actors in the private system and engage them as well in the implementation. A cross-departmental approach was also seen to be beneficial in creating a response that can be tailored to Manitoba specific issues. By working across departments we would be able to work specifically on issues that have the biggest impact on a province’s mental health system, like the high poverty and child welfare apprehension rates in Manitoba.

This also relates to the impact that this kind of approach would have on addressing the social determinants of health. There was a consensus that there was a lack of progress on addressing these issues. Working on mental health at times seems to be putting the cart before the horse. Addressing people’s mental health alone will be nearly impossible if they cannot meet their basic needs. Issues such as housing and social assistance were not seen to have a presence in this strategy. A cross-departmental approach could alleviate this by identifying and addressing the social determinants that impact people’s mental health most. From the front line perspective, the social determinants of mental health are still not well understood across the system. Consulting with front line workers who see the impacts of these social determinants on their clients’ daily lives would be helpful for implementing a mental health strategy.

Another reason why this kind of approach was seen to be beneficial was the recognition of how policies in other departments and other jurisdictions can have an impact on the mental

health system. The example provided showed that while this strategy aimed to increase access to mental health services in Manitoba, a federal policy in the justice department that was shifting the system away from rehabilitation and towards detention ended up reducing access to mental health services significantly for those involved with the criminal justice system. This helps explain the importance of understanding developments in other departments, sectors, and levels of government. Any policy issues that have impacts on the mental health system can be addressed by revising policy to meet these changes in the mental health subsystem environment.

Theme's relationship to theory.

The various departments and sectors involved in mental health compose Manitoba's mental health subsystem as described in Sabatier's Advocacy Coalition Framework (Sabatier, 1986). Each plays a role in changing policy in a given area and can be composed of various coalitions, which are seeking to have their policy goals achieved. The departments and sectors with common goals in mental health can be considered advocacy coalitions under the mental health subsystem. Each brings different resources and strategies with it, as well as a common interest in mental health. Each coalition also comes with competing interests; for example, the Department of Health may be pressured by government to focus its resources on a health crisis unrelated to mental health. According to Weible and Sabaiter (2007), by organizing these groups and coordinating their actions over time, the various departments and sectors can improve their strategies and learn how to work with competing interests, which would lead to more success in implementation. This would require more senior government leadership, from Cabinet and Cabinet Committees to senior level civil servants.

The beliefs of each of these coalitions are important to consider in these coordination efforts. The deep core beliefs of a coalition are the fundamental beliefs that generally remain

stable over time (Sabatier, 1986). Mental health stigma will likely play a critical role in each coalition's deep core beliefs; beliefs like the degree to which people with mental health concerns are deserving or undeserving of services, and whether or not mental health problems are caused by environmental circumstances or are seen as a localized problem within an individual will have impacts on a coalition's strategy toward mental health policy. The data from all narrators that related to either valuing the strategy's direction or desiring more services for the clients that they work with reflected the belief that people with mental health problems are deserving of services and that they deserve a comprehensive improvement to the system that is providing them with those services. The importance of addressing the social determinants of health was also brought up by some narrators, which reflected their beliefs that mental health problems are caused by a complex interaction of environmental factors.

A coalition's core policy beliefs include fundamental positions on policy strategies (Sabatier, 1986). Some coalitions in the mental health subsystem see the bio-medical approach as the best strategy for improving mental health; as Phillip described in his interview, there is a challenge in recruiting psychiatry as support for recovery and practices like peer support when its main goal is providing medication. However, others see the recovery approach as the best strategy; most of the narrators in this study described how they valued recovery and saw it as the direction that Manitoba's mental health system needed to go.

The secondary aspects of a coalition's belief system include the necessary instrumental decisions (Sabatier, 1986). In the mental health subsystem this would include the availability of resources. As many of the respondents indicated, this is a challenging area. While each coalition has an interest in mental health, it will also have other interests that will benefit from resources. For example, in terms of increasing access to services one narrator thought that more resources

needed to go to increasing community housing, while another narrator thought that more resources needed to go towards more inpatient psychiatric beds. Beliefs regarding how much funding should go to mental health have a large impact on policies aimed at transforming a mental health system and could have explained why there was so little funding for the implementation of this strategy. The lack of formally organized advocacy coalitions in this study may have impeded the successful coordination of beliefs, strategies, resources, and overall implementation across departments.

Theme 3: Mental Health System Complexity.

The third theme that became evident across the policy makers, administrators, and front line workers in this study is the complexity of the mental health system and how it can hinder policy implementation. As was made clear in the cross-departmental approach theme there are many different departments and sectors that play a role in the mental health system. There are also many different stakeholders within the area of service delivery for mental health that include a formal system (mental health treatment organizations, including psychiatry and other medical specialties), a semi-formal system (community organizations that are not directly linked to mental health services, but provide support to people with mental health concerns), an informal system (family, friends, and community supports), and a variety of private practitioners (psychological, psychiatric, therapeutic and counselling services).

It was clear from the respondents that the number of departments, sectors, formal organizations, semi-formal organizations, and informal supports makes our system for mental health very complex and creates a major challenge for implementing policy. A mental health policy aimed at system transformation would need to reach each of these stakeholders, which appears to have been a barrier in implementing this strategy. Distributing policy information

within an organization with clear lines of communication is one thing, but determining how to distribute that information to each self-help group, to each private practitioner, to each community organization with clients experiencing mental health issues, and to each community caregiver requires comprehensive implementation planning and resources. This appears to have been lacking in this policy response, which was made evident by the number of stakeholders involved in this study with direct ties to the mental health system who had no knowledge of the strategy prior to being invited for the interview. One of these stakeholders worked in the public mental health system for an organization directly related to the planning of this strategy. Another stakeholder who was unaware of the strategy was a long-standing professional from the private mental health system who reported having strong ties and partnerships with mental health professionals and administrators from different sectors of the mental health system. A strategy will not be adopted and a policy will not be implemented if stakeholders do not know about it.

It was expressed that within Manitoba's mental health system there is a disconnection between government and non-government services where the sharing of information between these different sectors is atypical. This lack of communication creates a significant barrier for implementing policy and creating change across a system. This lack of communication creates fragmentation in the system that so critically needs to be connected in order to move the system forward. Creating system change is impossible if the stakeholders involved are not communicating with each other and receiving the information needed to move forward together in a coordinated response

The complexity of the mental health system also leads to different organizations and stakeholders interpreting policies differently. For example, we saw in a couple of examples of how family participation may be easier said than done, such as for those receiving mental health

services within the criminal justice system. As a result of their family histories or their incarceration they may have cut ties with families, may not want family involved, or may have different ideas of what family means to them. So, implementing actions to include family participation may be more complicated in areas like criminal justice than in other areas where informal supports are more connected to someone receiving services.

Aside from the system being complex, mental health, as an issue to address, is extremely complex. As was seen with the need to have a cross-departmental approach, there are so many different issues that need to be addressed to improve the mental health of Manitobans. Prior to even considering mental health interventions, people need food to eat, they need a roof over head, they need to have supportive and stable childhoods, to name a few. The validity of addressing the social determinants of health as an approach to improving mental health has been widely accepted by health authorities across the world (Fernandez, MacKinnon, & Silver, 2015). So, creating a strategy based on system transformation is challenging because all of these areas need to be considered in a meaningful way. This is difficult to achieve in one policy response.

Mental health as a concept is also very complex. It is a concept that carries a significant amount of definitional ambiguity in terms of how it is understood (Mechanic et al., 2014; Shera & Ramon, 2013a; Ward et al., 2017). This challenge was found to exist with the implementation of this strategy. The most commonly referred to example in this strategy was the concept of recovery. This strategy and most of the narrators in this study viewed recovery as “being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life” (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011a). Others viewed recovery differently. Some people’s conceptualization is a person who is no longer at risk to themselves or simply the

reduction or absence of symptoms. As several narrators reported, you often hear this perspective from professionals in the bio-medical system, including some psychiatrists. If someone were to seek treatment for a broken arm, once it has been cast and healed and has returned to its pre-injury level of function, the person would have been referred to as having recovered from that injury. The bio-medical model has also referred to mental illnesses as a result of brain abnormalities and emphasizes pharmacological treatment (Deacon, 2013). A critical issue with this particular concept's definitional ambiguity is the fact that mental health issues are treated in both the bio-medical system and recovery oriented systems and according to Phillip, these two systems view the concept of recovery very differently.

The front line worker from the biomedical model did not see an improvement in access to services. For him, there was a high demand in his work that was not being met, which he felt could be improved by increasing the number of beds in psychiatric facilities. He was observing that resources were slowly shifting towards recovery-oriented services, and, as a result, action to improve psychiatric facilities seemed to have stalled. An examination of the province's health care expenditures was not able to confirm this statement because the specific allocations for institutional versus community care were not listed. However, expenditures for Selkirk Mental Health Centre were listed and these illustrated small increases to the Centre's funding each year from 2008 to 2017 (Manitoba Finance, 2008; Manitoba Finance, 2009; Manitoba Finance, 2010a; Manitoba Finance, 2011a; Manitoba Finance, 2012a; Manitoba Finance, 2013a; Manitoba Finance, 2014a; Manitoba Finance, 2015a; Manitoba Finance, 2016a; Manitoba Finance, 2017). While this does not discount the statement from the bio-medically oriented front line worker, it does show that resources have continued to increase, at least for certain institutions. So, even these different systems in which health professionals find themselves lead to different

interpretations of how well characteristics like access to services are being improved. While this narrator wanted to see more beds in psychiatric facilities, another narrator from the recovery-oriented system wanted to see resources shifted from institutions like these to community-based services. While staff members from different departments, sectors, or frameworks seem to agree that we need to improve mental health, there is a lot of disagreement on how to achieve that goal.

Theme's relationship to theory.

The complexity and lack of coordination within Manitoba's mental health system would be contributing factors as to why there appeared to be a lack of implementation seen with this strategy. According to the Advocacy Coalition Framework (Sabatier, 1986), Manitoba's mental health system would be identified as the policy subsystem. Within the subsystem various advocacy coalitions reside, which for the purpose of Manitoba's mental health policy subsystem would be composed of all the different departments and public, private, non-profit, self help organizations described earlier, which engage in coordinated activity over time (Sabatier, 1988). It is the organization of these groups and the coordination of their resources and strategies that increase a policy's level of implementation success (Weible & Sabatier, 2007). The various coalitions in Manitoba's policy subsystem were not engaged in coordinated activity over time and interviewees reported feeling that the implementation needed to achieve the goals set out in the strategy was not achieved. It was suggested by a number of narrators that the presence of an effective advocacy coalition might have facilitated higher implementation success.

The definitional ambiguity found in Manitoba's mental health system also relates to the ACF's premise that coalitions are organized around beliefs. According to the ACF, each coalition will aim to turn its beliefs, value priorities, and perceptions of causal relationships into policy (Sabatier, 1988). This study made clear that there are many competing interests across

various government departments, different ideas of what constitutes recovery across the mental health system, and perceptions of what the best approaches for improving mental health policies and treatment are. It was clear how these belief systems are the integrative elements of these groups, like the bio-medical versus recovery-oriented practices, and how this adds to the dichotomies, fragmentation, and complexity of Manitoba's mental health system.

Theme 4: Applicability to Front Line Practice.

A fourth theme that emerged from the data was how applicable this strategy is to front-line practice. This theme was common among the front line workers in this study and was also raised by a policy maker who had experience using the strategy in her role and in ensuring that organizational policies reached front line workers in her practice. Two respondents saw this strategy as something of value that they adopted in their own practices, while another two front line respondents did not see this as a valuable document for their practice. Either way, each of these respondents saw challenges in implementing this strategy in front line practice and described a disconnect between the policy goals and the realities of front line practice.

One of the challenges that came with implementing the strategy into front line practice was the lack of guidance on how to implement it. As one narrator expressed, it would have been beneficial to have instructions on how to implement these principles rather than all policy implementation actors being left to their own interpretations of what the strategy meant and how to implement it. Without this implementation plan, front line workers were left to choose whether or not to adopt the strategy and had to figure out their own ways to incorporate the strategy into their practice, which could lead to inconsistencies in implementation. Other challenges to front line implementation were in relation to the content of the strategy. There was evidence that some components of the strategy that were implemented were presented to certain

members of the mental health system. As one front line worker expressed, a program she was introduced to from the strategy was not applicable to her practice. She was being trained in mental health promotion exercises, like breathing exercises, which she explained were unrealistic strategies for the high needs of the clients with whom she was dealing. She saw this as more of a focus on upper management's goals rather than the realities of the problems with which her clients were dealing; this reflects a disconnection between policy and practice.

This disconnection has also been found with the inconsistencies between existing legislation and the goals of the strategy, which can restrict front line workers' ability to implement the strategy. For example, the Mental Health Act lays out situations in which physicians can involuntarily admit someone to a psychiatric facility and essentially take some of their civil liberties away; this acts in stark contrast to recovery oriented principles. These principles would not be applicable to front-line workers who find themselves in this role. While not all front line workers would find themselves in these situations and may be better able to incorporate recovery oriented principles into their practice, this issue highlights a disconnect between policy making and the realities that occur in front-line practice.

Similarly, there were inconsistencies found between bio-medical mental health practice and this strategy. The front line worker from the bio-medical system saw himself as not being able to adopt recovery oriented services within the scope of his practice. To him this strategy was simply rhetoric; it was nice sounding policy that had no applicable significance for his practice. This had a lot to do with his role and the hierarchy he spoke of within the system in which he was working. Treatment decisions came from psychiatrists, whom he implied subscribed to bio-medical principles over recovery-oriented principles. He also noted how his role was limited to conducting assessments and discharge planning, where he did not feel recovery oriented

principles could be incorporated. It could certainly be argued that recovery oriented principles be incorporated into discharge planning, but this reflects on an experience of a front-line worker who has recognized the disconnection between the work he was doing and the strategies outlined in *Rising to the Challenge*.

There was also an inconsistency found in how front line workers saw the strategy being implemented into their practice. The policy maker who reported having incorporated the strategy in her practice reported using it to guide the development of policies rather than using it as a strategy to work on the front lines with mental health service users. This seemed to be of value for her, which suggests that this strategy ended up serving more to assist further planning than it did to provide specified actions to improve the mental health of Manitobans directly through mental health practice.

Theme's relationship to theory.

One of the reasons why Sabatier (1986) used a synthesis approach to implementation was because of the value he saw in the resources and knowledge of front line workers. By using the bottom-up units of analysis he was able to incorporate the perspectives and strategies of those who were closest to the problem. Based on the responses in this study, it did not seem that the front-line workers, representing the bottom up units of analysis, were incorporated into implementation planning. While the strategy did describe using a variety of stakeholders in the development of the policy, it may have fallen short in not using front line workers to help specifically plan how they could translate the principles and actions of the strategy into practice.

The importance of using front line worker perspectives in implementation planning was also highlighted in Sabatier's work on advocacy coalitions (Sabatier, 1986). Front line workers work within the mental health policy subsystem and would be attached, whether officially or

unofficially, to a certain coalition based on their values and beliefs. According to the ACF, seeking out allies with similar policy goals and coordinating their actions helps advocacy coalitions to improve their strategies and learn how to work with competing coalitions, and, in turn, increase their levels of success (Weible & Sabatier, 2007). It would appear that seeking out the knowledge of the front line workers in Manitoba's mental health system and organizing the knowledge and resources at their disposal, could have helped implement this strategy's policy ideas into practice.

Theme 5: Time Constraints.

Another barrier that front-line workers reported in implementing this strategy was the lack of time they had to do so. All of the front line workers involved with this study reported having very busy caseloads, and this impeded their ability to implement the strategy. The results suggest that it comes down to a choice between taking time to read a strategy and figuring out how you are going to change your work to reflect the strategy's principles or using that time to help your clients in need. It appeared to be a prioritizing conflict in which reading a strategy like this one would get further and further down front line workers' lists of things to do as they have to prioritize the immediate needs of their clients. Attempts to inform front line workers about the strategy may have gone unnoticed; one worker explained how even if it had been sent in an e-mail, he likely would have ignored it, having so many other things to do. Another participant who attended the forum that presented the strategy to her organization saw attendance as a challenge since she had to arrange coverage to make sure her clients were taken care of in order for her to attend any sort of professional development meetings. Implementing a policy that is going to create changes in front line practice was challenging, given the high case loads that

virtually all front line workers had. This factor must be considered in creating implementation plans for strategies intended to reach the front lines.

This was not the only reason why time constraints were found to be a challenge. This also relates to the five-year timeline given for implementing the policy. Three of the respondents in the study noted how five years was not enough time to implement a policy aimed at system transformation. One respondent noted how she felt like the Government of Manitoba had barely got started with implementing Rising to the Challenge as of 2016. In order for the goals and directions to be followed through with concrete plans, a longer timeline was needed. It was suggested by two respondents that a ten year plan would have been much more realistic. An implementation plan for a strategy that is as broad as Rising to the Challenge would need to consider allocating a significant period of time in order for it to begin reaching its goals.

Theme's relationship to theory.

The challenge that the respondents reported with the time frame given for the policy was also reflected in Sabatier's (Sabatier, 1986) synthesis framework. He explained how the time frames set in most implementation studies of around five years are not long enough to see policy change occur. Five year time frames lead to premature judgments of policy while time frames of ten years or more allow for time to identify problems in implementation and to develop strategies to fix them (Mazmanian & Sabatier, 1983). The five-year time frame given for this study may have contributed to why a lack of policy change occurred with this strategy. There was not enough time for changes in the policy subsystem to be identified and revisions made to the policy to reflect those changes. Respondents identified how a longer time frame would have been useful to work towards the broad scale changes that they were looking for from this strategy.

The ability to identify problems and make revisions in order to improve the policy implementation process also relates to Sabatier's (Sabatier, 1986) concept of policy-oriented learning. Policy-oriented learning refers to the continuous alterations of thought and behavior resulting from experience in terms of the attainment or revision of policy objectives (Hecl, 1974), which is much more likely to occur with an extended period of time. The theory would suggest that this policy's time frame would not have allowed for improving the understanding of what variables will meet the policy's objectives, to reexamine any inaccurate assumptions a coalition may hold in its policy beliefs, and to identify and respond to unexpected changes that may occur within the mental health system during the implementation period (Sabatier, 1988). The opportunities to perceive and respond to these changes would have been increased for this strategy if policy-oriented learning occurred, given a longer time frame.

Theme 6: Organizational Culture of Support.

As was seen with the previous theme, time constraints challenge a front line worker's ability to take the needed time to read and find ways to adopt the strategy. It becomes even more unlikely for them to do this if the organization they work for is not encouraging them to do so. This brings us to the sixth theme that emerged from the narrators, having an organizational culture of support. Two of the respondents reported the lack of a culture of support within their organizations as a barrier to implementation. For one front line worker, the strategy was introduced to her, but there was nothing set in place for her organization to ensure that workers were using this strategy in their work or to support them in using it. The other front line worker was not introduced to the strategy and he attributed this to his work in the bio-medical system, which he saw as not as supportive of the strategy's guiding principles, such as recovery. Aside from the policy goals being less valued, he felt that his position was also less valued because he

was not communicated with on policy issues like this, nor was he encouraged to attend professional development trainings where he may have learned about this strategy. It was clear that in instances where organizational support of Rising to the Challenge did not exist, this created a barrier to implementation.

The lack of organizational support experienced by these respondents was not consistent among all respondents. Some front line workers felt that they experienced more of a culture of support. For one worker whose organization did not specifically encourage the implementation of the strategy, it did guide staff work by some of the principles that the strategy uses, such as recovery and the whole population approach to mental health. There were conversations about the strategy itself and the narrator felt supported in wanting to adopt the strategy into her own practice; she attributed this support to her organization's adoption of similar strategic principles. Another front line worker reported attending a forum where the regional health authority that she worked for promoted Rising to the Challenge. This is an indicator that this organization supported the strategy and was creating an environment in which its workers could become informed about the strategy. The narrator also saw her organization as more supportive of this strategy because of its recovery-oriented work and work in reducing stigma.

It seems that the organizations that were more supportive of this may have been so because their organizational values already aligned with those of the strategy. The extent of support also seemed to end at the guiding principles and there was less support for the specific actions proposed in the strategy. Respondents had recommended having more organizational support to facilitate implementation of the strategy in terms of having a team oriented approach to determining how to directly implement the strategy into practice; as well as having managerial support to ensure implementation through facilitating factors, such as training programs or

organizational protocols. While there was variation among respondents in terms of their organization's levels of support for the strategy, it was clear that not having the support created a barrier to implementation and that supportive environments can facilitate implementation.

Theme's relationship to theory.

The benefits of organizational cultures of support are also reiterated in Sabatier's (Sabatier, 1986) Advocacy Coalition Framework. One of the concepts included in his framework is in regards to the belief systems that hold a coalition together. According to Sabatier it is the organization and the shared beliefs towards common policy goals that are essential to effective implementation (Sabatier, 1986). These belief systems are evident in organizations and necessary for them to push policy ideas or agendas forward. If an organization includes a variety of actors with different policy beliefs regarding Rising to the Challenge, it is unlikely that the strategy will be pushed forward effectively. However, if there is a critical mass of formal and informal leaders who highly value a policy like this one and organize to see it pushed forward, it will have a higher likelihood of implementation.

Theme 7: Policy Role.

A challenge highlighted in creating this organizational culture of support is when various policy actors perceive the policy differently. The seventh theme that emerged from this study was the perception of the policy's role. It was clear from the interviews that the narrators had different ideas of what this strategy's role was and what it was intended to do. For some it was described as a directional planning document; something that outlined a philosophy and the principles that should guide our mental health system and connect the organizations within it. Others viewed the strategy as more of an action plan with specific actions that could be

implemented. Having this lack of consensus on the policy's role would certainly alter the implementation of this strategy. On one hand, staff used this as a tool to guide whatever work they were already doing in perhaps a different way based on the philosophy and principles outlined in the strategy. On the other hand, staff used it to implement the specific strategic actions that were articulated under each goal and objective in the strategy.

There was evidence of both of these perceptions in this strategy's implementation. One of the policy makers mentioned how she directly used the strategy as a guiding document for informing new policies she would formulate for her organization. So, anything new that would come from her work was meant to align with the principles of the document. Other respondents made note of specific changes in the mental health system that they saw as connected to this strategy. For example, some saw an improvement in access to services and mental health promotion. However, it was unclear to these respondents whether these changes were directly a result of the strategy or if the strategy simply set the stage for these activities to occur. There were more specific examples where funding was made available for specific actions to take place. One was the development of the Provincial Recovery Champions group, which was said to have only been made possible as a result of this strategy. Other respondents pointed to Rising to the Challenge's Summary of Achievement Reports to describe all of the specific actions that occurred as a result of implementing the strategic actions outlined in the strategy.

While there were different perspectives on whether this strategy served more as a guiding philosophical document or a measurable action plan, both perspectives provided evidence of implementation. Each perspective saw the strategy moving the system forward in different ways. The challenge in these different perspectives of the policy's role comes with the inevitable differences in perspectives of what the policy actors view their roles in implementation to be.

Some might see their role as using one of the strategy's key pillars, like mental health promotion, as a guiding principle where they may have changed their thoughts from a more illness based orientation to the whole population approach to mental health promotion. On the other hand, other staff may view their role in implementing this strategy in a more specific way, like using mental health promotion techniques with their clients on a day-to-day basis. While both perspectives may have implemented mental health promotion, the degree to which this is done is inconsistent and will not likely have the same impact. Using mental health promotion as a guiding principle may have macro-level impacts, such as reducing stigma or changing someone's perspective on how health authorities should be addressing mental health problems. Using mental health promotion techniques with clients may be more likely to have micro-level impacts, such as helping a person develop coping strategies or helping a person take an active role in her or his own treatment.

Theme's relationship to theory.

The different perspectives on the policy's role relate to the coalitions in Sabatier's (1986) framework and how their policy beliefs tie them together. It specifically relates to a coalition's policy core beliefs and the secondary aspects of a coalitions belief system. Policy core beliefs include the fundamental positions on policy strategy (Sabatier, 1986). A group's strategy for implementation will vary greatly if the policy's role is viewed as philosophical rather than as composed of specific actions to be implemented. Do staff need to just change the way that they think or do they have to change specific practices in their day to day work? The secondary aspects of a coalition's belief system include instrumental decisions to see a policy through, such as how a budget is allocated or what kind of human or technical resources are needed (Sabatier, 1986). If a policy is philosophical in nature and will guide similar work in a different direction, it

is less likely to require a change in policy instruments. Whereas a policy document with strategic actions will require funding for new programs, mental health professionals to operate those programs, or resources for professionals to understand how to adopt new practices into their work. Since both perspectives aligned with the strategy, the different policy beliefs regarding the role of this strategy that were evident in this study did not appear to drastically alter the course of its implementation in different directions. However, more consistent perceptions of the policy and its role may have led to a more coordinated approach to implementation and more deliverable outputs for Manitoba's mental health system.

Theme 8: Evaluation.

As was seen in the previous theme, different perspectives on the policy's role presented themselves. Different perspectives on what the policy is intended to do inevitably lead to different ideas of what the outcomes are supposed to look like. This leads to the eighth theme that emerged from the narratives, evaluation.

There were different perspectives among the respondents regarding how successful they thought the strategy was, but most respondents did not see the strategy as going very far. Overall, it was seen as a valuable document that "lost its legs" and now just "sits on a shelf". Implementation was not seen to have been followed through, nor did there appear to be any evaluation measures to ensure that it had been.

Implementation seemed to go as far as creating working groups to create action plans for making the strategic actions of the strategy more practical and specific. However, there was not a plan put in place to monitor this process, which likely led to its "fizzling out", as one respondent noted. Along with the lack of implementation process monitoring, there also were not any compliance measures or incentives for organizations to adopt the principles, goals, and

objectives of this strategy. It seems that without these measures, potential implementation actors may read the policy, then forget about it.

It can also be a great challenge to develop evaluation protocols for mental health policy, which would certainly present itself in a strategy as broad as this one. If we are looking to transform Manitoba's mental health system, what outcomes are we looking for and how will we know when we have accomplished them? How will we know what exactly contributed to outcomes? Is the goal to adopt a recovery-oriented framework successful if more organizations work from this framework, or is it not successful until recovery overrides the bio-medical mental health system? The complexities of determining what outcomes indicate a policy's success and how exactly to measure and monitor those indicators is certainly a major challenge in the mental health field and may have contributed to why there was a lack of monitoring and compliance measures for its implementation process.

While measurement was not prominent in this strategy's implementation and implementation was not seen to have been followed through, two reports were presented that summarized the achievements of this strategy for the first two years of its existence. Some narrators saw these reports as evidence that there was some success from the strategy, while others did not see these same achievements as a result of the strategy. Certain achievements, like the mental health court in Winnipeg, were said to have predated the strategy; as well, ideas like addressing the social determinants of mental health were already known to be best practices and practitioners were already acting on this. One narrator described the reports as "a bit of a misnomer" because it appeared that new developments that emerged in the mental health system after this strategy came out, were attributed to the strategy, rather than being developed as a

result the strategy. It was clear from the interview responses that the summary of achievement reports did not paint an accurate picture based on an evaluation process.

Many of the narrators described evaluation as important to the implementation process. Measuring outcomes and having a timeline were seen as important factors for tracking progress. The five-year time line could have been used not as an end point but to gauge how far government has gotten and to propose how government will continue to move the system forward based on the results that it has seen. It was also noted by a few narrators that policy change and the evaluation of it are evolving processes, where through a process of feedback we can constantly be learning how things are working or not working and refine our approach based on what is being found. Evaluation in this sense may not be an absolute measure of success or failure, but a learning process to guide system improvement over time.

Theme's relationship to theory.

Evaluation directly ties into one of the critical components of Sabatier's (1988) advocacy coalition framework, policy oriented learning. It refers to the learning that occurs throughout implementation as a result of experience. Through the use of feedback loops in Sabatier's framework, we learn how a policy's objectives are being implemented with the resources and strategies of different policy actors, how these are translating into practice, and how different environmental factors, like tragic events in the news or changes in government, affect the policy's implementation (Hecl, 1974; Sabatier, 1988). The key is in learning from this process and finding solutions which may lead to revisions in the policy that better suit the policy environment.

This process was not evident in the implementation of Manitoba's mental health strategic plan. It was referred to as losing its legs and sitting on a shelf, which represents a lack of

continuous learning and revision from what did not work. It appears that a number of factors that impeded this strategy's implementation put an end to the strategy, rather than acting as sources of learning leading to adjustment of the policy response accordingly. The five-year time frame allotted to this strategy also reduces the likelihood of policy oriented learning to occur. Five years is quite a short time to implement a policy, see some preliminary results, and revise the strategy if needed. Sabatier would suggest a period of ten years or more in order to allow for that process to occur and for learning to occur from continuous feedback loops over time. That being said, there was some evidence of those who had reported using this strategy's guiding principles in their day-to-day work. While there was no formalized evaluation process to monitor their adoption of the strategy, their commitment likely led to figuring out how to individually implement the strategy and have the power to adjust their approach based on experience.

Theme 9: Financial Resources.

Based on some of the evidence that arose in the discussion about evaluation some activities seem to have occurred as a result of the strategy and some did not. So, what was it that contributed to this variation in implementation? This leads us to the ninth theme, financial resources. This theme was frequently discussed among all of the public policy makers and administrators in this study. It was not a commonly discussed theme among front line workers, which can be attributed to the fact that their roles are not tied to determining how funds are distributed within the province and within organizations involved in the mental health system.

It was identified by each respondent that spoke to this theme that there is a significant lack of funding for mental health services in Manitoba and this lack of funding is a major barrier to implementing mental health policy. During this policy's time frame there was no specified mental health transfer funding available from the federal government, so aside from what is

regularly given for mental health through the Canada Health Transfer and the Canada Social Transfer as was described in the critical analysis of the strategy document section, the responsibility for funding this strategy was up to the province. Respondents identified how far off the mark Manitoba is in its funding of mental health services in the province. Manitoba was identified to spend 5% of its health care budget on mental health, which paled in comparison to other provinces in a country that pales in comparison to other G8 countries in terms of their mental health funding. It became clear that most negative interpretations of the implementation of this policy were less a result of the strategy itself and more because of the lack of financial capacity to achieve its broad, system transformative goals.

Aside from the clear deficiency of funding that is regularly provided for mental health services in Manitoba, it was also found that the practices used with the limited funding that was made available were ineffective. First of all, it was not made clear to those involved with the development of the strategy how much money would be allocated to the strategy's implementation or for what it would be used. The approach used with the limited amount of funding allocated was to pick pieces of the strategy to fund rather having a comprehensive funding approach to support the strategy in its entirety. This leads to a couple of questions. Why develop a strategy based on system transformation if you are only going to provide funding for a couple of programs? Why decide to create a strategy at all when you do not allocate the resources to implement it?

One respondent brought up the issue of how political factors tie into this factor. Creating the strategy for system change creates positive political appearances for the government supporting it. By funding a few programs, it creates the appearance of investment and communicates to the public that political promises are being followed through. This, of course, is

dependant on the public not fully understanding the scope of these issues and the resources needed to see these promises through to the scale that they were designed to meet.

With the deficiency of funding available for mental health services, funding new initiatives often occurs by reinvesting resources that always existed in the mental health system. This is a challenge because this often means that to open one door we have to close another. Programs may have to be shut down in order to provide the funding for another program to occur. This is not a sustainable way to fund a province's mental health system.

Closely related to providing financial resources for the implementation of this strategy comes the human resources that are also needed. It was noted that there were shortages of mental health professionals in certain areas, such as geriatric mental health as well as child and adolescent mental health. It is essential to have the right professionals in place at the right time for new mental health programs and initiatives to emerge as a result of the strategy. Even if financial resources were provided by the province to fund this strategy, we need the mental health care professionals there to see it through. Aside from providing funding to hire new professionals; this also includes increasing the numbers of students entering mental health educational training programs as well as providing training for current mental health professionals in ensuring their practices align with the principles and goals of the strategy, for example, making sure they can provide culturally competent recovery oriented services.

The importance of financial resources was also highlighted in the elements of the strategy that were found to be successful. There was evidence of some limited funding being provided to certain activities in the strategy, which enabled those activities to be implemented. Some of the activities reported in the summary of achievement reports (Manitoba Healthy Living and Seniors, 2012; Manitoba Healthy Living and Seniors, 2014) were examples of where funding

occurred to facilitate their success. In an examination of the Government of Manitoba's estimates and expenditure reports from the three years predating the strategy to the most current 2017 report, it was found that there was one notable change to the funding for the Mental Health and Spiritual Health Care Branch over the course of the strategy. In 2010, Mental Health and Spiritual Health was allocated \$3,790,000 (Manitoba Finance, 2010a); in 2008 and 2009, Mental Health and Spiritual Health were combined with addictions and had a higher budget, so it is not clear how much would have been allocated to the branch alone. The notable change occurred in 2011 when the strategy was introduced; there was an increase to Mental Health and Spiritual Health to \$5,508,000 (Manitoba Finance, 2011a). For the remaining years of the strategy's implementation, funding remained at a relatively stable amount between \$4,818,000 and \$5,198,000 (Manitoba Finance, 2012a; Manitoba Finance, 2013a; Manitoba Finance, 2014a; Manitoba Finance, 2015a; Manitoba Finance, 2016a). *Rising to the Challenge* was not specifically mentioned in these documents, but the increase in funding in 2011 may help explain the limited funding that was described by interviewees to fund certain activities from the strategy.

Respondents also identified other areas of success in the strategy. There were many activities in the strategy that were considered cost neutral activities, such as social inclusion, family participation, and recovery. While it is beneficial that movement could be made in these areas without significant funding, it does not quite accomplish what the strategy set out to do. The potential for mental health professionals to adopt the principles of the strategy existed; however, the potential to transform and expand the mental health system is stifled without significant investment.

A way to work with the limitations of funding in the mental health system was identified by a few narrators, and this was to reallocate existing funds. Most often, those responsible for determining where the limited mental health funding will be spent have to figure out the most cost effective ways to move existing funds around, without alienating stakeholders and jeopardizing the government's relationships with them. Sometimes this means that tough decisions need to be made on what services need to close down and how they can use that money in a better way. While this may be a facilitating factor for new programs, it may mean reducing other services that were helpful to people, even if they are found to not be as cost effective. Lillian provided an example of one such reduction of services with the closure of beds at the Grace Hospital. It was also suggested that having a better approach to cost sharing across departments would help in this process of reallocating funds and would help unload some of the burden to other departments that work significantly on mental health issues. An example was used involving the mental health court because it saves resources for the justice system; but these resources are not reinvested into the mental health system. Paying for the development and maintenance of programs and reallocating funds cross-departmentally reflects the collaborative approach needed to reduce the financial strain on the mental health system.

With all of the issues that were identified relating to the financial resource barrier to implementation, it was clear and identified in the interviews that a large overall investment was needed to improve Manitoba's mental health system. Without it, it becomes nearly impossible to make any significant advancement in any mental health area. A recommendation from a couple of narrators was to foster more public policy advocates. We need more people who are willing to speak out and advocate for better provincial and federal funding and more effective advocacy coalitions to support the improvements we need for Manitoba's mental health system.

Theme's relationship to theory.

In Sabatier's Advocacy Coalition Framework (Sabatier, 1986), financial resources constitute an important variable occurring inside and outside of a given subsystem. Changes in a budget would be an example of an external event that can significantly increase or decrease the ability to work towards policy solutions (Weible et al., 2009). While there appears to not have been a change in Manitoba's mental health budget based on the review of the government expenditure documents, the low levels of funding available limits the capacity for this policy to be implemented and increases the range of barriers that implementers encountered as government tries to enact the policy's strategic actions. As we will see in the following theme, other external variables also affect financial resources. Mental health stigma still exists and effects political decisions and resource allocation. A number of the interviewees suggested that reducing the constraints of external variables like stigma would create changes in the political environment that may allow for more financial resources and subsequently for more policy objectives to be met. It was also suggested that the presence of effective advocacy coalitions could have facilitated pressure on the government to secure more funding for the implementation of this strategy.

Theme 10: Public and Political Support.

This leads us into the next theme to arise from the data, public and political support. The public and political support theme refers to issues related to the support needed to facilitate policy change and higher levels of financial resources. It was clear from the respondents that this support is needed to facilitate the motivation needed to increase the allocation of resources. This kind of support in the interview data included political and public support as two elements, yet are closely linked to one another.

In terms of political support, it is crucial to have government support because government is in control of the province's finances and makes the final decisions on how resources will be expended. So, it is clear that there was some level of support from the provincial government since it made the decision to develop a mental health strategy, but the lack of comprehensive investment indicates that this support only went so far. Since *Rising to the Challenge* was a provincial strategy, it was up to the provincial government to provide the funding for it; a government's willingness to do this depends on what its priorities are. The lack of funding indicates that this was not a major priority, which was a significant barrier to implementation.

It was also made clear by the narrators how challenging it is to secure this political support. One reason for this is that even if there are politicians who are advocating for these changes, they have to compete for funding with other departments, which are advocating for funding to manage the myriad of other problems facing the province. Another reason for this is that political support is challenged by stigma. If those who are in control of the province's resources have negative views towards mental illness they will be less likely to support those initiatives. This was made clear by one of the policy makers who noted how much harder it is to convince a government to fund a new psychiatric drug than it is to convince it to fund a new chemotherapy drug for cancer.

In order to create the support needed to facilitate more funding, the support of the public is needed, which ties in closely with political support. Public support is needed to influence political priorities and platforms. Public social outcry and a public social movement are needed in order to rally more political attention to the issue. If people do not speak out about how mental health issues are important to them and demand the resources that are required to make advancements in this field, politicians will give their attention to other issues that appear more

prominent for the public. It is unlikely that politicians will champion mental health issues on their own volition when union leaders are protesting for the rights of workers, when post-secondary students are speaking out about the need for universal education, or when families are rallying against the rise of drugs and overdoses in the province. When it comes to political support, the squeaky wheel gets the grease. The more public outcry we have, the more political support an issue will have, and the more resources will be allocated to it.

Unfortunately public support is also greatly impacted by stigma. The media play a significant role in shaping public opinion, but quite often stories involving mental health highlight tragic events. More often than not these stories reinforce stigma and push public perceptions, and subsequently political perceptions, in the wrong direction (Baun, 2009; Edney, 2004). Politicians may also receive less support from the public and from their colleagues for mental health expenditures because of the stigmatizing status of mental health. In order to move in a more positive direction we need to mobilize the public and mobilize government. Public and political advocacy are essential for reducing the stigma that influences the public and for making mental health a political priority.

Theme's relationship to theory.

The variables of public support and political support in this theme play a significant role in both the policy subsystem and the external environment in Sabatier's (1986) Advocacy Coalition Framework. The relatively stable parameters in the framework include variables like the basic attributes of the problem area and fundamental socio-cultural values. This directly relates to how a community or a province generally views mental health and the degree to which it believes it is an issue to address. This affects both the external system events and the long-term coalition opportunity structures. The external system events include changes in public opinion,

which may occur as the result of a tragic event. In terms of the long-term coalition opportunity structures, the degree of consensus needed is important for major policy change as is the openness of political systems; in this sense, it would be best if all stakeholders and members of the public agreed on mental health policy issues and could use this consensus as an opportunity in which to influence the government in regard to such policy.

All of these external events that we have seen with this strategy (stigma, tragic events, and a lack of political support) also affect the fourth environmental factor in Sabatier's (1986) framework, the short-term constraints and resources of subsystem actors. Each of those variables puts constraints on policy actors' abilities to push their agenda forward and reduces the likelihood that they will have the budget they need to accomplish their goals. Each of these external issues cycles into the policy subsystem as policy responses are developed. The work that advocacy coalitions do is guided by their belief systems and their resources, and the outputs and outcomes of the policies put forward will be a reflection of those inputs and the broader environment. But, as Sabatier shows, this is a continuous cycle that unfolds over time; as policies are implemented, changes can occur in the environment. If there is a reduction in stigma, more positive public opinion, and more political support, implementation actors will be less constrained and will have more resources to implement mental health policies effectively.

Theme 11: Leadership.

As we learned in the last theme, external mental health advocacy is crucial for creating the support needed to influence public and political opinion, and we need people willing to lead that charge. The final theme that emerged from the data was leadership. There were a number of examples that came up that illustrated leadership as a facilitating factor in implementing the mental health strategy. Administrators and front line workers who saw value in this strategy,

took the initiative to implement the strategy by taking their own time to read it and adjusting their own practices to reflect its values and goals. Learning how to work in a more recovery oriented way, hiring peer support workers, and including people with lived experience and family members in policy and organizational decisions were all methods used that indicate parts of the strategy were implemented. While there were a limited number of interview participants in this study, the data showed more evidence of implementation at an individual grassroots level, than as an organized system wide process of implementation. However, while there were a couple of respondents who reported feeling somewhat supported by their organizations in adopting the strategy, there did not appear to be a committed policy champion ensuring that the policy was being followed through and implemented properly. The evidence of leadership in this study consisted of workers adopting the strategy's principles on an individual basis.

There was a deviation in the perception of implementation between some administrators and front line workers and the policy makers involved in the development of this strategy. Many policy makers perceived this strategy as having not been implemented and falling off the table; however, as a result of the leadership shown by dedicated workers in the mental health system, implementation within a more limited sphere was made possible. While the impacts of this implementation may not be as transformative as the strategy's original intention, even these small changes may have made significant impacts in the lives of clients receiving services from these dedicated workers.

Aside from the evidence of leadership that did occur, leadership was seen as an important factor that is needed to move a mental health system forward. The term policy champion came up a couple of times in reference to the need for strong leaders who are committed to the policy and could provide focused direction to its implementation at policy levels, organizational levels,

and front line levels. Some respondents had specific suggestions for what is needed in a strong advocate, such as having political allies with political will and a strong awareness of the health budget, or having someone from an external mental health organization who can push more than those who work directly for government. Whatever kind of advocates they may be, the leadership component of these advocacy activities was certainly viewed as a facilitating factor for implementing mental health policy.

Theme's relationship to theory.

Leadership relates to the Advocacy Coalition Framework (Sabatier, 1986) in terms of the external events that affect implementation and policy oriented learning, and how coalitions are organized. Leadership affects the environment in which the policy subsystem operates. Just as public opinion and stigma can impact policy change over time, the opposite effect that comes from dedicated leadership in influencing policy turning into practice would also impact the policy subsystem in a more positive way. Leadership also leads to a decreased likelihood of the policy falling off the table and an increase in the cycles of the policy going through the advocacy framework. Policy champions would play an important role in learning from the implementation experience, discovering what is working and what is not working, and leading the efforts to reformulate the policy to continue to make it better. Sabatier's (1986) theory also describes how the organization and coordination of an advocacy coalition's beliefs and strategies are essential for implementation (Sabatier, 1986). The Advocacy Coalition might suggest that a lack of leadership in this strategy's implementation contributed to the reason why coordinated coalitions did not emerge. Dedicated leadership is needed in a coalition to ensure that this organization and coordination occur. Having strong leadership responsibilities within provincial government

structures, among Cabinet Ministers and senior government officials, would be integral in facilitating this process.

Table 2 describes the distribution of themes across the narratives. The most common theme discussed by the narrators was policy design. All policy makers and administrators, as well as half of the front line workers made comments related to this theme. This highlights the importance, across implementation levels, of having a well-informed document with clear goals. Two other common themes were the need for a cross-departmental approach to implementation and issues regarding time constraints. The cross-departmental approach was noted by all administrators, almost all policy makers, and two front line workers, which suggests system wide recognition of the relationship that mental health has with different departments and jurisdictions. Time constraints were described by a majority of narrators from each implementation level, both in regards to the time frame given to implement the strategy and the time constraints that front line practitioners have to commit to policy implementation. The mental health system complexity theme emerged less frequently than the previous themes, but was also common across all levels, which speaks to the challenges that all implementation levels experienced with coordinating policy change. The leadership theme was also noted less frequently in the narratives but still presented itself across all levels in regards to both advocacy efforts, and having policy champions at policy, administrator, and front line levels.

The evaluation, financial resources, and public and political support themes were common across the policy maker and administrator levels. These themes emerged from virtually all narrators from these levels, and virtually none of the front line workers, aside from one front line worker comment about the importance of evaluation. This is likely due to policy makers and

Table 2: Distribution of themes across narratives

IMPLEMENTATION LEVEL		NARRATIVE											
		1	2	3	4	5	6	7	8	9	10	11	12
Policy	Lillian	X	X	X					X	X	X	X	
Policy	Maria	X			X	X	X	X	X	X			
Policy/Admin	Anna	X	X	X		X		X	X	X	X		
Policy/Admin	Janine	X	X			X			X	X	X	X	
Policy/Admin	Heather	X	X						X	X	X	X	
Admin	Phillip	X	X	X	X	X	X			X	X	X	
FLW/Admin	Peter	X	X	X			X		X				
FLW	Kate	X			X	X	X	X					X
FLW	Rebecca		X	X	X	X	X						
FLW	Michael			X	X	X	X	X					
		Policy Design											
		Cross Departmental Approach											
		Mental Health System Complexity											
		Applicability to Front Line Practice											
		Time Constraints											
		Organizational Culture of Support											
		Policy Role											
		Evaluation											
		Financial Resources											
		Public and Political Support											
		Leadership											

THEME

administrators having responsibilities to engage in evaluation and financial distribution in their roles, as well as benefiting from a strong understanding of how political dynamics impact policy and administrative work. The applicability to front line practice and organizational culture of support themes were much more common among the front line worker narrators than among the policy makers or administrators. This is a reflection of their direct experiences with the impacts that an organization's level of support can have on policy implementation. It also reflects their experiences with how applicable a policy is to the direct work that they do with their clients.

The least common theme across narrators was the policy role theme. Two policy makers and half of the front line workers had comments related to this theme, yet no administrators did. The polarization of these responses symbolizes the disconnect that can occur between the policy making level and the front line level in regards to varying perspectives of a policy's role.

Aside from the distribution of the themes across narratives, they each also carry a weight in terms of how impactful they were to the implementation process. The themes that carried the most weight were financial resources, public and political support, and leadership. Financial resources stood alone as the most significant factor based on it being brought up first by most narrators and because the lack of financial resources essentially prevents strategic actions from coming to fruition. This is also closely tied with public and political support. The lack of political support from those who determine how provincial funds will be spent was a contributing factor for the lack of financial resources. As will be discussed in greater detail in the document analysis, changes in the provincial economy followed by a number of major political decisions and a deteriorating fiscal climate also contributed to the limitations in financial resources. The public support needed to put pressure on the governing party was also lacking, as was made clear with the lack of advocacy coalitions; this also relates to the lack of leadership at the external

advocacy level. Leadership also carried a lot of weight in terms of the lack of policy leadership in the department responsible for the strategy due to human resource turnover, and the facilitation of implementation through leadership at the front line levels. These themes carry the most weight because, without financial resources, public and political support, or leadership, implementation success is very unlikely.

The themes that carried a moderate amount of weight were policy design, mental health system complexity, a cross-departmental approach, and time constraints. The design of the policy was well informed, but lacked a specific implementation plan. This is important, especially for a system as complex as Manitoba's mental health system. This complexity and the lack of a cross-departmental and cross-sectoral approach created significant challenges in moving implementation forward. Having an organizational culture of support within mental health organizations was a facilitating factor for those who had it and a barrier for those who did not. This level of support also impacted how much time was given to front line workers to learn about the strategy and its implementation. Time was also a challenge in terms of the five-year time frame given for implementation and the change in departmental priority that further limited this time. These themes carry a moderate amount of weight because in this case study, they were seen to reduce implementation success, but were not seen as impeding it entirely.

The themes that carried the least weight were evaluation, applicability to front line practice and policy role. Evaluation carried little weight in this study simply because implementation essentially did not get to a point where this response could be adequately evaluated, and because the minimal evaluation efforts that did occur through the summary of achievement reports, carried little weight with narrators. Applicability to front line practice carried little weight because the general consensus was that this strategy, overall, did not reach

the front lines. The policy role theme carried less weight because, while different actors interpreted it differently and may have proceeded with implementation differently, no one deviated strongly from the strategy's pillars and goals. While each of these themes are important factors in implementation, they did not impact implementation as much as the others.

Document Analysis

Attempts to access document sources from the Department of Healthy Living and Seniors, the Winnipeg Regional Health Authority, Manitoba Health, and community organizations were not successful. There was a lack of cooperation from the Department of Healthy Living and Seniors in that it reported how it would not be able to be forthcoming with any document sources. After further attempts to obtain these data the department described how official documentation, such as an organizational chart of the implementation actors, documents with statistical indicators that indicate change related to implementation, documents regarding the policy instruments and resources available to the policy makers and implementers, meeting agendas and minutes, implementation proposals and evaluations did not exist. Meeting notes were said to have been jotted down on a piece of loose leaf and not distributed officially as meeting minutes to the group, with inferences that the whereabouts of these unofficial notes was unknown.

In my communications with staff from WRHA, and community organizations, it was made clear that there was not official documentation from this strategy's implementation. Furthermore, they described how the people involved in the steering committee and working groups have virtually all moved on to different positions, which created a barrier to contacting them to determine if they kept records of any document sources that they may have been able to be provided for analysis in this study. Inquiries were made into the existence of any records or

documents from the interview participants. None of the participants could recall document sources and reported not having any document information to offer to the study. The lack of documentation and record keeping is a problem for implementation in itself. The following documents consist of public documents obtained from the Manitoba government website, newspaper articles, mental health organization reports, scholarly articles, as well as working group documents that were obtained from one of the working groups members.

Provincial Departmental Annual Reviews.

The weight of the departmental responsibility for mental health changed across the timeline of this strategy. In 2010-2011, mental health was described more in the annual report for Manitoba Health, with some mention in the annual report for Manitoba Healthy Living, Youth and Seniors. In 2011-2012, the department name was changed to Manitoba Healthy Living, Seniors and Consumer Affairs and its annual report indicated a higher responsibility for mental health services, while the Manitoba Health annual report for that year only reported on the Selkirk Mental Health Centre. These departmental responsibilities remained the same for 2012-2013. In 2013-2014, the responsibilities remained the same, but the department responsible for mental health changed its name to Manitoba Health, Healthy Living and Seniors. Annual reports for both departments were obtained from 2010-2011 to 2013-2014. In 2014-2015 to 2015-2016 the annual reports for Manitoba Health, Healthy Living and Seniors were amalgamated into one report and were included in this analysis, as well.

These annual reports describe the departmental objectives, expected and actual results, and expenditures for the year for both Manitoba Healthy Living Seniors and Consumer Affairs and for Manitoba Health. The annual reports for Manitoba Health only include the mental health services related to Selkirk Mental Health Centre; this section of these reports describes the

objectives, expected and actual results, and expenditures for the year for Selkirk Mental Health Centre, which remained the same over the timeline of the strategy's implementation. The objectives for the Mental Health and Spiritual Health Care Branch remain the same every year, aside from a couple of changes in language; however the message remains the same across each report.

Manitoba Healthy Living, Youth and Seniors Annual Report 2010-2011.

This annual report reported on a period prior to and during the announcement of the strategy (Manitoba Healthy Living, Youth and Seniors, 2011); it could not show evidence of policy implementation but serves as a baseline to study the following years of annual reports. There was not a heavy focus on mental health in this department's annual report at the time other than stating an objective to enhance positive mental health, among other healthy living activities. One of the results described in this report is the continued expansion of the Manitoba in Motion strategy, a strategy that celebrated its fifth anniversary in 2010 according to the report. In Rising to the Challenge's first summary report of achievements, a 30 second information spot to support mental health through physical activity for Manitoba in Motion was noted as an accomplishment. It is clear that Manitoba in Motion was a strategy in progress prior to Rising to the Challenge. This supports evidence that some of the noted accomplishments pre-dated the strategy; however, it is unclear whether or not Rising to the Challenge influenced Manitoba in Motion to take a mental health angle, or whether this would have happened regardless of the strategy.

Manitoba Health Annual Report 2010-2011.

This report makes mention of the first stages of the provincial mental health strategy in that it was reported that a collaborative process with stakeholders was occurring to validate a

draft of this strategy (Manitoba Health, 2011a). This report also sets the stage for the following years of annual reports. In this report there were a number of activities that were noted to be continuing, including the creation of the Crisis Response Centre, the Mental Health Court, the development of a Northern Youth Crisis Service, and planning for a summer institute through the Co-occurring Disorders initiative. The continuation of this work during 2010-2011 indicates that these activities were ongoing and that Rising to the Challenge served to support these ongoing initiatives rather than initiating them. Each of these activities was also listed in the summary report of achievements in 2012 as being underway, aside from the Mental Health Court and summer institute, which were listed as accomplished.

This report also lists results for suicide prevention that came from the provincial Youth Suicide Prevention Strategy. Many of the initiatives listed here were also listed in Rising to the Challenge's summary report of achievements in year 1. These accomplishments are referred to as being accomplished as a result of two separate strategies. This also lends itself to the argument that the mental health strategy's noted accomplishments were not actually as a result of the strategy, but that the strategy supported ongoing initiatives. The overall strategic directions of Rising to the Challenge do align with the Youth Suicide Prevention strategy; therefore it is not surprising that it would continue this work; however, listing it as accomplishments of two different strategies leads to questions about measurement and evaluation.

Manitoba Healthy Living, Seniors and Consumer Affairs Annual Report 2011-2012.

This annual report describes how Rising to the Challenge was developed during this reporting period (Manitoba Healthy Living, Seniors and Consumer Affairs, 2012). It also describes other activities from this year that reflect some of the goals and objectives of the strategy. It made note of continued work that was also reported in the previous year's annual

report. The department noted that it continued work on the Crisis Response Centre, Mental Health Court, and the planning for the co-occurring disorders summer institute. As with some of the activities from the previous reports, these activities seem to predate the strategy. Considering that they were not specific strategic actions mentioned in the strategy, these activities being listed in the summary of achievement reports shows that these documents reflect activities that align with the strategy rather than being initiated by it.

The only concrete action noted was how the department hosted a Mental Health Summit in Winnipeg, which was also noted in the summary of achievement reports. This activity was not listed as a strategic activity to be accomplished but does align with the mental health promotion pillar. Some new activities were noted to have started during this reporting period, which included work towards providing peer support and public education, improving access to services for Aboriginal youth, the creation of recovery teams, and suicide prevention. While suicide prevention is noted in a couple of strategic actions in the mental health strategy, the activities noted in this annual report relate these activities to the separate Youth Suicide Prevention Strategy. This report certainly indicates that work aligning with Rising to the Challenge continued, as well as new activities initiated that were likely that a result of the strategy. Even though there were no concrete results as this point, it was clear work was being started.

Manitoba Health Annual Report 2011-2012.

Selkirk Mental Health Centre is noted in the strategy as a stakeholder in which innovation and research were to be strengthened, promoted and supported through Rising to the Challenge (Manitoba Health, 2012a). There was evidence of this in this annual report. The report described how audit tools confirmed the use of recovery plans and family participation, which relates to the

recovery pillar. It also provides evidence of implementation for innovation and research, family participation, and workforce development goals. The report also describes how wait times were reduced for admission and discharge through bed utilization strategies, which provides evidence of implementation of the access to services goal. This report provided concrete examples of some areas where the pillars and goals of Rising to the Challenge were implemented.

Manitoba Health Annual Report 2012-2013.

This report identified that wait times had increased for admission to the Selkirk Mental Health Centre due to delayed discharges caused by lack of housing and community supports (Manitoba Health, 2013a). This provides evidence that access was certainly not increased during this reporting period. This is particularly interesting as government documents do not often appear to be critical of their own operations. This is also particularly interesting because one of the interview respondents critiqued Rising to the Challenge for not focusing enough on housing. So while there was some evidence of Rising to the Challenge in the response, unanticipated consequences due to the lack of community supports and housing led to decreased outcomes in other areas of the strategy, like access. This certainly adds to the argument of the interview respondent that there was not enough of a focus on housing and this could be seen as a failure of the strategy.

However, the report did also note how communication and coordination between service providers was happening in order to strategically work to reduce wait times. The department's response to this problem does reflect the knowledge exchange and collaboration as noted in the innovation and research goal of Rising to the Challenge. This report also noted that technology was used to engage more staff in strategic planning activities and to keep staff informed about new initiatives and projects. It is not clear whether this was used to promote Rising to the

Challenge, but it does relate to the knowledge exchange and collaboration strategic actions of the strategy and indicates some forward movement in this area.

Manitoba Healthy Living, Seniors and Consumer Affairs Annual Report 2012-2013.

This annual report's specific mention of Rising to the Challenge describes how, during this reporting period, the Mental Health and Spiritual Health Care Branch worked with stakeholders to develop recommendations for implementation (Manitoba Healthy Living, Seniors and Consumer Affairs, 2013). The timeline allocated for this strategy is limited as is and in the second year of this strategy's implementation it appears that implementers are still trying to figure out how to implement it. This also provides support for the notion that the results noted prior to this and the results noted within this annual report were not a result of Rising to the Challenge, since the implementation plan was not yet up and running.

More evidence was noted in this report about activities that were in line with Rising to the Challenge. Work began on increasing access for children and youth, which related to the access goal. Plans to provide funding for Mental Health First Aid were finalized, which helped support the mental health promotion and workforce development goals. The department continued working to provide peer support workers and public education, which relates to mental health promotion and workforce development. The department continued work to increase access for Aboriginal youth by continuing the planning for a Northern Youth Crisis Service, which relates to the access goal. Similar to the previous year's report, this one notes continued work towards the Crisis Response Centre.

Two things that were accomplished this year were the opening of the Mental Health Court, which began seeing cases in this year and the delivery of the co-occurring disorders summer institute. Both of these were ongoing prior to the strategy, but were also noted as

accomplishments of Rising to the Challenge. Similar to last year's report the Youth Suicide Prevention Strategy provided funding for many programs that align with Rising to the Challenge's suicide prevention strategic actions. If funding was provided by this previous strategy, it is hard to attribute the success of these programs to Rising to the Challenge. This year's report described the recovery teams, again, which relates to the recovery pillar; however this year they were not referred to as time limited, which they were in the previous year. This could be only a minor oversight in the use of language in this report, yet it could also be evidence that the need for these recovery teams was acknowledged and longer term support for them was provided.

Manitoba Health, Healthy Living and Seniors Annual Report 2013-2014.

This year's report describes how, as part of Rising to the Challenge's ongoing work, the department began a process to review and implement recommendations related to recovery-oriented services and practices (Manitoba Health, 2014; Manitoba Health, Healthy Living and Seniors, 2014a). This aligns with the interview respondents' accounts, which reported how the recovery pillar was the most successful part of this strategy. This report does not specifically discuss what has been done to move other elements of the strategy forward. Many other activities were listed to have been accomplished and developed through this department over the reporting period. The Adult Eating Disorders Day Program was expanded, which was listed as an achievement of Rising to the Challenge, the department participated in knowledge transfer and education opportunities with community partners, it supported development of a University of Manitoba campus mental health strategy, and the report made mention, again, of the department's continued work towards providing peer support workers and public education, and continued planning for the Northern Youth Crisis Facility.

Overall, the report shows a lot of the same developments being reported year after year, without noting any significant progress. While healthcare system change does take time, saying something is continuing does not indicate that any movement is happening at all. During this reporting period the Youth Suicide Prevention Strategy was said to have completed its final year of implementation. It also noted that some suicide prevention activities, again, may have been a result of this strategy rather than Rising to the Challenge. Evidence of suicide prevention activities in the coming year's annual report, may indicate more of an influence from Rising to the Challenge, since the other strategy's implementation is said to be complete.

Manitoba Health Annual Report 2013-2014.

This report outlined general results based on the operations of the Selkirk Mental Health Centre (Manitoba Health, 2014). Similar to other reports, the activities listed reflect the strategy, but would not be a direct result of it. For example, pharmacists expanded their roles to educate patients about medications, which related to social inclusion and mental health promotion. The continuing work to improve access to beds was also listed. There were no concrete results that relate to Rising to the Challenge described in this report.

Manitoba Health, Healthy Living and Seniors 2014-2015 Annual Report.

This is the first year where the two departments' reports were amalgamated, so this report also includes departmental objectives, expected and actual results, as well as the expenditures for Selkirk Mental Health Centre (Manitoba Health, Healthy Living and Seniors, 2015). All of the results listed in this report could be said to reflect the strategy in some way. Work continued in the following areas: online child and youth mental health navigational tool, planning of Northern

Youth Crisis Facility, continued work in suicide prevention, co-occurring disorders, and recovery planning. While work was said to have continued, no concrete results were listed.

The report makes note of how this is the Youth Suicide Prevention Strategy's sixth year of implementation, which is inconsistent with the previous year's report that describes the 2013-2014 period as being the final year of this strategy's implementation. It would be more likely that most suicide prevention activities would be attributed to the Youth Suicide Prevention Strategy, rather than to Rising to the Challenge. This report's description of the specific actions taken through Rising to the Challenge included the establishment of the Recovery Champions Committee, which works towards the development and implementation of recovery recommendations. This was not a specific proposed action in the strategy; however, it strongly aligns with the recovery pillar and objectives. It was also noted as being a successful aspect of the implementation of this strategy by some of the interview respondents.

The report also provided general results based on the operations of the Selkirk Mental Health Centre. Some activities were listed, like working on trauma informed care, however there were no concrete results attributed to Rising to the Challenge in this report.

Manitoba Health, Healthy Living and Seniors 2015-2016 Annual Report.

This report listed activities that strengthened work aligning with the strategy, like system coordination, mental health promotion, co-occurring disorders; as well as collaboration with individuals with lived experience, family members and different departments (Manitoba Health, Healthy Living and Seniors, 2016). It also provided concrete evidence of implementation. Stresshacks.ca, an online tool for children and youth, was launched this year. It relates well to the access goal and was also noted in the summary of achievements. It was also reported that construction commenced during this year for the Northern Youth Crisis facility in Thompson.

While the five-year time frame would still be active during this reporting period, this is the first annual report since the announcement of Rising to the Challenge, in which the strategy is not recognized by name. Activities that were thought to have originated with it were still noted, such as the Provincial Recovery Champions Committee and other results that were noted in the same way in each reporting period, such as enhanced peer support. This is also a reporting period in which there was a change in provincial government. This may factor in to why the department decided not to mention a strategy developed by the previous government. However, the report did still make mention of the Youth Suicide Prevention Strategy and how it was operating in its seventh year of implementation. Rising to the Challenge may not have been mentioned since it could have been considered that it was in its final year, while the Youth Suicide Prevention strategy was ongoing. However, this cannot be confirmed.

The general results based on the operations of the Selkirk Mental Health Centre continued to show activities that are consistent with the strategy, but are not necessarily a result of it, like continuing to work on trauma informed care. The report mentioned the continuation of work to improve access to beds by working with regional health authorities and improving coordination and integration within the provincial mental health system. No concrete results attributed to Rising to the Challenge were identified in this report.

Provincial Department Document Conclusions.

The annual reports from the provincial departments responsible for the strategy provided an incomplete representation of the implementation of Rising to the Challenge. A number of initiatives that were being worked on were related to the strategy. While some of these initiatives were concrete examples that appear to be directly caused by the strategy, which is supported by other documents in this analysis, some were ongoing prior to the strategy. This implies that the

strategy did not initiate these activities. Rather, it supported them because they aligned with the strategic goals. There were also some overlapping activities between Rising to the Challenge and the Youth Suicide Prevention Strategy, which leads to questions about how the departments were able to measure and evaluate the effectiveness of either of these strategies.

There was nothing in the reports to show how each goal was being acted on or any specifics as to how the strategy was being implemented, such as identifying any financial or human resources that may have been involved. The department is more likely to publish the actions or the progress that it was making rather than discussing implementation problems. Aside from the one challenge of increased wait times listed, which is rare to see in a government document, annual reports are less likely to include initiatives that are not going well. These documents do help to explain the implementation process throughout the time line by describing when it started, the collaborative process that was used to develop the strategy, the drafting of the strategy, the development of recommendations, and the review and implementation of recommendations. However, there are inconsistencies in the initiatives that were reported on in each of these annual reports, including the earliest years, because the reports also show that implementation of the recommendations had not started until 2013/2014. While these annual reports do help to describe elements of this strategy's implementation, the overall process and implications are unclear.

Winnipeg Regional Health Authority (WRHA) Annual Reports.

There was no specific mention of Rising to the Challenge in the WRHA annual reports from 2011-2016. Since there was no specific implementation plan in place or requirements for the authority to implement or take action on specific activities, and because the authority is not the main body that held the responsibility for this strategy, it is not surprising that the strategy

was not specifically mentioned. As the perception of this policy's role was as a directional planning document, according to some interview participants, developments in these reports can only be speculatively identified as a result of the strategy. They may have been guided by it, but it cannot be clearly established that these results were a result of the strategy. The evidence following relates to what was found when searching for information on mental health goals, initiatives, and statistics.

WRHA 2010-2011 Annual Report.

This report includes statistics regarding how many clients were served through the authority's mental health community program (Winnipeg Regional Health Authority, 2011). This year's report serves as a baseline to which the following years' reports will be compared in order to determine if there are increases or decreases to the number of clients served. This may shed light on Rising to the Challenge's access goal. One of the goals outlined in this report describes how the authority has implemented strategies to improve the health of the population, including mental health, over the past year. Since Rising to the Challenge was just starting up at this point, this likely refers to WRHA led strategies or could relate to previous mental health strategies, like the Youth Suicide Prevention strategy. The report addresses the existence and success of the Operational Stress Injuries Clinic, which addresses mental health care needs of soldiers and veterans. This is funded federally by Veteran Affairs Canada and does not directly relate to the strategy.

Most of the report's points about mental health were general, in the sense that this is an area on which the authority reported working. The report has a section on the Mental Health Crisis Response Centre and notes how construction began during this year, which implies planning for it was in the works long before Rising to the Challenge. Costs were outlined, as

well, which would not have been attached to the strategy. The report discussed the services that were planned for and noted that the Centre was expected to be open in Autumn 2012.

Another goal that is discussed is to incorporate public and client feedback into the WRHA strategic plan. The authority also mentions ongoing advisory structures to do this, which include a Mental Health Advisory Council. This indicates that consumer/family participation and inclusion were not new concepts brought up by Rising to the Challenge. This supports evidence that the strategy did not provide new initiatives and that it only supported and outlined work that was already being done in the system.

WRHA 2011-2012 Annual Report.

In this report, the Mental Health Community Program Statistics did not change drastically from the previous year (Winnipeg Regional Health Authority, 2012). There were small decreases in the contacts by Therapeutic Treatment Services, Mental Health Access Services, and with people served by Specialized Mental Health Case Management. There were small increases in contacts by Community Mental Health Crisis response services and with those served by geographically based Community Mental Health Workers. There is no discussion in the report on what these statistics mean. It is difficult to make inferences on whether or not these increases mean that mental health of the population is getting worse, or mental health promotion has led to stigma reduction and more people are seeking services, or if this means access to services has been increased.

The report also noted activities, including town hall discussions with physicians to talk about “Shared Care” models to address conditions like mental health. This relates to a collaborative approach and reflects more of a recovery oriented approach. The report noted how the Crisis Response Centre was still under construction at this point and that there was continued

work with the authority's Mental Health Advisory Council to engage stakeholders in mental health service planning, implementation and evaluation.

WRHA 2012-2013 Annual Report.

The Mental Health Crisis Response Centre was said to have opened this year (Winnipeg Regional Health Authority, 2013). The report lists the services the CRC offers but does not list any results. The Mental Health Community Program statistics did not vary significantly from the last year. A comparison of the five years of statistics that took place during Rising to the Challenge's implementation will be included below in the document analysis section.

The report makes note of a Patient Flow Strategic Plan where the WRHA is working with stakeholders and community organizations to reduce the demand on emergency departments and improve patient flow. This speaks to the goals of utilizing a collaborative approach and improving access to mental health services. The report also discusses work with community mental health services and the Canadian Mental Health Association regarding housing and social services to address socio-economic concerns. While it does not note results, it speaks to addressing the social determinants of mental health and inter-organizational collaboration, which were outlined in the strategy.

The report explained how the Mental Health Advisory Council met this year to discuss family involvement in mental health services. This could be evidence of the strategic direction and goal for family participation and social inclusion in the strategy, by using family members and service users in the Council. The authority also drafted a practice guideline for involving families.

WRHA 2013-2014 Annual Report.

There was not as much in this report about mental health as there was in previous reports (Winnipeg Regional Health Authority, 2014). ACCESS Winnipeg West by the Grace Hospital opened this year and offers mental health services; as a new facility, this leads to evidence of increased access. It also notes how the authority will be adding a Mental Health Program for Assertive Community Treatment (PACT) in the next year. Like previous reports, this one mentions ongoing work with the Mental Health Advisory Council, but does not note specific actions or outcomes.

WRHA 2014-2015 Annual Report.

This reporting year mentions little about mental health initiatives for the WRHA (Winnipeg Regional Health Authority, 2015). It discusses how new ACCESS centres are being developed in St. Boniface and Fort Garry and that these will offer mental health services, which is progress towards greater access for services. Aside from these centres, there was not much development this year or indications of implementation

WRHA 2015-2016 Annual Report.

This year's report indicated more activity regarding mental health initiatives than the last couple of years' reports did (Winnipeg Regional Health Authority, 2016). The report notes the ongoing work of the Mental Health Advisory Committee and how it has a strategy to integrate programs and service areas between health sectors, like mental health, chronic disease, and maternal/child health. The report does not show evidence of this, but it shows evidence of integrating services within the mental health system, which was a strategic direction of the mental health strategy. This could imply that Rising to the Challenge's strategic directions have

influenced WRHA strategies. It may serve to guide WRHA policies, but since the report does not make mention of the Rising to the Challenge strategy, it is hard to determine from where this came. This report notes that there is ongoing work in the Operational Stress Injury Clinic in helping serve the mental health needs of military personnel and veterans. Plans are indicated to be underway to expand this to provide services to more people. This adds to evidence of increasing access to services. Also, adding to this evidence was that the ACCESS centres in St. Boniface and Fort Garry were opened this year and began providing mental health services. There was no specific mention of the PACT⁹ program that was opening up last year, according to the 2013-2014 annual report.

Winnipeg Regional Health Authority Document Conclusions.

The Winnipeg Regional Health Authority Annual Reports do not provide direct evidence of the implementation of Rising to the Challenge. The main reason for this is that the mental health strategy is not identified in any of these reports. There were a number of activities noted that aligned with the strategy, such as developing ACCESS Centres and addressing the social determinants of health, but since there was no evidence of a specific implementation plan put into action, it is not clear what the impetus was for these activities. The reports also mention initiatives that the Summary Report of Achievements list as accomplishments of the strategy, such as the Crisis Response Centre. However, these reports also show some of these activities as pre-dating the strategy. Rather than reporting directly on the implementation of Rising to the Challenge, these annual reports indicate the developments within their organization, many of which do align with the mental health strategy. While the implementation of Rising to the Challenge may have influenced these activities, there is nothing directly confirming this.

⁹ Program for Assertive Community Treatment

Hansard.

A search through the Hansard documents for both the legislative assembly and for the committee debates was conducted in order to discover what evidence existed of any discussions regarding Rising to the Challenge in the debates and proceedings of the Manitoba Legislative Assembly. Hansard documents were obtained through the years 2010-2011 (5th session of the 39th legislature) to 2015-2016 (5th session of the 40th legislature). The search included the phrases “Rising to the Challenge” and “mental health strategy”. In total, ten documents were found within that timeline that correspond to those search terms.

5th Session of the 39th Legislature (2010-2011).

Rising to the Challenge was only discussed during one day of this session on May 13th, 2011 (Manitoba Legislative Assembly, 2011, May 13). A Progressive Conservative (PC) Member of the Legislative Assembly (MLA) asked the Minister of Health how the strategy was going. The response from the Minister of Health indicated that extensive work had been done on it, with broad consultation. Presentation of the strategy was said to be occurring in the coming weeks. The Minister talked less about implementation and more about the document itself. This comment relates to those made in the interview regarding how Manitoba makes great policy, but we fall short at the implementation stage.

1st Session of the 40th Legislature (2011-2012).

The strategy was discussed during two days of this session. During a prepared member statement on May 3, 2012 about National Mental Health Week. A New Democratic Party (NDP) MLA mentioned Rising to the Challenge, how it is designated to promote good mental health, and how mental health promotion is a priority for the government (Manitoba Legislative

Assembly, 2012, May 3). This indicates that the strategy is in the works at this point. The MLA goes on to say that the government has doubled funding for mental health services and community based services since 1999. This comment was not directly attached to the strategy and speaks more to what the government has done financially in the past. This also does not line up with comments in interviews made about the historic lack of funding put aside for mental health in Manitoba. The MLA does not give a description of where the strategy is in its implementation, just what it intends to do.

On May 22, 2012 (Manitoba Legislative Assembly, 2012, May 22), Rising to the Challenge was brought up twice. It was first mentioned in the context of the Mental Health Commission of Canada's (MHCC) National Mental Health Strategy. An NDP Minister mentioned how, at the Mental Health Summit the government hosted, which was mentioned in the summary of achievement reports, the government talked to people who developed the national strategy and encouraged them to borrow from Manitoba's strategy. He later goes on to say that the government wanted its strategy to be consistent with the National strategy. When asked about the status of the national strategy, the Minister used vague language, such as "I understand that there is a federal-provincial rollout of the strategy" and "I believe that we're in discussions, they say." This indicates that there is not a lot of understanding of how the federal and provincial plans are coordinating their efforts. Later in the same day, the same PC MLA asked specifically about the provincial mental health plan and how the estimate books describe finalizing, distributing, and implementing the plan, and further asks about what stage it is at. In response, the same Minister explains how the plan was introduced in June, that there has been committee work, but that the government was trying to wait until the federal strategy came out to determine if there were any inconsistencies between the two, "so what we're trying to do is not

finalize our implementation, because we didn't want to have our strategy over here and the feds' strategy over here and not be linked." This implies that implementation had begun, but the Minister also makes it sound like the government had to pause it to make sure it was consistent with the national plan.

Since the provincial plan was already released, it is unclear how changes to it would have been made if the national plan ended up being inconsistent. The question could be asked whether, politically, the government was using the national strategy's release date as a bit of a scapegoat for the lack of implementation that was evident at this time. The Minister goes on to say that the strategies were deemed to be comparable, so *now* government could move forward with the provincial strategy. This statement comes a year after the strategy was announced. Since the provincial strategy was based on sound research and the expertise of committee members, a national strategy should not have stalled provincial responses to mental health issues. The Minister notes that a number of groups are working on implementation. He makes note of all of the sectors converging for it and that he has a "good feeling about this moving forward." Later he notes that aside from working groups, some things are being implemented, "now that the federal group is done we can move it forward very, very quickly".

2nd Session of the 40th Legislature (2012-2013).

The strategy was only mentioned once during this session (Manitoba Legislative Assembly, 2013, May 1). This alone is suspect, considering how much work was said to have started in the last session and how quickly the government said it would be getting moving on implementation. *Rising to the Challenge* is mentioned in a member statement about National Mental Health Week. The NDP MLA mentions that through this strategy, the government is working to promote mental wellness and improve services and supports. He also mentions how

initiatives like the Northern Mobile Crisis Team and the CRC are part of this. This implies that work is being done, that the government is moving on this and that these initiatives are because of this strategy. This is inconsistent with interview participants saying these initiatives were already in place

3rd Session of the 40th Legislature (2013-2014).

The strategy came up three times during this session. On March 12th, 2014 (Manitoba Legislative Assembly, 2014, Mar 12) during question period, a PC MLA uses Rising to the Challenge to see if the NDP government will help a little girl, who is on a wait list to see a psychiatrist. The NDP Minister responded by saying that mental illness is a priority for the government and that it is making investments in key areas, like Rising to the Challenge. The Minister makes mention of the mental health summit that was held. These comments imply that actions are being taken and investments are being put towards implementation.

On March 14th, 2014 (Manitoba Legislative Assembly, 2014, Mar 14) during question period the opposition asks what the government is going to do about the same girl who is on the wait list to see a psychiatrist. The opposition MLA makes note of Rising to the Challenge and how four years into it, there are no services to help this one child. The opposition MLA accused the government of failing to address issues set forward in the strategy. The government responded, saying that staff had contacted the girl's family and the regional health authority of the region she lived in to connect her with services. While the government referred to having provided the needed services in this case this does not necessarily reflect the services to which the general population would have access. The accusation by the opposition MLA provides evidence that the strategy may not have been implemented as much as it had been described by

the government and provides evidence of Manitobans who are having trouble accessing mental health services.

On March 18th, 2014 (Manitoba Legislative Assembly, 2014, Mar 18) in a budget response speech, a PC MLA accused the NDP of failing to deal with mental illness and notes that schools have also said this. She goes on to say, “this government cannot respond to its propaganda and its announcements with regard to mental health”. This indicates that the opposition sees this as more of a symbolic policy and adds to the narrator comments about politicians trying to make quick wins rather than produce real results. The opposition accuses the government of failing to address the basic promises in the strategy. It makes note of a shortage of psychiatrists, however this is not really what the strategy was pushing for in its shift to recovery oriented services. The PC MLA made note that she did not believe anything has changed in the last 4 to 5 years.

4th Session of the 40th Legislature (2014-2015).

During this session, the strategy is mentioned three times in total. On May 4th, 2015 (Manitoba Legislative Assembly, 2015, May 4) an NDP MLA talks about the recent announcement of a multi-year strategy for child and youth mental health, which was said to be a part of Rising to the Challenge. This strategy did not come up in any of the interviews nor could it be found on the government web page. However, upcoming documents reveal that priorities were altered to focus on child and youth mental health. The documents refer to this as a “new provincial strategy” for a specific age group. It seems suspect that government would be working on a new mental health strategy when it appears that it has not finished implementing the last one.

The MLA makes note of new funding for the Towards Flourishing program, which is also listed in the summary report of achievements. The MLA then mentions that in February, 2015 the government announced “another multi-year early childhood development strategy” and how these two strategies will work together. He notes how the new child strategy includes new funding. This raises the question of where money came from for this new strategy that was a part of Rising to the Challenge, when interview participants said that there virtually was not any additional funding for Rising to the Challenge itself.

On May 5th, 2015 (Manitoba Legislative Assembly, 2015, May 5) an NDP Minister notes that mental health funding has more than doubled from \$89 million in 1998/1999 to \$226 million in 2013-2014. This contradicts what the interview participants said about the historic lack of funding. It is also unclear how much of this would be due to inflation or contributions from other departments outside of Health. The PC response also contradicts this by saying that funding has reduced by 10% over the last two budgets, and added “so much for the NDP’s multi-year strategy”. The Minister starts listing things from the summary report of achievements in defense; however the results do not necessarily indicate political support or effective change.

On November 4th, 2015 (Manitoba Legislative Assembly, 2015, Nov 4) an NDP MLA expresses the government’s commitment to addressing mental health in the Committee of Supply for Children and Youth Opportunities. The government, again, makes mention of the strategy for Child and Youth Mental Health and how it was part of Rising to the Challenge. The government notes how budget 2015 commits \$2 million in new funding for the first year of this ten-year strategy. The Committee deliberates for a while about this strategy but does not talk about the status of Rising to the Challenge. While this new strategy does sound like part of Rising to the Challenge, it may also provide evidence of Rising to the Challenge falling off the table. The

government goes on to say that money for the youth strategy is being put forward for Towards Flourishing. An earlier Hansard document said that money from Rising to the Challenge was put aside for this program. The only program specific funding mentioned through Hansard from both of these strategies was funding for Towards Flourishing.

5th Session of the 40th Legislature (2015-2016).

There was no mention of Rising to the Challenge or a mental health strategy during this session. This provides more evidence that the strategy fell off the table and a lack of political commitment. This session was also leading up to an election year in which there was a change in government, where there may have been a greater focus on election specific issues or blackout periods regarding new program announcements.

Hansard Documents Limitations and Conclusions.

Mental health is touched on in different ways in Hansard. The strategy could have been mentioned throughout Hansard without referring to the search terms. It is possible that the Government may have just talked about mental health/illness and services and how these are improving or not, without directly referring to the strategy. Also, when an opposition party makes accusations towards a governing party it is not necessarily factual. The opposition saying that the Government is failing at mental health is the opposition's opinion and strategy for challenging the Government and is not necessarily accurate. The statements that the Government MLAs and Ministers make during the legislative assembly debates and proceedings as well as committee debates are also not necessarily accurate. It is on the record, so the statements that are made are significant; however, they are not necessarily the most accurate reflection of what is happening.

The Hansard documents shed some light on the how political factors contribute to the implementation process. While the government MLAs appeared to use Rising to the Challenge as an example of their commitment to addressing mental health issues, the strategy was not discussed often in the legislative sessions that occurred over the strategy's timeline. Only ten documents were found that referred to the strategy, and there was an entire session where it was not even mentioned once. It is also important to note that the majority of times the strategy was brought up was in response to opposition MLAs asking about its status and what the government is doing to address mental health problems. The documents provide some evidence of the design and implementation processes for the strategy; government MLAs talk about the consultations that have happened in the development of the strategy, the preparation of the strategy, when it will be announced, and that a number of groups that were working on implementation. The government MLAs also mention how action is being taken on specific initiatives, such as the Crisis Response Centre and the Northern Mobile Crisis team; however, the opposition MLAs challenged these assertions by saying that they are not seeing any results from the government's response to mental health issues. While there is evidence of Rising to the Challenge existing and being implemented in the political realm, the adversarial nature of these documented accounts does not allow for a completely accurate representation of the implementation process.

Summary Reports of Achievements.

The section of the Department of Health, Healthy Living and Seniors website that includes information about Rising to the Challenge also includes documents that were created that list the accomplishments of the strategy for each year in the five year time frame. In the section of the Rising to the Challenge Strategy document that explains how accomplishments will be measured, it explains how these reports will demonstrate how key accomplishments have

moved us towards the strategy's vision. The website only listed the summary reports of achievement for the first two years of the strategy's timeline.

Summary Report of Achievements: Year One.

This document was released just over a year after the strategy was announced. An introduction to the document notes how much work has been accomplished in the first year and describes the six working groups' roles as developing recommendations to work towards implementation (Manitoba Healthy Living and Seniors, 2012). This implies that it was not their direct role to implement the strategy, but to recommend to others how their specific goal areas should be implemented. The document provides a list of notable accomplishments from year one. There were 13 activities listed as accomplished in the first year, including hosting the national Mental Health Promotion and Mental Illness Prevention Summit among other things. It also listed four activities that were underway, including the development of the Northern Youth Crisis Service facility and the development of the Crisis Response Centre.

This list implies that these accomplishments were made as a result of the strategy. Some activities listed in this report were noted in the interviews to have predated the strategy and were not a result thereof; for example, the Crisis Response Centre and the Mental Health Court. It is unclear if the listed accomplishments indicate that the strategy's goals were met because the report does not indicate how these actions directly align with the strategy. It does not list outcomes, nor explain how the accomplishments line up with specific strategic actions, objectives, or goals. Nowhere in the strategy does it say that the activities listed in this report will be planned for and accomplished. There are specific actions listed in the strategy, and it is unclear whether the reported achievements line up, or were a result of those specific strategic action plans. There is no way to measure or evaluate the effectiveness of the strategy if we

cannot outline how the goals, objectives, and actions relate to the outcomes, which appear to be these accomplishments, listed in this report. If we are to perceive this strategy as a directional planning document, then it lines up; these accomplishments are certainly in the direction of the strategy. It is also important to note that the majority of achievements listed are activities in Winnipeg. The strategy does not appear to have reached out to northern and rural communities as much as is needed.

Summary Report of Achievements: Year Two.

This report for year two came out in 2014, two years after the report for year one came out. There was no evidence indicating why year two came out three years after the strategy was announced. While it is unclear whether or not the accomplishments listed in this report include everything accomplished in the past two years since the release of the first summary report of achievements, the heading notes the list refers to ‘Notable Accomplishments in Year Two’.

The summary report of year one noted how there were activities underway; yet this report describes how working groups are just now, two years later, finalizing an action plan on how to initiate these activities (Manitoba Healthy Living and Seniors, 2014). In the introduction of this report it notes that since year one, the working groups whose role it was to develop recommendations to implement the strategic plan, had completed the recommendations process and that an action plan was being finalized. The report lists a number of activities, as it did in year one, that were said to be achievements of this strategy. Implementation, thus, would have already begun. This lack of clarity makes it seem like the department is making action plans for how to implement initiatives that appear to already be in the process of implementation. This also confirms the interview accounts that suggest many of these listed accomplishments were already underway prior to the announcement of this strategy.

As with the first year's report, this one lists accomplishments, which imply that they are the result of the strategy. Again, it does not allow for measurement in that it does not list what strategic action, what objective or what goal with which each accomplishment lines up, which leaves no way to measure and evaluate the effectiveness of the strategy. As with the first year's report, the accomplishments are more meaningful if this strategy was perceived as more of a directional planning document as accomplishments can be seen to align with the direction of the strategy. This report also outlines a number of other projects that are noted to be currently underway.

Summary Reports of Achievements: Years Three, Four, and Five.

The Summary Reports of Achievements for the last three years of the strategy's implementation do not exist. A search conducted in April of 2017 showed no evidence of these documents being released. Since this was past the five-year time frame and since there was a change in government in April 2016, it is unlikely that any further reports would be released to show any other accomplishments related to Rising to the Challenge.

Summary Report of Achievement Document Conclusions.

These documents provide some evidence of the processes and timeline involved in implementing this strategy. They were meant to show how the strategy has succeeded by listing the accomplishments that it made; however, the reports only provide an incomplete representation of this process because they only include only the first two years. The fact that the first report came out on time, the second report was a year late, and that there were no further reports listing what the strategy had accomplished relates to the interview evidence that showed that the strategy fell off the table without the organizational support needed to keep it going.

Another inconsistency with the timeline was that the second year's report described how an action plan for implementation was being finalized, while at the same time the department was publishing these reports of activities that were being implemented.

The documents imply that the activities listed were complete or were underway as a result of the strategy; however, the reports did not include evaluation measures to show how each of these activities was attached to any of the strategy's goals. While these documents do not clarify what activities were directly caused by the strategy and how, they do help to describe some of the developments in Manitoba's mental health system over the five-year time frame and they provide evidence of when the priorities for implementing the strategy changed.

Government Press Releases.

To search for press releases related to the strategy, the terms "Rising to the Challenge" and "mental health strategy" were searched for on the Government of Manitoba's Press Release webpage. Five press release documents emerged as a result of this search. Most of the initiatives that they announce appear to have been implemented well, which shows the benefits of political support for implementation. However, government press releases tend to only announce successes of government, so it is unlikely that this would be an accurate record for the components of the strategy that were not implemented well.

The search strategy used was only intended to locate evidence connecting government action to the strategy itself, but it is possible that programs or initiatives related to the strategy could have been included in press releases that did not come out of these search terms. These results may not include instances where mental health programs may have been referred to independently of the strategy.

Province Releases Mental-health Strategic Plan, Creates Trauma Centre – Strategic Plan, Investment will Improve Access, Promote Better Mental Health for Manitobans: Oswald.

This press release announces the release of *Rising to the Challenge* (Government of Manitoba, 2011). It notes that \$400,000 will be invested into initiatives such as a trauma resource centre. This evidence is in contrast to interview data that said there was not specific funding put forward for this strategy, aside from some for *Towards Flourishing* and perhaps a few other initiatives. The noted \$400,000 is certainly not enough money to accomplish all of the broad system transformative goals included in the strategy. The document does not note where else for programs articulated in the strategy this \$400,000 will go aside from the trauma resource centre.

There were no specific strategic actions that referred to creating something like a trauma resource centre aside from enhancing the competence of the mental health workforce in trauma-informed care. This trauma resource centre was also not listed in either summary of achievement reports, even in the projects that were listed as underway. In searching for this, in the year 2 summary of achievement reports, it notes how the department responsible for this strategy provided \$400,000 in funding for each of two new housing projects that incorporate mental health services, but noted nothing specific about these funds going toward trauma informed care.

In searching for whether or not this centre existed outside of what was reported in the summary of achievement reports, the Manitoba Trauma Information and Education Centre (MTIEC) was found. On the MTIEC website (Manitoba Trauma Information and Education Centre, 2017), it describes how it was established in 2011 by the Province of Manitoba, which lines up with what is said in this press release; however, it also goes on to say that the creation of the MTIEC was a direct result of a provincial forum on trauma that took place in 2007. This is

more evidence that the credit for the programs whose development were already well underway was given to Rising to the Challenge. Perhaps the press release did not intend to say that this trauma informed centre was directly related to the strategy, but announcing this in the same press release and saying the strategy will invest in programs “like” this one is suggestive that these two initiatives are related.

The press release made note of how a 20 person advisory team was created to advise the strategy and how service users, families, and service providers were consulted in developing it. A quotation from the CEO of the Mental Health Commission of Canada said that she was pleased with how Manitoba used the National strategy to inform its work. It is unclear how this was done, especially since the National strategy had not even been released at the point in time that this announcement was released.

Manitoba Hosts National Summit on Mental-Health Promotion, Illness Prevention – Conference to Focus on Governments, Communities, Individuals Working Together: Selinger.

This press release announces how the government will be holding a National Summit to bring experts together to share experience and expertise related to mental health (Government of Manitoba, 2012a). This was also noted to be occurring in one of the Hansard documents. While this summit was not specifically noted as an activity that would occur in the strategy document, it could easily be related to components of the strategy, such as the sixth goal, which aims to develop competencies within the mental health work force. The summary report of achievements, year one, lists this summit as one of the strategy’s achievements.

Based on one of the strategic actions in the sixth goal of the strategy, which is to enhance the competency of the mental health workforce with a focus on cultural competency, co-occurring disorders, and trauma informed care, it would appear that this summit is a good

example of implementation within this strategy. A goal was made with a related objective and strategic action, the activity was accomplished, and then it was listed as an accomplishment of the strategy. The news release does note that the Premier agreed to host this summit during a meeting in Vancouver in the summer of 2011, which was after the strategy was announced. This provides evidence that this summit was not an example of something that pre-dated the strategy, like some of the other activities attributed to the strategy that were critiqued to pre-date it, and that this summit appears to be a result of the implementation of this strategy. There is also evidence that the Premiers of Canada took action in their provinces as a result of this summit. In efforts to build upon the discussion that took place at the summit, Premiers directed their health ministers to meet with private and public sector leaders to improve workplace mental health and wellness, to develop best-practices in mental health promotion and mental illness prevention, and to identify how to ensure mental health services are accessible to all communities in Canada (Council of the Federation Secretariat, 2013). While the press release did not directly attach the summit to the Rising to the Challenge, it does conclude by making note of how the province has developed this strategy to help address mental health problems in the province.

New Winnipeg Complex Will Provide Safe, Affordable, Supportive Homes for People with Mental Illness: Selinger – Province’s Promised Delivery of 1,500 Affordable Housing Units Approaching 1,000 Units.

This press release announces the government’s assistance in building a 28-unit complex run by the Sara Riel Foundation to help with the housing needs and mental health supports for those who are living with mental health challenges (Government of Manitoba, 2012b). The news release states that this would be funded with \$8.2 million from HOMEWorks!, Manitoba’s long-term housing strategy, which was a part of Manitoba’s poverty reduction strategy. Both of these

points are noted in the summary report of achievements for year one under projects that are underway.

The news release also includes an announcement that an additional \$400,000 from Manitoba Health would go towards mental health support services at Sara Riel¹⁰. In the summary report of achievements for year 2, this housing complex was also announced and referred to as ‘Place Bernadette Poirier’ and it was noted that \$400,000 would be put towards this and it was noted as being accomplished in this year. It was noted that this funding would help support Rising to the Challenge.

This news release adds to some confusion that was noted in a previous news release where it was announced that \$400,000 would be invested for Rising to the Challenge. Here we see that it is used for this complex, but also that there is an additional \$8.2 million from Manitoba’s long-term housing strategy. While it is not clear from these press releases how much money was provided for the mental health strategy’s implementation in total and how it was distributed, it is clear that there is evidence of cross-departmental collaboration because the policy makers of the mental health strategy and the policy makers of the poverty reduction strategy both noticed the importance of housing for both of their causes and worked together on this. In the Rising to the Challenge document under the recovery-oriented service goal, there is an objective with a strategic action to work with partners to improve access to safe, affordable housing and supports for people with mental health problems and illnesses. This activity is another example of what looks like effective implementation. The strategy outlined a need, targeted funding was provided to this project, the project was accomplished, and it was listed as an accomplishment of the strategy.

¹⁰ Sara Riel is a charitable organization in Winnipeg that provides mental health services.

Province Launches New Website to Help Children, Youth in Need of Mental Health Support – New Website to Provide Tips to Promote Positive Mental Health, Locate Needed Resources: Minister Crothers.

This press release announces the initiation of an online mental health navigation tool for youth (Government of Manitoba, 2015c). It says that funding for this came from the province's Children and Youth Mental Health Strategy. It also notes that the idea for this resource came from the consultations conducted during the development of Rising to the Challenge as well as the consultations for the Child and Youth Mental Health Strategy. This project is noted in the summary report of achievements for year two as a project underway and it also says that \$295,000 was provided by the province for this.

The fact that this statement is in Rising to the Challenge's summary report of achievements makes it seem like this funding came from this strategy, but the press release says that the funding for this came from the Child and Youth Mental Health Strategy. While the development of Rising to the Challenge may have contributed to the idea for this project, it is not clear that it contributed funding to its development. Rising to the Challenge may have been a contributing factor, but it seems that this project would be best to be listed in an achievement report for the Child and Youth Mental Health Strategy.

Construction Underway on \$7-Million Northern Crisis Unit for Youth in Thompson: Minister Blady.

This press release announces that construction is underway for a mental health and addictions services facility for youth who are in crisis (Government of Manitoba, 2015a). The report notes that the crisis unit is intended to support the goals of Rising to the Challenge and the province's Northern Development Strategy. In Rising the Challenge's goal of increasing access

to mental health services, it includes strategic actions such as creating opportunities to enhance equitable access to mental health services closer to home, especially in rural and northern communities, to which this activity would certainly relate. The press release does not specify how funding was determined for this crisis unit or what strategy this money would have come from. The summary report of achievements for year two lists the establishment of a Northern Youth Crisis Stabilization Unit in Thompson as underway.

Press Release Document Conclusions.

The press releases provide some evidence of the implementation process and the initiatives that were implemented as a result of Rising to the Challenge. One of the releases makes note of how a twenty person advisory team helped develop the strategy and that the strategy was informed by the national mental health strategy, which supports other evidence from this study regarding the processes that were put in place for implementation. The releases describe activities implemented over the strategy's time frame, including a trauma resource centre, a national summit on mental health, affordable housing units, an online mental health system navigation tool for youth, and a crisis unit in Thompson. These press releases provide evidence of these activities being directly related to the strategy because the strategy is directly related to their development, money was announced to have been allocated for their implementation, and they occurred within the timeline of the strategy rather than prior to it.

While the press releases do provide evidence of financial support, the evidence is inconsistent. In the first press release that announces the strategy, it notes that \$400,000 will be provided to implement initiatives related to the strategy. This amount of money alone certainly would not cover all of the funding for the number of initiatives needed to accomplish all of the objectives included in the strategy. This could help explain why the strategy's implementation

process was not completed. Another press release uses the same amount, \$400,000, to describe the funding that was allocated just for the development of two housing complexes. The press releases were not clear regarding how much money was provided for the mental health strategy's implementation in total and how it was distributed. What was made clear regarding the financial resources that were allocated is evidence of cross-departmental collaboration because funding was reported to have been contributed through the mental health strategy, the province's poverty reduction strategy, and the Child and Youth Mental Health Strategy.

It is also important to note the bias in this source of evidence. The press releases make announcements about initiatives that have been implemented well. The government would not use press releases to make announcements about initiatives that were not being implemented well. For the activities that are being implemented well, these documents help to illustrate how political support can facilitate implementation; but overall, the bias in these press releases provides an inaccurate record of the implementation process as a whole.

Manitoba Health, Seniors and Active Living Annual Statistics.

The annual statistics for Manitoba's Department of Health, Seniors and Active Living were obtained for the years 2010-2011 to 2015-2016 (Manitoba Health, 2011b; Manitoba Health, 2012b; Manitoba Health, 2013b; Manitoba Health, Healthy Living and Seniors, 2014b; Manitoba Health, Seniors and Active Living, 2015; Manitoba Health, Seniors and Active Living, 2016).

The intent of including these documents is to inquire whether or not significant statistical changes occurred regarding the prevalence of treated mental illness and the use of services during the implementation of this strategy. Each document reports on the annual percentage of Manitobans receiving medical care for mental illness, rates of self-inflicted injury, suicide completion, anxiety, depression, personality disorders, schizophrenia, and substance abuse. The

rates for Manitobans receiving care for mood and anxiety disorders, personality disorders, schizophrenia, and substance abuse are based on one or more hospitalizations, physician visits, or prescriptions as a result of those diagnoses. Self-inflicted injury rates are based on hospitalizations and suicide rates are based on death records in vital statistics data that identify self-inflicted injury as the cause of death (Manitoba Health, 2011b; Manitoba Health, 2012b; Manitoba Health, 2013b; Manitoba Health, Healthy Living and Seniors, 2014b; Manitoba Health, Seniors and Active Living, 2015; Manitoba Health, Seniors and Active Living, 2016). The following discussion provides an overview of how each of these areas changed over the reporting years of 2010/2011 to 2015/2016.

Medical Care.

There was not a significant change in the percentage of Manitobans receiving medical care for mental illness over the implementation period; it remained at 25% of Manitobans, with an insignificant shift to 25.6% in the last reporting year. Rates of those in Brandon, Winnipeg, and Parkland were significantly higher than the rate of Manitoba overall and this also did not change over this time period. This service use is likely a result of the fact that these are the most populated cities in Manitoba and there is a higher concentration of healthcare services located there.

Self-Inflicted Injury.

The rates of those who were hospitalized because of a self-inflicted injury per 100,000 residents did not change dramatically over the strategy's time frame. However, there was a small increase from 2012-2014, which receded afterwards. The rates are 53.1 in 2011, 58.5 in 2012, 56.6 in 2013, 54.1 in 2014 50.0 in 2015, and 50.2 in 2016. While there are some changes in these

rates, it does not indicate a clear significant shift that the strategy may or may not have influenced. The reports also note that there were significantly higher rates in Burntwood, NOR-MAN, and Parkland with Parkland and NOR-MAN with rates in these communities being over three times higher than the Manitoba rate. These areas also did not vary significantly over the years with the Northern and Prairie Mountain Regions demonstrating the highest rates.

Suicide.

The rates of suicide also did not vary significantly throughout the implementation of this strategy. Rates were reported over the four-year period preceding each report. In the reports from 2011-2014, the suicide rates in Manitoba were 0.17 per 1,000 population. In 2015 and 2016, the rates increased to 0.18 per 1,000 population. The rates were also noted as higher for males than females in each year. The numbers and rates of suicides in Manitoba do not show that the strategy had an impact on reducing suicide over these years.

Mood and Anxiety Disorders.

The rates of mood and anxiety disorders did not vary significantly over the time period. Rates varied from 22.1% to 23.4% of Manitobans over the age of 10. Rates in Winnipeg and Prairie Mountain were significantly higher than the overall Manitoba rate, which is also likely due to the fact that there are higher concentrations of healthcare services located in these areas.

Personality Disorders.

The rates for personality disorders did not vary drastically throughout the strategy's timeline. However there was a small increase in rates over the five years. In 2011, 7,885 Manitobans were treated for a personality disorder at a rate of 0.79% of Manitobans over 10 years old. After a small decrease in 2012 to a rate of 0.77%, rates raised back to 0.79% in 2013

and 2014, to 0.81% in 2015, and 0.83% in 2016 with 9,154 Manitobans being treated for a personality disorder. It is hard to determine what caused changes in these numbers, but they do not show that the strategy had a positive impact on reducing these numbers over the implementation period.

Schizophrenia.

The rates of Manitobans treated for schizophrenia did not change significantly over the five year time frame. The rates ranged from 0.75% of Manitobans over the age of 10 to 0.78%. These rates also show a lack of significant impact from the strategy over these years.

Substance Abuse.

The rates of substance abuse also did not vary greatly throughout the implementation of this strategy. The numbers ranged from 5.0% of Manitobans over 10 years old treated for substance abuse to 5.2%. The rates in the Northern Health Region were noted as significantly higher than the overall Manitoba rate, which indicates a high need for services to be directed to that area. Unfortunately, most of the services noted as initiated or supported through this strategy were concentrated in Winnipeg.

Statistical Document Conclusions and Limitations.

None of the statistics related to mental health changed significantly over the course of the strategy. The evidence that these documents provide regarding the implementation of Rising to the Challenge is inconclusive. It may be difficult to detect significant changes in these numbers as a result of strategy like this within a five year timeline. With the piecemeal approach to funding a number of programs for the strategy, it takes time for these programs to develop and contribute to changing the mental health outcomes of a population. As is noted in the Advocacy

Coalition Framework, it takes a period of ten years or more to be able to effectively detect policy change over time.

Newspaper Articles.

A search was conducted through the Winnipeg Free Press Archives using the search terms 'Rising to the Challenge' and 'mental health strategy'. The results were narrowed by searching a year preceding and extending past the years that the strategy's timeline was in operation, from 2010-2017. The search for 'Rising to the Challenge' resulted in 25 articles, none of which actually related to the province's mental health strategy.

The search for 'mental health strategy' yielded 9 results, 6 of which note government led mental health strategies. Four of the five articles made reference to the national mental health strategy for Canada; however one of these articles made reference to the National Summit which was listed as an achievement of Rising to the Challenge (Kusch, 2012). While not directly discussing the provincial strategy, it does show how the successful implementation of one of its initiatives, the National Summit, was picked up by media and not just by government directed news releases and documents like the summary report of achievements.

The two remaining documents were the only news articles found that directly referred to Manitoba's mental health strategy. One outlined the challenges that people face in accessing mental health services and referred to Manitoba's five-year mental health strategy and how the Crisis Response Centre, that appears to be linked to the strategy in this article, will alleviate some of the barriers that people have experienced in accessing services (Reynolds, 2012). It describes how the Centre will be opening in the year 2013 and that \$12.5 million is the cost of building it. In the first press release that was described in this chapter it noted how \$400,000 would go towards initiatives supporting Rising to the Challenge (Government of Manitoba,

2011); The funding described in this article for the Crisis Response Centre goes beyond the funding that was said to be allocated to support the entire mental health strategy. This adds to the evidence that the Crisis Response Centre was an initiative that was developed and funded independently from Rising to the Challenge. This article also implies that there has been implementation of the strategy with the anticipated opening of the Crisis Response Centre. Yet, this contradicts interview data that identified this initiative as not being a result of the strategy.

The final article is a letter to the Editor that makes reference to the previous article (Redding, 2012). The author makes reference to the strategy by applauding the provincial government for developing such a strategy. This article provided no evidence of the implementation of the strategy.

Newspaper Article Document Conclusions.

The fact that so few news articles existed regarding the strategy shows that it was not highly publicized. This helps explain why some of the narrators who were not directly involved with the planning of the strategy were completely unaware of its existence. It is also important to note that there was absence of news stories about advocacy coalition activities, which adds to the evidence of advocacy coalitions not being active in the implementation of this strategy. The articles highlight some of the inconsistencies in implementation found throughout the interview and document data. One article provides evidence of the implementation of a specific initiative, the National Summit, by corroborating other evidence of its implementation from the Summary of Achievement Reports and government news releases. However, another article that appears to be providing evidence of the implementation of the Crisis Response Centre actually corroborates evidence that the Centre was developed independently of the strategy. With so few articles, a complete representation of implementation could not be constructed from these document

sources. However, the articles that were presented here do provide some evidence of implementation and support other evidence presented throughout this study.

Meeting Notes from the Working Groups for Research and Innovation.

A member of the working group that developed recommendations for the Research and Innovation goal of Rising to the Challenge provided access to a binder of documents related to the work that was done by this group. The binder included a letter of acknowledgement and appreciation, meeting agendas, meeting summaries, the group's terms of reference, a document that outlines how recommendations should align with the strategy's pillars, e-mail correspondence, drafts of working group recommendations, a list of action items for the recommendations, and a document comparing the national mental health strategy to Rising to the Challenge.

In a letter of acknowledgement and appreciation for the member's contribution to the working group from the co-chair of this group, the work was noted to have had a one year mandate, which occurred between December 2011 and December 2012. The letter also noted how the group's work concluded by providing a work plan that identified and ranked activities to advance the research and innovation goal (Manitoba Healthy Living, Seniors and Consumer Affairs, 2013, May 16). This confirms that the department's implementation plan at least made it to this point. It also identified the next phase in which the Coordinating Committee would consider and prioritize all of the recommendations. Yet, there is not any evidence confirming whether or not this occurred.

In the terms of reference document for the working group on research and innovation, a section entitled 'Implementation and Accountability' notes how, in addition to the six expert working groups, there would be an evaluation work group responsible for developing an

evaluation framework for the plan (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011b). This had not been mentioned throughout any of the data, and since there was a general consensus that the strategy fell off the table from interview participants and there was not any evidence of summary achievement reports past year two, it would appear that this stage of the implementation process did not occur. The document also notes how the strategic plan process is accountable to Manitoba Health, which has strong links to a Cross-Departmental Steering Committee composed of relevant assistant deputy ministers from different departments. A section describing the timeline noted how the first priority of the working group was to develop recommendations specific to years one and two of the plan by Spring, 2012 with the five year plan to be completed by Fall, 2012 (Manitoba Healthy Living, Seniors and Consumer Affairs, 2011b). This may be why only years one and two of the summary report of achievements came out. This part of the implementation occurred, whereas the process to plan the remaining five years may not have occurred.

The next document was titled *Rising to the Challenge: Pillar Lens*. It was used as a tool to ensure that the working group's recommendations line up with the strategy's pillars (Manitoba Health, Mental Health and Spiritual Health Care, 2011). Each recommendation was to be subjected to a series of questions to determine if it was consistent with each pillar; for example, for the mental health promotion pillar. The document asks, "does the recommendation encompass a whole population approach, promote flourishing, promote resilience, and include targeted prevention activities for at-risk groups?" This provides evidence that the actions were to have a degree of measurable accountability to the research foundation of the strategy.

In a documented e-mail from one of the administrators responsible for the strategy, the working group member was informed during the third year of implementing *Rising to the*

Challenge, that the Mental Health and Spiritual Health Care Branch was directed to prioritize child and youth mental health (Manitoba Health, Mental Health and Spiritual Health Care, 2014). This explains why a child and youth mental health strategy emerged and why Rising to the Challenge faded into the background. Recommendations from the working groups were incorporated into a draft action framework for child and youth mental health. The document does not say that work will not go forward for Rising to the Challenge, but it seems that prioritizing this new strategy contributed to Rising to the Challenge falling off the table.

Meeting minutes from working group meetings were also included in the binder (Manitoba Healthy Living, Seniors and Consumer Affairs, 2012, Oct 11). The minutes made note of how certain recommendations from the national mental health strategy would be incorporated into the Manitoba plan. They also included how work to develop an evaluation work group was in progress; however no evidence was found in the rest of the data that this stage was completed. The minutes made note that the working group would not be responsible for evaluation of the strategic actions themselves; but also did not make a specific note of who would be.

Also included in the binder was a report on the recommendations that were developed by this working group. It broke down the objectives and strategic actions of the goal and included the recommendations provided by the working group (Manitoba Healthy Living, Seniors and Consumer Affairs, 2012, Nov 6). This document confirms that this working group did complete the recommendation development phase of the implementation process.

Working Group Meeting Note Document Conclusions.

These documents help to explain some of the processes that were in place for implementation and what planning was occurring. The documents confirm that the working

groups were in place and working on creating more specific action plans for implementation.

The meeting notes also provide evidence for the strategy's implementation timeline and why this process appears to have stalled when it did. Evidence regarding a change in priority helps to explain the lack of evidence that the working group's recommendations were acted on and why summary reports of achievements stopped being published after year two. These documents were a useful source of data by filling in a number of gaps that were present in the other sources of data.

Documents Describing the Economic, Political, and Cultural Context.

Documents were gathered to help describe the economic, political, and cultural context within which the strategy was implemented. These documents include economic forecasts from the Conference Board of Canada, scholarly articles describing the political and economic factors in Manitoba during this time, Manitoba's provincial budget papers, and organizational reports that indicate societal attitudes towards mental health problems. The following discussion will help describe the exogenous factors that the Advocacy Coalition Framework utilizes in analyzing policy change over time.

When *Rising to the Challenge* was announced, Manitoba existed in a context of political and economic stability (Conference Board of Canada, 2011; Levasseur, 2013). The New Democratic Party (NDP) government, which had been in power for 11 years and continued to be for another five years, had relatively stable revenue gathering and expenditure practices since 1993 (Levasseur, 2013). An examination of the provincial budgets from 2010 to 2016, the year preceding and years during the strategy's implementation, also showed relative stability with only small increases each year (Manitoba Finance, 2010a; Manitoba Finance, 2011a; Manitoba Finance, 2012a; Manitoba Finance, 2013a; Manitoba Finance, 2014a; Manitoba Finance, 2015a;

Manitoba Finance, 2016a). These small increases were not reflected in the budget expenditures provided for mental health; as described in the financial resources theme in the cross-narrative analysis. There was only one notable increase to mental health funding, in 2011, and funding remained at a relatively stable amount over the course of the strategy's implementation (Manitoba Finance, 2011a; Manitoba Finance, 2012a; Manitoba Finance, 2013a; Manitoba Finance, 2014a; Manitoba Finance, 2015a; Manitoba Finance, 2016a).

From 2010 to 2016 the provincial budgets also show that there were deficits each year; the deficit numbers remained stable each year ranging from \$357 million to \$545 million aside from a much larger deficit of \$911 million in the 2016 budget (Manitoba Finance, 2010b; Manitoba Finance, 2011b; Manitoba Finance, 2012b; Manitoba Finance, 2013b; Manitoba Finance, 2014b; Manitoba Finance, 2015b; Manitoba Finance, 2016b). While a larger deficit like this may cause a government to reduce expenditures, this did not appear to impact the expenditures for mental health in the 2016 budget. However, the debt that continued to grow each year of the strategy's implementation, from \$13.995 million in 2010/2011 up to \$23.149 million in 2016/2017, is an indicator of a government's financial position (Manitoba Finance, 2010b; Manitoba Finance, 2011b; Manitoba Finance, 2012b; Manitoba Finance, 2013b; Manitoba Finance, 2014b; Manitoba Finance, 2015b; Manitoba Finance, 2016b). The growing debt may have contributed to the overall lack of funding described by many of the interview participants.

Manitoba has been known for having a strong and diverse provincial economy. In 2011 and 2012 there were expansions in goods-producing industries, high demand for aerospace products, solid income growth, low interest rates, a solid manufacturing base, job growth, and strong population growth (Conference Board of Canada, 2011; Conference Board of Canada,

2012) that helped strengthen the economy. However, there were events that placed economic strain on the province that began to change the resources and strategies of the NDP government (Conference Board of Canada, 2011; Levasseur, 2013).

In 2009, Manitoba was impacted by significant spring flooding and the H1NI crisis¹¹. These impacts continued when Manitoba was hit hard by spring flooding again in 2011 (Conference Board of Canada, 2011; Levasseur, 2013). The province was also facing challenges due to an aging infrastructure (Levasseur, 2013). While the strengths in other industries may have compensated for the setbacks for agriculture and the spending needed to address the H1NI epidemic (Conference Board of Canada, 2011), the provincial government implemented austerity measures to offset these economic impacts (Conference Board of Canada, 2012). Despite these impacts and economic restraints, the economy was still looking strong, with GDPs expected to grow throughout 2011 and 2012 (Conference Board of Canada, 2011; Conference Board of Canada, 2012). The economic and political stability enjoyed during these two years may have been why implementation efforts and summary of achievement reports appeared to move along smoothly during these years.

The political and economic background in Manitoba took a negative turn in 2013. While the provincial economy demonstrated gains across various industries, like construction, manufacturing, and agriculture, there were weaknesses in the mining sector, declining housing starts and weak growth in service sector industries that resulted from public spending restraints (Conference Board of Canada, 2013a; Conference Board of Canada, 2013b). In order to address the economic impacts that were accumulating for the province, the Selinger NDP government increased the PST to gain additional revenue rather than cutting provincial services (Levasseur,

¹¹ An influenza pandemic involving the H1N1 influenza virus

2013). This may have been due to the government waiving the requirement for a referendum on taxation changes or public desire to have change to such a long-standing government, but support for the NDP declined after this decision (Levasseur, 2013; Levasseur, 2014).

More political instability occurred later on this year that impacted operations that were responsible for the mental health strategy. In October 2013, Premier Selinger reshuffled his cabinet to refocus public policy, increase public support, or possibly both (Levasseur, 2014). This change included moving the health minister. While this change was seen as a promotion to a stronger portfolio (Levasseur, 2014), this minister was the longest standing health minister in Manitoba's history and was in place when the strategy was developed and announced.

In 2014, the provincial economy had some strong industries and weaker sectors, but had slightly stronger growth than in the year before (Conference Board of Canada, 2014). While the economy was modestly improving, more political turmoil presented itself. Due to the Premier's allegedly not listening to the advice of his cabinet, five ministers publicly asked for his resignation (Levasseur, 2015). After announcing that he was not going to resign as leader, each of the five ministers resigned their positions (Levasseur, 2015). This meant that the cabinet shuffle that occurred in 2013 was followed by another shuffle just over a year later. Health was, again, included in this change, which meant that the department responsible for *Rising to the Challenge* had three ministers over the period of this strategy. After the longest-standing health minister left the role, the next minister was only there for 13 months, and the following minister would have been in place for the last two years of the strategy's implementation.

These changes are particularly important because short-term leadership does not help facilitate large-scale policy change over time (Levasseur, 2015). Considering that this strategy was based on system transformation, these changes would have been a significant hindrance for

its implementation. Since it takes ministers a significant amount of time to familiarize themselves with the portfolio they've been assigned (Levasseur, 2015), it is unlikely that the minister assigned after the first re-shuffling would have had time to help facilitate movement of the strategy, leaving the last minister with also a short period of time to familiarize herself with the strategy at a point when the strategy's timeline was coming to a close.

Events that led to more instability continued in the two years that followed. While 2015 was a good year for the economy, with growth across the key sectors in Manitoba (Conference Board of Canada, 2015), the political climate continued to be strained. A leadership convention occurred this year, which concluded with Selinger remaining as premier. A political event like this can create challenges for running a government and certain issues can be overlooked or neglected as the government's focus shifts to campaign issues (Levasseur, 2015). Since interview respondents noted that mental health is always the first thing to go it would not be surprising if the strategy was put on the backburner this year.

2016 saw economic gains and losses; but Manitoba remained as one of the top provincial performers (Conference Board of Canada, 2016). This year also marks when the strategy's five-year time frame is complete and also when a provincial election led to a change from a NDP government to a Progressive Conservative government. Given that the momentum of this strategy stalled with the economic and political instability over the years and given that governments rarely utilize documents or strategies created by a previous administration, this year illustrated the end of this strategy and any likelihood of it moving forward.

Economic, Political, and Cultural Document Conclusions.

These documents provided evidence of the exogeneous factors described in the ACF that were evident in this case study. They helped to provide more detail on the macro-level factors

that impacted the implementation processes, as well as the barriers and facilitating factors that were described by interviewees. It was clear that economic pressures had significant impacts on political resources and created an unstable political environment for the implementation of this strategy. These documents provide important details about the exogenous barriers that existed during the implementation of this strategy.

Research Questions

This final section of the findings chapter brings the analysis of the strategy document, cross-narrative thematic interview analysis, and the document analysis together. The data gathered from each of these sources are used to answer the research question posed by this study. The primary research question asks what are the factors, processes, challenges, and successes that effect the implementation of *Rising to the Challenge: A Strategic Plan for the Mental Health and Well-being of Manitobans*. In order to answer this question, 10 sub-questions were developed to further inquire about the factors, processes, challenges, and successes that were evident in the implementation of this strategy. The following discussion answers each of those questions.

Has an implementation plan, model, or theory been put in place by the Government of Manitoba in the planning of this policy instrument?

The strategy was seen to be a very strong document in terms of how the goals, objectives and strategic actions were designed to align with the philosophical pillars of the document and the connections with the problems they articulated. Interview data showed that all implementation levels valued the document because it was well informed by research, stakeholder engagement, and collaboration. This consultation process was also noted in a government press release. However, based on the results of this study, the implementation of the

strategy was not as strong. As was made clear through the analysis of the strategy document, the theory that connected the goals of the strategy to the problems they were meant to address was not well articulated. Not having strong causal connections creates barriers, making the process for implementation more difficult.

Nevertheless, a process for implementation, lacking a specific theory or model, began after the strategy was announced. In the documents that provided evidence of this process, implementing actors were not specifically identified; however groups were identified to initiate implementation planning. The plan included working groups for each goal, Summary of Achievement reports, and an evaluation working group.

The working groups were put in place to create implementation plans and to create more specific, valid and measurable outcomes. This was confirmed through a number of document sources. In Hansard, a minister described how a number of groups were working on implementation and the annual report of the activities of the Mental Health and Spiritual Health Care Branch describe that it was working with stakeholders to develop recommendations for implementation. E-mail correspondence confirmed that working groups had a one-year mandate between December 2011 and December 2012, and confirmed that they had completed their tasks to develop work plans. The work plan reports for the recommendations included in the document analysis also confirm that this stage was completed.

Summary reports of achievements were part of the implementation plan to show how implementation was progressing during the strategy's timeline. The introduction of these documents also describe the six working groups' roles as developing recommendations to work towards implementation, implying that it was not their direct role to implement the strategy, but to provide recommendations to others regarding how each goal area should be implemented.

Documentation also explained how an Evaluation Work Group responsible for developing an evaluation framework for the plan would be developed, which was not mentioned in any of the interviews. Given that there was a general consensus that the strategy fell off the table from interview participants and that there was not any evidence of summary achievement reports past year two, there is no evidence suggesting that further stages of the implementation process occurred.

Past the working groups' development of recommendations, official attention to implementation plans dissipated. It is clear that the implementation plan was initiated, but that it did not reach completion. Documents describing the political and economic context during the strategy's implementation suggest that the economic and political stability that existed in Manitoba during the first two years of the strategy's timeline facilitated the ease in moving forward with the implementation plans during 2011 and 2012. However, the growing economic and political instability that resulted in a number of political and governance conflicts after these initial two years contributed to the dissipation of the implementation process.

How did the design of the policy affect the implementation process? Was it realistic or symbolic? Are the goals, objectives, and strategic actions specific enough to support implementation?

The policy design included 6 key pillars that served as the philosophical basis of the strategy and 6 goals that were meant to be accomplished through corresponding objectives and strategic actions. While the document's design process was done well by being informed by research and stakeholder consultations, it was, overall, not specific enough to support a complete implementation process. Written with vague language, the goals lack specific targets and theoretical connections to the problems they are meant to address, which led to different

interpretations of the strategy and challenges in evaluating it. While there was a process in place to make the strategy's goals more specific, the process for implementation stalled, not allowing a determination as to whether the working group plans would have been able to better support implementation.

Strategies are often seen as more symbolic in comparison to legislation and stricter forms of policy. This, as noted in the analysis of the strategy document, is because they are much less clear about what specific actions are required for implementation and who is responsible for doing so. There are also fewer assurances that strategies will be followed through with success because there are no legal requirements to follow through as there is with legislation (McKenzie & Wharf, 2010). Based on the responses from the policy makers involved in the development of the strategy, there was no evidence that it was ever intended to be a symbolic policy response; they expected specific actions to be taken as a result of the strategy's implementation. However, to other people involved in the study, the strategy seemed symbolic as was seen with the private practice and bio-medically oriented respondents. It was seen as rhetoric that really meant nothing for their practices. Opposition MLAs also appeared to see this as a symbolic response, referring to it as propaganda and an opportunity for the NDP government to make an announcement to the public. The lack of both specific financial resource allocation and a specific evaluation plan also indicate a symbolic nature to this strategy. However, the philosophical basis seems to have been embraced by other respondents as it allowed a freedom to interpret and localize implementation responses. Other interview respondents explained how they used these pillars to guide their work in developing policy and in working directly with clients.

There was also a lack of clarity in the purpose of the strategy. The parts of the document describing what the strategy is meant for are not strongly connected to each other, which adds to

the different interpretations among interview participants regarding what the purpose was. Some saw it as a directional planning guide to move the system forward while others saw it as outlining specific implementable actions that would change their practice. The interview and document evidence that described how the summary reports of achievements did not align directly with the strategy also add to the argument that the goals, objectives, strategic actions, and costs were not specific enough to support implementation.

If the policy is being implemented well, what can we learn from this?

While there were challenges to the implementation of Rising to the Challenge, there was some evidence of implementation working well. Financial resources play an important role in implementing mental health or any other policy. The funds that were dedicated to the strategy enabled a small number of initiatives to occur. Hansard excerpts, interview data, and the summary of achievement reports provide evidence that Towards Flourishing was one of these projects. Document and interview data also show that funding was made available for the Provincial Recovery Champions group. This also corroborates interview data that reported the recovery pillar was the most successful part of this strategy.

Having government support increased the likelihood that funding would be secured for the strategic actions. In an excerpt from Hansard, a minister expressed how mental illness was a priority for the government and it was making investments in key areas like Rising to the Challenge, which explains why at least some initiatives were funded. While it is clear that there was some level of support from the provincial government, the lack of comprehensive investments indicates that this support was limited.

Since public funding for mental health initiatives remains low, the strategy's cost-neutral activities had a stronger likelihood of being implemented. There was a strong uptake of using the

philosophical pillars to guide the work of particular practitioners from each implementation level in this study; these included a public health policy maker, a community mental health organization administer, and a public health front line worker. This simply required a change of thinking and a reassessment of the way they practice rather than requiring financial resources or structural change. While financial resources could have helped practitioners learn how to change the way they practice through training or by lowering caseloads to allow time to learn how to practice differently, there was no evidence indicating this support was provided, which left practitioners making these changes based on their own initiative. Concepts like social inclusion, family participation, and recovery were seen as concepts that could be implemented by this change in thinking by some interview participants.

Having a culture of support within an organization was found to work well in increasing knowledge retention, increasing the number of implementers, and fostering leadership in implementation. Interview data provided a couple of examples of this; one participant was introduced to the strategy when it was promoted through an educational forum organized by her employer, and another participant was exposed to promotion of the strategy through conversations with supervisors, which were said to have helped her feel supported in adopting the strategy's principles into her work. For this particular participant, leadership was also identified as a facilitating factor in implementation. She and a couple of other participants saw value in this strategy and took the initiative to use their own time to read the strategy and adjust their practices to reflect its values and goals, essentially becoming policy champions within their organizations. Identifying a policy champion would be helpful for ensuring implementation within an organization.

What, if any, conflicts or complications have emerged in the implementation process? What seems to have contributed to their emergence?

Complications emerged with the occurrence of significant human resource turnover, which left the teams involved with initiating and implementing the strategy short-staffed. This also contributed to the sense that the implementation of the strategy fell off the table. Interview data provided evidence that while there was an organizational structure for the steering committee and working groups, this structure and the implementation processes that followed was impacted by the attrition within these groups.

The sheer complexity and fragmentation of Manitoba's mental health system with the many organizations dispersed between formal, semi-formal, and informal systems also created complications in disseminating policy and ensuring it was implemented. Interview data found that there had been a historic disconnection between government and non-government services and that the sharing of information among different sectors was atypical. This point was exemplified by the fact that, reportedly, many people in the mental health system, including a number of interview participants, were unaware of the existence of this strategy prior to their involvement in this study.

Various policy actors within the system interpreted the strategy's role differently, which created conflicting perceptions of their implementation roles and led to inconsistencies in implementation and evaluation. Mental health and the concept of recovery were seen as ambiguous concepts in their definitions that carried different interpretations for implementers based on whether they worked in the recovery-oriented system or the bio-medical system. The lack of goal clarity in the strategy document, itself, also led to different interpretations of what would be implemented.

Front-line workers in the bio-medical system did not see the strategy as realistic or applicable for their work. It was also found that time constraints on account of their heavy caseloads and a lack of guidance created conflict in their ability to implement the strategy. Time constraints were also seen as a conflict in terms of the five-year time frame given for the strategy. Interview respondents expressed how a longer timeline was needed in order for the goals and directions to be followed through.

The lack of funding available to support this strategy was a major conflict for translating its vision into a reality. The general lack of funding for mental health in Manitoba and in Canada was at the foundation of this conflict. Adding to this, was the fact that it was not made clear how much money would be allocated to the strategy during its planning phases. It should be noted that excerpts from Hansard included a government MLA's expression that funding for mental health has doubled since the 1990s, which is in stark contrast to the historically low and stagnant levels of funding described by interview participants. However, in 2015 an opposition MLA in the same Hansard excerpt challenges the government MLA by saying that funding has reduced by 10% over the past two budgets. A review of provincial budgets did show a reduction in expenditures for the Mental Health and Spiritual Health Branch from \$5,198,000 in 2013 to \$4,900,000 in 2014 to \$4,818,000 in 2015 (Manitoba Finance, 2013a; Manitoba Finance, 2014a; Manitoba Finance, 2015a). While these data do support the opposition member's statement, the overall conflicting quotations from opposing MLAs within Hansard suggest a lack of clarity, understanding, and commitment from governing officials for comprehensive funding for mental health in the province.

Funding was announced for the strategy in press releases after the document was finalized, but interview respondents noted how the approach to funding the strategy was a

piecemeal approach in which funds were only made available for a few chosen projects. A press release noted that \$400,000 would be invested into initiatives for Rising to the Challenge. This number is very low and would not be able to meet the system transformative goals that were intended through the strategy. This funding method was seen as ineffective in the mental health system and often led to funding for new initiatives having to be reallocated from somewhere else within the mental health system. This often meant that funding a new project would close the doors on another project.

The political support needed to secure this funding was also seen as a conflict in moving this strategy forward. The infrequency with which this strategy was brought up in the Hansard documents over the five-year time frame indicates that it was of low priority. There were also a number of economic and political conflicts that contributed to this lack of priority. Manitoba's economy was buffeted by the H1N1 crisis in 2009, two major floods in 2009 and 2011, and the province was facing an aging infrastructure. This caused the NDP government to adopt financial restraint measures which included increasing the PST in 2013. This action created a few years of political conflicts, which included a reshuffling of cabinet, a leadership convention, the resignation of five cabinet members, and a subsequent reshuffling of cabinet. This created a lack of ministerial leadership for mental health over the strategy's time frame and a lack of focus with the priorities of the government shifting to party and campaign issues.

How have the policy processes (goals, objectives, and strategic actions) changed as they were implemented? Has the experience gained in implementation resulted in any alterations? What has been adapted and how has it been adapted?

With only five years given as a time frame for the strategy, not enough time was provided to properly facilitate a process of policy oriented learning. When barriers did occur, they caused

implementation to stall rather than fostering revisions. However, the Mental Health and Spiritual Health Branch was directed to prioritize children and youth mental health within the Rising to the Challenge timeline; it was not indicated if this was a result of learning from implementation or an unrelated government decision. Nonetheless, this change in priority did not lead to revisions or adaptations of Rising to the Challenge; rather, it led to the development of an entirely new strategy with a more specific focus.

In a Hansard excerpt, an NDP MLA discussed the announcement of the child and youth mental health strategy and said it was to be part of Rising to the Challenge. In reality, the data suggest that rather than it being a part of Rising to the Challenge, the working group recommendations from Rising to the Challenge were incorporated into a draft action framework for the child and youth mental health strategy. This change was not seen as an opportunity to adapt Rising to the Challenge to focus more on children and youth, rather, information was taken from Rising to the Challenge to inform elements of this new strategy.

Evidence of the priority change was only found at the last stage of document data collection where documents from a working group member's records were obtained. A copy of an e-mail explains how the Mental Health and Spiritual Health Care Branch was directed to prioritize children and youth mental health. No public documents or interview data made note of this shift. The documents appear to suggest a clear reason for why the strategy "fell off the table;" yet it is peculiar that none of the interview participants noted this as a factor when they were discussing the lack of implementation. This change also helps to explain why summary of achievement reports did not exist for years three, four, or five. In 2016, a change in the provincial governing party saw a shift in priorities and ideas for a new strategy, rather than continuing with and creating alterations to Rising to the Challenge.

Were outcome indicators developed as part of the implementation process? If so, what are they? How do implementers think they are related to goals?

Evidence of outcome indicators was only mentioned in the strategy document itself, and was not specifically mentioned in interview data. The only outcome indicators listed in the strategy were referred to as “high level outcomes” and referred to the goals of the strategy, for example, reducing mental health problems and illness, and increasing access to services. The working groups were intended to create more specific, valid, and measurable outputs and outcomes, and these were to guide the implementation of the strategy. But, their work produced recommended outputs that were not publicized or communicated to implementation actors responsible to follow through. The recommendations were not specifically referred to as outcomes or outputs, but they did describe more specific activities to move the high level outcomes forward, such as “ensuring evaluations are used in the process of assessing ongoing funding of existing projects and the planning for new projects” and “identify and develop an inventory of the mental health related research partners, that exist in health and other domains” (Manitoba Healthy Living, Seniors and Consumer Affairs, 2012, Nov 6).

Implementers who were not involved in these working groups likely never accessed the information on the recommendations so it cannot be determined how they thought they were related to the goals. However, the documents outlining the recommendations show a clear line of logic between goals, objectives, strategic actions, and recommendations. This shows that efforts were made to relate these outcomes to the goals of the strategy. It should also be noted that if the recommendations were to be taken as the outputs and outcomes of this strategy, the mandate of the working groups finished in December 2012, a year and a half after the strategy was announced. With the short time frame available to implement the strategy, it is peculiar that these

more specific actions were not predetermined when the strategy was announced. It raises the question, why announce the strategy, prior to knowing what the desired outcomes are, how they will be measured, and what actions will be taken to implement the strategy?

How are the outcome variables, established by the policy makers, being measured?

In the strategy document, it was said that accomplishments would be measured by creating working groups to develop specific and measurable outcomes, a corresponding evaluation plan would measure the strategy's success, and Summary Reports of Achievements would demonstrate the accomplishments that resulted from this strategy. There is no evidence that the development of an evaluation group or evaluation plan to measure the strategic plan's successes, as noted in the strategy, ever occurred. While measures for outcome success were lacking in this process there were indicators in place for the working groups to ensure their recommendations aligned with the philosophical basis of the strategy. The Pillar Lens document (Manitoba Health, Mental Health and Spiritual Health Care, 2011) provided a guide to ensure that each recommendation made followed the pillars of the strategy, the goal area that each group was working on, as well as the corresponding objectives and strategic actions.

Annual reports on achievements were to demonstrate key accomplishments toward the strategy's vision; however the achievements described were not directly related to the strategy and activities were only reported for the first two years of implementation. It is also unclear how this stage of the measurement process occurred without the evaluation design stage that was supposed to occur prior to the production of these reports. Since the more specific outcomes were not articulated until 2012 and since there was no evaluation process to measure them, the accomplishments in these documents could only be measured against the criteria of high-level goals. This would be a challenge since goals were not operationalized specifically enough to be

measured at this stage. Adding to this challenge was the fact that the strategy was missing theory to connect the goals and problems, as was found in the analysis of the strategy document.

Despite the publicized planning and accomplishment claims related to the strategy, there is no evidence that evaluation occurred.

The interview analysis found that there were different perspectives among the respondents regarding how successful they thought the strategy was and how accurate the Summary of Achievement Reports were. The list of activities on the Summary of Achievement Reports imply that these activities occurred as a result of the strategy; however, they do not list their related outcomes or explain how each accomplishment coheres with the strategic actions, objectives and goals. Some respondents saw the reports as evidence of success for the strategy, while others did not see the achievements as being caused by the strategy. Many achievements listed were noted as pre-dating the strategy. Documents from 2010 and 2011, like Manitoba Health's annual report showed how a number of activities, such as the creation of the Crisis Response Centre, the Mental Health Court, the development of a Northern Youth Crisis Service, and planning for a summer institute through the Co-occurring Disorders Initiative were ongoing projects when the strategy began. This indicates that these activities did pre-date the strategy and were not taken as a result of it.

Some activities did appear to be more directly related to the strategy, such as the Mental Health Summit in Winnipeg and stresshacks.ca; however with the lack of measurement tools in place, it is unclear whether this was an idea that aligned with the strategy or if there was a rationale that connected these activities, with specific goals, objectives, and strategic actions of the strategy. Annual reports from Manitoba Health, Manitoba Health, Health Living and Seniors, and the Winnipeg Regional Health Authority provide evidence of ongoing activities in relation to

the accomplishments listed in the summary of achievement reports; however, without specific measurement tools in place, it is difficult to determine what caused these activities to occur or how they contribute to the strategy's outcomes.

Overall, there was a consensus among respondents that they did not see the strategy as going very far. Respondents noted both a lack of evaluation processes in place and a lack of incentives for organizations to adopt the principles, goals, and objectives of the strategy. The lack of change in the statistics related to mental health over the course of the strategy shows that the actions taken in the strategy were either not directly related to these outcomes, or were not successful in achieving changes to these outcomes. A lack of success was also noted by opposition MLAs in Hansard where it was said that it did not appear that desired changes had occurred over the course of the strategy and that their constituents were continuing to experience difficulty accessing services.

Who is the network of actors who have been made aware of this policy and how are they implementing it? Why is it so low profile? What efforts are being made to implement this policy?

Efforts at implementation began with the working groups creating recommendations for implementation. However, it was not their direct role to implement the strategy, just to further specify it. There is no evidence that the recommendations were implemented. The analysis of the strategy document and the document analysis, which included the recommendations of one of the working groups, showed that while actions for implementation were developed, there was no identification as to who was responsible for taking these actions.

It was not clear whether a network of implementing actors was actually identified for this strategy. Interview participants were also unclear on which organizations would take what

implementation roles. Knowledge of this strategy appeared to remain within the organizations that were involved in developing it. It was not evident that the policy makers actively encouraged a wide variety of organizations to adopt the strategy aside from the organizations that were involved in its development. Some of the interview respondents were completely unaware of the strategy and it was seen as unlikely that the policy makers would have reached out to all sectors involved in the mental health system, including the private sector. However, there was evidence that information regarding the strategy was distributed to some staff of the WRHA through an educational forum.

While the policy makers in this study saw implementation as falling off the table, there is evidence that some front line workers took the initiative and made efforts to implement the strategy in their practices. These practitioners were not directly identified as implementers. However, they were more closely connected to the organizations which were involved in developing the strategy; so this may provide evidence of the strength of having a forum to inform staff and could also show the strength of spreading information by word of mouth through organizations exhibiting cultures of support. Efforts toward implementation by front line workers revolved around the philosophical pillars. They used these pillars to try to consciously shift the way they thought and the perspectives they used in working with clients and working with policy. These workers tried to ensure that the decisions they made in their work were in line with the pillars of the strategy.

There was also evidence that politicians were making efforts at implementing the strategy by discussing the progress of the implementation process in the Legislature and announcing some investments towards mental health programs in relation to the strategy. The direct acknowledgment of the strategy in press releases along with attaching funding to some of the

activities in these announcements shows direct efforts at implementation. While it is questionable how directly related the activities were to the work of the strategy, these actions still provide evidence of implementing pieces of the strategy, whether the action is closer to a strategic action or more in line with one of the pillars.

It is clear that the strategy was low profile since many informants were unaware of its existence and since it did not go as far as policy makers had announced. Part of this was due to the shift in priority towards child and youth mental health, which played a major role in limiting the prioritization of Rising to the Challenge. However, the lack of substantial funding allocated to the strategy at its outset shows a lack of will to make it a higher profile strategy. This could be evidence of this strategy being more of a symbolic response than a real shift in policy. The robust scope of change that this strategy intended to accomplish was seen as unrealistic by some participants who did see this more as rhetoric than a real attempt at system change, such as the front line worker in the bio-medial system. Adding to this are the words from opposition MLAs who referred to this strategy as being nothing more than an opportunity for the government to make an announcement about the strategy. This implies that the government was merely looking for a quick political win and to create the appearance that it was making mental health a priority.

What are the effects of policy implementation on front line staff?

The lack of expectation for front line workers to be active in implementation led to this strategy's implementation process not having significant effects on front line staff. For the front line workers who were made aware of the strategy, they struggled with time constraints in both reading the strategy and in determining how to adapt their practice. They all described having busy caseloads, which impeded their ability to be involved in implementation. Even for the worker who attended the forum where the strategy was described, this meant her having to find

coverage for the clients she would normally be seeing during that scheduled time. The lack of guidance from managerial staff also made front line workers' thoughts about determining how to implement the strategy more overwhelming, and decreased commitment in doing so.

Having an organizational culture of support caused some front line workers to implement the strategy into their practice. The data were inconclusive on how widespread this culture of support was for the strategy. While most respondents described their organizations' philosophies as aligning with the strategy, this does not automatically mean the organization would have adopted the strategy. Time constraints and a lack of awareness of the strategy's existence appear to also have prevented a number of organizations from supporting the strategy's implementation. But overall, those who described a lack of organizational support for the strategy came from the private sector and bio-medical system.

Different interpretations of the strategy's role led mental health professionals to adapt the strategy to fit into their specific work place, however they saw fit; one saw it as useful guide to develop future policy where another saw it as useful in empowering her clients. Some chose not to implement it due to it not being applicable to their particular practice. One front line worker thought that what was offered in the strategy was not helpful for the needs of her clients. She noted how practices like mental health promotion were not priorities for her clients who suffered from very severe and persistent mental illnesses. The front line worker from the biomedical system saw the strategy as not being applicable within his hospital workplace setting. Not seeing concepts like recovery fitting into either the system he was working with or his role in assessments and discharge planning, implementing the strategy was not even considered by him. These examples highlight important disconnections between policy and practice.

What is the extent to which goals/implementation plans are shared across implementing organizations? Does there seem to be variation in how goals and implementation plans are valued? Are there incompatible implementation goals among implementers?

Most respondents valued the strategy to some extent, whether or not they saw it as realistic for their practice. However, the various roles and underlying philosophies of those across the mental health system led to the strategy being valued and interpreted differently. In a couple of examples, family participation was viewed as seemingly good, but not necessarily appropriate for all when considering that some people do not have positive connections with family.

Concepts like recovery were seen to have definitional ambiguity in that they are interpreted differently in the biomedical and recovery oriented systems. While both systems value recovery, they may not be referring to the same thing. Many practitioners from the biomedical system, as noted in the literature, often regard recovery from mental illness as an absence of symptoms rather than as an enhanced quality of life (Deacon, 2013). As we saw with the front line worker from the biomedical system, the strategy's version of recovery was not of value to him.

There were also some goals that were incompatible between the biomedical and recovery oriented systems. Access to services in the biomedical model meant more inpatient beds, according to interview data. Whereas the recovery model, while not undervaluing the biomedical system's contributions to mental health, has a more community oriented focus for access to services. Furthermore, with the limited budget, and reallocation measures that have become

evident, increased access on one side of the spectrum likely means decreased access on the other side.

Two respondents saw this strategy as something of value that they adopted in their practice, while another two respondents did not see this as a valuable document for their practice. Interview data highlighted the different ideas of what this strategy's role was and what it was intended to do. For some it was described as a directional planning document that outlined a philosophy and the principles intended to guide our mental health system forward. Others viewed the strategy as more of an action plan with specific actions that could be implemented. These different views of the policy's role altered the implementation of this strategy. While some used it to guide future policy, others used it in their daily work with clients.

Primary Research Question: What are the factors, processes, challenges, and successes that affect the implementation of Rising to the Challenge: A Strategic Plan for the Mental Health and Well-being of Manitobans?

The answers to the previous ten questions help to provide the details for the answer of the primary research question. As indicated throughout these answers, there were a number of processes and factors that contributed to both the challenges and successes found with the implementation of this strategy. The process of implementation began with the design of the policy. While the strategy's design was well informed by research and stakeholder collaboration, it was not designed with specific and measurable outcome indicators or specific implementation methods, which was a barrier to its implementation. An implementation plan was put in place to create working groups, which would turn the strategy's high-level outcomes into more specific and measurable actions. Aside from these working groups, implementation actors were not specifically identified.

Recommendations were created by the working groups, but there was no evidence that these were acted on. This stage of the implementation process coincided with direction from the Mental Health Branch to shift the working group priorities towards children and youth mental health, which impeded the implementation process for Rising to the Challenge. The implementation plan also included initiatives for developing an evaluation group for the design of an evaluation framework and for preparing Summary of Achievement Reports to be released to demonstrate the accomplishments of the strategy. There is no evidence that an evaluation group or plan was formed, which were barriers to the measurement of any implementation actions taken and to allowing a process of policy oriented learning to occur. Despite this evaluation not being in place, Summary of Achievement Reports were released for the strategy's first two years. Evidence showed that many of the initiatives listed in these reports pre-dated the strategy and were not a result of its implementation; however, there was evidence that some of the initiatives were a direct result of implementing the strategy. It was clear that an implementation was initiated, but that it did not reach completion.

A number of other factors were evident in the processes described above that impacted the implementation of Rising to the Challenge. The complexity of the mental health system was found to be a barrier to implementation because of the atypical sharing of information between the wide variety of organizations involved in the mental health system, the different models used for treatment, and because of the definitional ambiguity of various concepts of the strategy being interpreted differently among various organizations. Lack of clarity in the policy's role was also found to be an important factor for implementation; different interpretations of what the strategy was intended to do caused some inconsistencies with implementation. Having an organizational culture of support was found to be a facilitating factor for some interviewees in implementing the

strategy and the lack of a culture of support was found to be a barrier to implementation when organizations did not value or provide support for front line workers to adopt it.

The applicability of the strategy to front line practice was found to be a barrier to implementation in cases where people were working with high-needs clients or in the biomedical system. Time constraints were also a barrier to front line workers implementing the strategy because their busy caseloads prevented them from learning about the strategy and determining how to incorporate it into their practice. Time constraints were also determined to be a barrier in terms of the five-year time frame not being enough time to implement all of the changes the policy makers had proposed in the strategy. An important factor for implementation that came up frequently in this study was the need for financial resources. Overall, this was a barrier to implementation because there was a lack funding provided for the strategy. However, the funding that was given for a small number of initiatives helped to facilitate their implementation.

A factor that was found necessary to be present to ensure financial resources was the need for both political and public support. Overall, political support was found to be lacking for the strategy, and this created a barrier to implementing the strategy in its entirety. However, it was seen to be a facilitating factor in instances where political support was provided for specific initiatives related to the strategy. A period of economic and political instability during the strategy's timeframe created barriers to achieving higher levels of political support. The public support needed to put pressure on the government to implement mental health initiatives was also found to be needed, but lacking in this case. Also lacking was the coordinated activity of active advocacy coalitions, which reduced the coordination of this response contributed to further impeding the implementation process. Finally, leadership was found to be a facilitator factor for implementation in a number of cases where practitioners emerged as policy champions

by taking the initiative to learn about the strategy and determine how they could implement it within their practice. A detailed summary of the findings will be provided at the beginning of the next chapter.

Chapter V: Discussion

Summary of Findings

This study set out to examine what the processes, factors, challenges, and facilitating factors were in the implementation of Manitoba's mental health strategic plan, *Rising to the Challenge*. Through a critical analysis of the document itself, a narrative thematic analysis of interviews with ten participants, and a thematic analysis of available document data, an in-depth examination of the implementation stage of this strategy's policy process was achieved. The findings reveal important details about this strategy's process of implementation in terms of the policy design, implementation planning; as well as outcome development and measurement. The findings also helped describe how important concepts from the Advocacy Coalition Framework (ACF) related to this strategy's implementation, such as the mental health policy subsystem, the policy belief systems of different coalitions, the time frame that was utilized, the exogenous factors that played a role, and the extent of policy oriented learning. Finally, the findings highlight the lessons learned from this implementation response by incorporating the barriers and facilitating factors that presented themselves. These factors provide important considerations for future policy and strategic planning.

Strengths and Weaknesses.

A number of strengths and weaknesses were identified within the process of this strategy's implementation. In terms of the policy design, the fact that it was informed by leading research and stakeholders was seen to be a facilitating factor. It fostered implementation by setting the stage by identifying the areas of the mental health system in which implementers

would need to act, and it identified and included the stakeholders inside the mental health system who would also likely play a role in implementation.

While the use of a variety of stakeholders was seen as a strength of the strategy, there was no evidence that the development of the strategy was inclusive of a number of professional associations, such as association for family physicians, psychiatrists, clinical psychologists, registered psychiatric nurses, registered nurses, social workers, and occupational therapists. Some of these professional associations, especially those that are involved in the bio-medical system, may not have been included in the strategy's development because of its focus on recovery oriented services rather than bio-medically oriented services. However, by not including them, the policy makers would have excluded important perspective from practitioners who make up a large and dominant sector of the mental health system. These practitioners could play integral roles in the recovery process within a multi-disciplinary approach and they may be able to provide insight on how to promote and incorporate recovery oriented services into the bio-medical system.

There are also other ways in which the policy design was identified as a barrier. The strategy document itself was not seen as having specific enough goals and targets to support implementation. The only outcome indicators mentioned in the strategy were the goals themselves and these were referred to as "high level outcomes". While it is recognized that a process was intended to create more specific outcome indicators, this process was not completed and the recommendations that were developed were not put into action, which left the strategy document as the main source of information for implementation.

Strategies, in general, were identified in the analysis as often regarded as symbolic policy responses because they usually lack specific actions. The broad nature of the goals and actions

support this assertion, as did interview data from respondents who viewed this policy as a symbolic response, and document data that highlighted a lack of comprehensive political commitment. However, there was also what may have been an unintended facilitating factor in the inclusion of the six philosophical pillars in the policy design. While these did not define specific actions, a number of implementers on the front line used these to adjust their own practice philosophies and the way they conducted their work.

Aside from the processes for designing the policy and developing outcome indicators, the process put in place for measuring the outcomes of this strategy was seen as a barrier. The process, as described in the strategy, included the development of working groups to specify and operationalize outcomes, the development of an evaluation plan, and the dissemination of Summary of Achievement reports that would list the accomplishments. As described above, working groups did create more specific outcomes, but this process stopped before the outcomes could be implemented. Document data revealed that this was likely due to an announcement that the priorities of the Mental Health Branch would be shifted to the Child and Youth Mental Health Strategy. This may also be why no evidence was found to show that a corresponding evaluation plan ever existed.

Despite the lack of measurement tools and outcome criteria in place, summary reports of achievements were published for years one and two. Interview respondents expressed different perspectives on how accurate these reports were. Interview and document data revealed that many of the activities pre-dated the strategy and were therefore not a result of its implementation. However, according to other interview responses and documents, some of the activities listed did appear to have been accomplished as a result of the strategy. Overall, the strategy was not seen to have gone very far or to have completed implementation according to

interview respondents, departmental and statistical documents, and because summary reports of achievements stopped being published after year two.

The focus of this study was on the implementation stage of the policy process. However, the findings demonstrate not only the strategy's implementation failure, but also a failure in policy design and evaluation. While the interview questions were focused on implementation, policy design emerged as the most common theme discussed by narrators from each implementation level. This highlighted the importance of having a well-informed document that frames the issue and articulates clear goals, clear policy instruments, and includes formal implementation, funding, and accountability planning (Pal, 2006). While, overall, narrators saw the design of the strategy as a strength, there were inconsistencies in their perceptions regarding the policy actors' roles and the steps that would be taken to implement the policy, which both suggest a lack of clarity in the policy design.

The critical analysis of the strategy document also highlighted some strength in the policy design, but also found that it did not specify policy tools, nor did it contain clear or measurable goals. While there were plans for working groups to develop more specific actions for implementation, the recommendations of the working groups did not move forward. Without this important component, the strategy was left with a design that lacked clear implementation roles and responsibilities, identification of policy tools, and clear policy goals, which limited the strategy's implementation potential and contributed to a number of implementation barriers that were highlighted in the findings.

With the problems that emerged during the policy design and implementation stages, it comes as no surprise that the findings demonstrate a failure of the evaluation stage, as well. Evaluation essentially creates accountability by determining how successful a policy has been,

whether or not it has met its goals and objectives, where it fell short, and where it could be improved (Pal, 2006). The lack of clear goals, policy actor roles, and policy instruments would render evaluation a very difficult process. Monitoring and evaluation also emerged as a theme by the narrators, who identified that this stage was lacking and that there were inconsistencies with the summary of achievement reports. These reports represented the only evidence of an evaluation attempt by presenting initiatives that occurred as a result of the strategy. However, as the findings demonstrated, many of the identified initiatives pre-dated the strategy and were not a result of its implementation. The lack of evidence indicating follow through with developing an evaluation group and plan also contributes to the strategy's evaluation failure.

Implementation is an important stage of the policy process in determining how policies turn into practice. However, this stage does not act alone. There were clear connections between the problems in the policy design stage, implementation stage, and evaluation stage. The evidence that emerged regarding each of these policy stages indicates how this strategy was not just a failure in implementation, but also an overall failure of the policy process.

Advocacy Coalition Framework.

The application of the ACF to this policy response revealed important factors that impacted this strategy's implementation. The ACF's focus on policy subsystems allowed for the examination of Manitoba's mental health system as a subsystem and the analysis of the network of policy actors working within it. The complexity of the mental health system was identified as a barrier to implementation with its wide variety of stakeholders and organizations from different systems, sectors, and departments. This, as well as the breadth of the strategy's scope, created difficulties in determining who the implementing actors and organizations needed to be, in coordinating various beliefs and strategies for how to accomplish goals.

Coalitions were not formally defined in the design of this strategy and there was a lack of evidence of active coordinated coalitions advocating for its implementation. However, it was clear that different groups existed that held different beliefs, had access to different resources, and interpreted the strategy differently. These groups included those working in the public mental health system, the private mental health system, semi-formal organizations, self-help organizations, and those providing informal mental health supports. The most notable example of what competing coalitions might look like in this case was those who were working from a biomedical orientation versus those who were working from a recovery orientation. For example, a respondent from the biomedical system did not believe the strategy was of use to him because of its emphasis on recovery, which led to a lack of implementation effort. The policy actors involved in this study also held different interpretations of what the role of the strategy was, which was also identified as a barrier. While some saw the strategy as a directional planning document for guiding future activities, others saw it as more of an action plan with specific guidelines to be implemented. Aside from the different policy beliefs within coalition groups, these differing interpretations also likely occurred as a result of a lack of communication and guidance on the strategy's intended role upon its release.

There are also issues with the coherence of the ACF to the Westminster model under which this strategy and Manitoba's mental health system reside. Under the Westminster model, once laws are enacted they are very difficult to overturn (Sabatier, 1998). When policy decisions are made through government, especially a majority government, it is unlikely that the decision will be changed by external advocates, which is much more reflective of a top-down approach than it is of a synthesis approach like the ACF. In Manitoba, when laws are being passed, advocacy coalitions and members of the public have the opportunity to advocate for or against a

bill. Realistically, these practices virtually never make significant, if any, impact on overturning government decisions. It has also been argued that policy oriented learning is challenged in the Westminster model because of the ingrained norms of secrecy in the civil service (Sabatier, 1998). This relates directly to the provincial department representatives restricting access to document data for this study. Without a transparent approach to policy-oriented learning, future mental health policies may be planned without the accurate knowledge needed for effective implementation. As a result of the top-down nature of these processes, there is a lack of coherence between the ACF and Westminster model.

However, there is still room for advocacy coalitions in the Westminster model if they adjust their strategies. One example relates to the advocacy at bill hearings noted above and the potential for influencing amendments. While an amendment might not have as much impact as an advocacy coalition might aim for, there are strategies they can use to make this smaller step towards their policy goals. Coalitions are more likely to make this happen with a strong coalition composed of a number of people, including those with influence, and by gaining the support of opposition parties. As noted earlier, majority governments are unlikely to change their minds on proposed legislation, however, they do have the power to change their minds at any point (Sabatier, 1998). This may require coalitions to make longer term, allied relationships with political parties to ensure that their policy interest will be of priority on the political agenda. A lack of awareness and understanding regarding these strategies may have prevented mental health advocacy coalitions from emerging in the implementation of this strategy.

The challenges experienced by advocacy coalitions, as well as the necessary adjustments in strategy, relates to the literature on civil society organizations and advocacy efforts. The literature shows that there is an overall lack of advocacy efforts by non-profit organizations.

There are very few non-profits that have advocacy as their primary purpose; most organizations primarily deliver services to clients and only allocate a small percentage of funding and staffing to advocacy efforts (Almog-Bat & Schmid, 2014). As noted above, this can be due to a lack of competence and awareness of their options for entering the political arena, as well as a fear of negative consequences, such as having charitable status revoked (Almog-Bat & Schmid, 2014; Desantis & Mule, 2017; Schmid, Bar & Nirel, 2008). These findings from the literature may relate to why there was a lack of emerging advocacy coalitions in this case study.

The non-profit advocacy literature also highlights who is engaged in advocacy efforts and why. In the United States, it was found that most advocacy groups are from private and business sectors rather than grassroots organizations (Jenkins, 2006). This is likely due to the greater resources the former would possess and their independence from government. Since many mental health organizations in Manitoba fall in the public and non-profit sectors, they are less likely to be in powerful positions to advocate without consequence. However, this does highlight an opportunity for private mental health organizations, like private psychology and psychiatry practices, to engage in more advocacy efforts.

The literature also highlighted that those organizations which are involved in these efforts need incentive to participate. It was noted that solidarity alone is not enough, and that policy actors need moral, material, and social incentives in order to commit to advocacy efforts (Jenkins, 2006). These incentives relate to the extent that advocacy efforts serve an individual's own interests. Incentives may involve the extent to which the individual is able to create strong ties in a professional network, the opportunities they may have for education and employment, the amount of power an individual is given within these efforts in meeting their reputational and decision-making needs, and the extent to which efforts identify with an individual's personal and

professional ideology (Jenkins, 2006). This relates to the complexities of policy beliefs in the ACF. Having similar policy beliefs does not necessarily hold a coalition together, especially in an environment in which policy actors are ambivalent to advocate, as was identified with the lack of active advocacy coalitions in the implementation of Rising to the Challenge.

There are a number of other challenges that hinder non-profit organizations' abilities to advocate. The main challenge is a lack of resources. Non-profits lack the time, staff, and funds to fully engage in effective advocacy efforts (Almog-Bat & Schmid, 2014; Desantis & Mule, 2017; Schmid, Bar & Nirel, 2008). The resources of advocacy coalitions are an important element of the ACF in pushing policy goals forward and this also helps to explain why they did not emerge. Non-profit organizations are highly dependent on external resources, which often take the form of government contracts (Almog-Bat & Schmid, 2014). This allows governments to impose policies, regulations, and procedures as conditions for funding, which often include restrictions regarding advocacy and political activities (Almog-Bat & Schmid, 2014; Desantis & Mule, 2017; Schmid, Bar & Nirel, 2008). Not wanting to lose integral organizational funding, causes a dependence on government and an ambivalence to speak out for or against different policy interests.

In Canada, the government and non-profit relationship does not easily allow for advocacy. There has been an increase in government surveillance through the imposition of rules regarding advocacy and muzzle clauses in non-profit agency contracts, which go along with ongoing funding cuts (Desantis & Mule, 2017). With non-profits receiving less funding, they are more dependant on the funds they do receive and the contractual obligations through which they receive those funds. This limits both the resources and the strategies that non-profits can use to push their policy goals forward.

As noted above, an important consideration for the ACF is how the strategies of non-profit advocacy have changed within this restricted environment of the Westminster parliamentary system. There are different advocacy approaches that can be taken which include political advocacy, which focuses on influencing government decision making; and social advocacy, which focuses on influencing public opinion (Jenkins, 2006). Most public advocacy efforts in mental health organizations are social in nature and aim to reduce stigma. Within the political advocacy efforts, there is an external strategy that is more aggressive and confrontational, and an internal strategy that is less aggressive, more cooperative, and includes activities such as meeting with government officials and working on advisory groups (Almog-Bat & Schmid, 2014; Desantis & Mule, 2017).

With the increase of collaboration in government program design, implementation, and evaluation, there has been a greater trend toward this kind of advocacy in Canada (Almog-Bat & Schmid, 2014; Desantis & Mule, 2017). Insider advocacy, also referred to as better reflecting policy participation rather than advocacy (Desantis & Mule, 2017), may be a more effective way for advocacy coalitions to reach their policy goals over time. By developing longer term, allied relationships with government, organizations build capacity and can potentially integrate their policy beliefs and goals into the government process (Almog-Bat & Schmid, 2014). The ACF may be more congruent with insider advocacy because it includes the government-focused subsystem, but still includes the long-term coalition structures, resources, and strategies of advocacy coalitions. However, it was also highlighted in the literature that external pressure is a more effective strategy for advocacy than the less aggressive activities that occur within internal advocacy efforts because it enables advocates to be more assertive and persistent in their negotiations with government (Schmid, Bar & Nirel, 2008). It would be important for the ACF to

consider the difference between external versus internal advocacy and how these relate to the ACF and the parliamentary system under which they operate.

The policy actors within Manitoba's mental health policy subsystem were found to be lacking significant financial resources, which was identified as a major barrier to implementation. Interview and document data determined that the amount of funding provided would not be sufficient to fully implement the strategy. However, the funding that was allocated to the strategy was also identified as a facilitating factor for a select number of activities that were chosen for implementation.

Further examination of the processes within the policy subsystem uncovered significant findings regarding implementation at the front line level. Time constraints were found to be a significant barrier to implementation due to the heavy caseloads that all front line respondents reported. A disconnect between policy and practice in terms of how applicable the strategy was to front line workers was also identified as a barrier. Components of the strategy, such as mental health promotion, were not seen to be realistic goals for clients struggling with the most severe and persistent of mental illnesses.

Organizations that did not find the strategy applicable, philosophically or in practice, did not provide their front line workers with the organizational culture of support needed to facilitate implementation, which was found to be a barrier. However, organizations that did have a culture of support for the strategy facilitated implementation through communication and guidance. Having this support fostered leadership in implementation actors, which was found to be another facilitating factor in this strategy's implementation. While many of the policy actors involved in the design of the strategy assumed the policy had not gone any further, front line workers who were made aware of the strategy assumed leadership roles by taking the initiative to learn about

the strategy and in determining how they could apply it to their practice. This took the form of changing the way they worked with their clients and of determining how organizational planning documents should be articulated to reflect the strategy's pillars and goals.

The application of the ACF to the implementation of the strategy also included important factors that were exogenous to the policy subsystem. Just as time constraints were identified as a barrier for front line workers, they were also identified as a barrier in terms of the time line given to implement this strategy. The ACF uses a timeframe of ten years or more to study policy change over time and this implies that the five-year time frame given for this strategy would lead to pre-mature judgments of implementation and would not allow enough time to learn and revise elements of the strategy that needed to be changed. The exogenous factors also included political, economic, and social external system events that impacted the implementation of the strategy. For example, the lack of financial resources that was found in this study was related to a lack of political commitment in allocating funding. This lack of political will may have been further related to the mental health stigma that exists in the societal context and the lack of public pressure on the government to make significant changes.

A review of documents also highlighted a number of events that negatively impacted Manitoba's economy, including two major floods, an aging infrastructure, and the H1NI crisis. These events caused changes in government strategy and an unprecedented tax increase, which led to the occurrence of a number of political conflicts over the course of this strategy's implementation. Included in these conflicts were a reshuffling of cabinet members in 2013, the resignation of five cabinet members followed by another reshuffling of cabinet in 2014, a leadership convention in 2015, and an election that saw a change in the provincial governing party in 2016. These conflicts would have had inevitable impacts on the implementation of the

strategy. The government would have been focusing attention and resources on leadership and election issues rather than ensuring the implementation of a strategy in a small branch of the Health Department. The cabinet changes also led to instability and a lack of leadership within the department responsible for the strategy. There were three different health ministers over the course of the strategy and the latter two would have had to take a significant amount of time to familiarize themselves with the portfolio and the strategy.

Given all of the dynamics within the mental health policy subsystem and the dynamics within the external policy environment, there were many issues that arose during the implementation of this strategy. The potential for policy-oriented learning existed, and a number of the barriers identified could have been addressed in a revision of the implementation response. However, a process of policy-oriented learning was not evident. The occurrence of barriers brought implementation to a halt rather than creating adaptations for improvement. The limited time given for implementation of this strategy and the change in priority to focus on the Child and Youth Mental Health Strategy also prevented a process of policy oriented learning to occur.

The application of the ACF to the implementation of Rising to the Challenge was helpful in describing the processes, factors, challenges, and facilitating factors that impacted this stage in the policy process. The interviews and documents served as very rich sources of data for this description. The findings of this study have important implications for theory, policy practice, front-line practice, and for the literature. The following sections discuss these implications. The chapter concludes with a discussion of the limitations of this study.

Implications for Theory

This study embodies important implications for the theoretical foundation used in this research. The application of the Advocacy Coalition Framework was used to help describe the

processes occurring throughout the course of the implementation of Rising to the Challenge. It was also helpful for identifying processes that did not occur, and concepts that were different than those included in the ACF, and how these differences contributed to implementation failure.

The ACF's concept of a policy subsystem was a useful way to describe Manitoba's mental health system. Manitoba's mental health system has been described as very complex, with its variety of different organizations and roles in both primary and tertiary mental health care settings. The synthesis approach and the ACF are appropriate for studying this system because of their potential to incorporate the perspectives of these various policy actors while providing a structure in a province with such a complex system. However, there were some issues with a lack of coherence between the ACF and the Westminster model in which the mental health system resides. The top-down nature of this model requires different strategies by coalitions in order to create long-term allied relationships with political parties. The lack of active advocacy coalitions in this case may be an indicator of a lack of awareness of how to strategize advocacy efforts within this system. The challenge regarding the norm of secrecy within this civil service also limits the extent of policy oriented learning that can occur for mental health policy implementation and may put future efforts at creating effective implementation plans at risk.

Although active advocacy coalitions did not emerge, the ACF was useful in describing Manitoba's mental health system by considering different groups as advocacy coalitions. Examples could include private mental health organizations as opposed to public mental health organizations; each may hold different beliefs and strategies about how to move their policy ideas forward and each would have different resources at their disposal. Other examples of advocacy coalitions could be recovery oriented organizations and bio-medically oriented

organizations. These groups have different beliefs about treating mental illnesses and different resources. The findings of this study and the discussion on non-profit advocacy highlighted how solidarity is not enough to bind advocacy coalitions together. Considerations could be made for the ACF to look at deviations in policy beliefs within coalitions and what incentives exist to keep policy actors involved in advocacy efforts.

According to Sabatier (1986), these coalitions compete with each other to dominate policy making. While there was no evidence that the bio-medical system worked together to advocate for their interests, it is clear that the biomedical system has dominated the mental health system and usually secures the most financial resources. This is partially due to the funding arrangements for the Canada Health Act being based on insured and extended health services and because the bio-medical system is funded differently than the rest of the mental health system. The Canada Health Act includes funding arrangements for physician and hospital services and does not include community mental health services (Canada Health Act, 1985 c. C-6). This highlights how the provinces have agreed that physician and hospital services are central to the publicly insured health services system and helps to explain why the bio-medical system consumes the greatest part of the health care budget. As per these arrangements, physician services receive fee for service funding and hospital services are globally funded, whereby community mental health organizations are provided grant funding through provincial contracts. This gives community organizations less discretionary power in the services that they provide since they must meet the contractual obligations set out by the province. The nature of physician and hospital services funding, as well as their centralization in publicly insured health services, contributes to the dominance of the bio-medical system in Manitoba's mental health system. The ACF would suggest that community-based and recovery oriented organizations would have to

band together, learn to work with competing coalitions, and coordinate their activity to overcome the dominance of the biomedical model. There was not evidence of this happening over the course of this strategy.

While the policy subsystem concept was useful to describe Manitoba's mental health system, some of the concepts within the ACF's subsystem were not present in this particular strategy. Advocacy coalitions were not officially defined for the strategy and all of the departments and sectors involved in the mental health system were not involved for the strategy. The most applicable organizations that could be included would be the organizations that were involved in its planning, such as the Mental Health Branch, WRHA, and self-help groups. But these groups were not as oppositional in nature as the ones described in the ACF and, while they may have held some different values and beliefs, they were generally working towards the same goal. Policy brokers also were not officially defined throughout the implementation of this strategy. It could be said that the Mental Health and Spiritual Health Care Branch was the policy broker because it heard from a variety of stakeholders in order to develop the strategy document. Since it would be expected for coalitions and brokers to be formally organized in applying the Advocacy Coalition framework, the lack of definition in this case study implies that there can be difficulties in applying this theory to define coalitions in this field, especially for policies or strategies as broad as this case study, and this may help to explain why there are limited ACF applications in the mental health field. However, the fact that there were no formally organized and active coalitions, can serve to partially explain implementation failure because coalitions were not present to advocate for implementation of the policy. This demonstrates the importance of advocacy coalitions in policy implementation.

The ACF is also useful for determining the many policy actors that are involved in a policy response. Identifying those who are in these coalitions can help in understanding how strategies are developed and how dealing with groups working towards different policy goals is handled. However, the policy actors involved in this response were not directly identified aside from the policy makers. Front line workers were not a focus of the implementation of this even though they play an implementation role. They were not consulted in developing the strategy or implementation plan, even though they are the policy actors who work closest to the problem at hand and with those who are impacted by mental health issues. This is an example of how this model may help explain the evidence of implementation failure. Front line workers were not even expected to have a role in this, according to policy makers, so it was not a true attempt at a synthesis approach to implementation.

The application of the ACF was useful in understanding the belief systems that exist in Manitoba's mental health system. Organizing different groups within the subsystem based on their belief systems helps with understanding this policy's implementation process in a more systematic way. For example, it was made clear that professionals who adopt a recovery approach value different policy goals than those who adopt a bio-medical approach to mental health. According to Sabatier (Sabatier, 1986), the support of advocacy coalitions sharing the same beliefs and seeking to change common policy goals over time is essential for effective implementation; it is the organization of these groups that can actually implement policy ideas into practice. We saw this with examples where recovery-oriented organizations were supportive of a front line worker wanting to learn about the strategy and subsequently finding ways to implement it into her work. This was similar to the policy maker who found the strategy very applicable to her work. This relates to the theme of how the presence of organizational cultures

of support helps to facilitate implementation. However, we also saw how different beliefs moved the implementation of this policy in different directions. Front line workers, especially, implemented it in different ways based on how they interpreted the policy's role, and the lack of articulation of the policy provided a lot of space for different interpretations.

The application of the ACF was useful in describing the elements of implementation that were outside of the policy's subsystem. Using these concepts was a useful way to describe what was occurring socially, economically, and politically in the context of this strategy. These are important factors to consider and certainly effected the implementation of the strategy. This application helped describe this policy's implementation in terms of the unstable political context within which it operated, the economic changes that altered the financial strategies for the governing party, and showed how important financial resources were to the implementation. It also helped describe the social impacts on the policy, such as how this policy operated within a context where mental health issues are still stigmatized. This also impacted the degree of political support this strategy received, and subsequently impacted the amount of financial resources that were allocated to its implementation. Other exogenous variables included the short-term constraints and resources of subsystem actors. It was clear that the lack of financial resources applied to the strategy impeded policy actors' abilities to implement the strategy. It was also evident that the time constraints of policy actors created a challenge in implementing this policy over time.

The five-year time frame utilized for this strategy was much shorter than the ACF's ten-year timeline for studying policy implementation. However, it is useful in describing some of the issues that arose as a result of using this timeline. As was described in the literature, limited time frames of less than ten years may lead to premature judgments about the effectiveness of the

strategy (Sabatier, 1988). According to Sabatier's approach, the five year period of time would not have given policy makers enough time to implement objectives, observe them operating in practice, evaluate them, and revise them as necessary. Given the fact that the policy makers did not complete five years of implementing the strategy with it starting slow and having another strategy take priority over it a few years in, objectives were not achieved and an evaluation and revision process did not occur. For a policy with as much breadth as this one, reformulating the policy would be almost inevitable; the short time line for implementation did not allow this to happen. While having a timeline of ten years or more is not typical in government settings, it would allow for a better process of policy oriented learning to occur. An assessment of partial objectives could be said to have occurred to understand the implementation of the strategy within this limited timeframe, but as was described earlier, many of the initiatives included in the Summary of Achievement reports were not directly related to the strategy.

While evaluation and revisions did not occur, there were lessons that were learned as this policy was implemented that could have contributed to a process of policy-oriented learning. It was learned that a significant number of people were not aware of the policy; this could have been addressed over time by adjusting the plans for how to distribute information about the strategy across the mental health system. It was learned that a stronger cross-departmental and cross-sectoral approach was needed to improve implementation; this could also have been addressed with further consultation with these groups regarding how to incorporate them into the implementation plan. It was also learned that there were some issues that arose that did not allow for simple solutions and revisions. Funding for this strategy was limited, and given the historic low levels of funding for mental health, it is unlikely that this will change and this barrier will continue to stall attempts at implementing system transformative change. We also learned

through this process about the conflicts between the recovery approaches and bio-medical approaches; this would be a very difficult conflict to address and would require significant effort to determine how to incorporate recovery-oriented systems into the bio-medical model.

It should also be noted that facilitating factors were identified through the implementation process, as well. We saw how, over time, implementers learned to pick out the cost-neutral activities of the strategy because of the limited funding to implement the more costly activities included in the strategy. This is why there was a strong uptake of the philosophical pillars for front line workers. Despite the barriers to implementation, these policy actors went forward and implemented the strategy in the best way they could. Unfortunately, there was not an expectation for front line workers to be involved in implementation. This study showed that there is a lot that we could learn from the role they took in this, but that their views were not considered. The lessons learned from their experience would not have been included in a process of policy oriented learning and would not have contributed to what could have been positive changes in the implementation approach.

This application of this theory to Rising to the Challenge raises important questions about the ACF. The first set of questions is in regard to the policy actors who are involved in implementation. In the synthesis model tradition, the ACF utilizes actors from top down and bottom up approaches to marshal all the resources and strategies from all of the actors in a policy subsystem. However, it is not clear how policy actors are expected to be involved. Does everyone need to be directly aware of the strategy to be involved in its implementation? Perhaps the fact that most front line workers were not aware of the strategy would hinder attempts at implementation. It is also important to note that it would be nearly impossible to have absolutely everyone in Manitoba who plays a role in supporting people with mental illness be aware of the

strategy and have an active role in it. This is an important factor to consider. It would be helpful for the ACF to clarify what the scope is of the policy actors who are involved in implementation.

It would also be helpful to clarify the roles of frontline workers in policy change. In this application of the ACF, a number of front line workers who were not expected to play an implementation role ended up adopting the strategy into their practice. It may be useful for the ACF to examine policy change from the perspective of front line workers who implement policy in the absence of structural changes to programs or modified practice guidelines.

This study also raises questions about the concept of advocacy coalitions in the ACF. As has been expressed throughout this thesis, Manitoba's mental health system is very complex and operates within and outside of a formally defined scope. This limits a researcher's ability to clearly define the advocacy coalitions that may exist within the subsystem. With Manitoba's mental health system being so complex, how can there truly be coordinated policy activity over time with formal, semi, and informal systems, with private and public systems, with various departments, and with other health and social services involved? Granted, there are bodies that carry more of the responsibility for coordinating activities over time, such as the provincial government and regional health authorities, but it has already been determined that many organizations were not involved in the coordination of this policy response. The theory would need to account for the interaction among different organizations, along with their different mandates and accountabilities. Unless the ACF can add information about the coordination of complex and fragmented systems, the ACF may not be an appropriate theoretical foundation for studying mental health policy implementation.

More questions arose about the process of revising policy through policy-oriented learning. Through this study we learned that respondents interpreted and implemented the policy

differently based on their beliefs about the strategy's role and purpose. The ACF implies that alterations like these would lead to an overall revision for this one strategic initiative and it would continue with those changes having been made to it. But, in reality, the strategy appeared to take on different directions rather than it being revised in the cyclical direction illustrated in the ACF's flow diagram. A policy maker used it as a theoretical foundation; a manager used it to start a mental health promotion program; a front line worker used it to increase social inclusion and empower her clients; a steering committee member thought it had fallen off the table. It appears that the strategy was an initiative that had grown in different directions, rather than flowing in one direction through feedback loops, policy oriented learning, and revision. It would be helpful if the ACF could include how different beliefs, interpretations, and changing contexts can lead to enduring deviations in the implementation process.

Finally, this study raises questions about the ACF's relationship to the synthesis model of policy implementation. It is not clear to what extent the ACF utilizes the bottom up approach. The theory implies that front line workers are involved in the coalitions that work to move their policy ideas forward, but how do they play a role in the implementation process? This study was unique compared to other implementation studies in that it included front line workers as opposed to most studies that primarily study the experiences of policy makers and managers (Awenva et al., 2010; Beidas et al., 2013; Elrod et al., 2006; Fleury et al., 2014; Lloyd-Evans et al., 2017; Proctor et al., 2007; Smith et al., 2017). This study illustrated how front line workers were implementing this policy differently, but it is not clear how this changes the processes through feedback loops. Would policies always be revised based on how front line workers are experiencing them? Would this even be realistic, given that there are large numbers of front line workers within the complex mental health system of Manitoba? It is not clear how the policy

feedback loops could realistically incorporate all of these perspectives, beliefs, and strategies within a process of implementation. This would need to be organized as part of the implementation process.

These questions raise important implications for the application of the ACF to mental health policy implementation studies. This theoretical framework has significant potential for furthering the understanding of policy change in the mental health field, so it would be helpful to gain an understanding about how these factors impact this model. Exploring these questions through further research is needed to create a clearer picture of how the ACF can best be applied in this field.

Implications for Practice

Policy Practice.

The findings of this study help to explain the factors, process, challenges and facilitating factors that effected the implementing of Rising to the Challenge. They also highlight important implications for policy practice. By describing these findings and the challenges that implementers experienced with the policy, this study can help policy makers in this field plan more effectively. The discussion of the following strategies may have some implications for implementation that the current government may consider for provincial mental health strategic planning.

It was indicated in the findings that a clear implementation and evaluation plan was not developed for the strategy and that this challenged the implementers' capacity to see implementation through to its completion. Implementation was further hindered by the lack of clear, measurable goals and clear outcome indicators in the strategy document that implementers were left with since the plan to create clearer goals did not come to fruition. The importance of

clear and measurable goals along with a plan for implementation was highlighted in the literature (Barry, 2007; Lund et al., 2014; Shera & Ramon, 2013b). This implies the importance for future policy makers to ensure the creation of specific implementation and evaluation plans to coincide with a strategy, inclusive of clear and measurable goals.

The findings also indicated how leadership was a strong facilitating factor in implementing the strategy. Front line workers who found value in the strategy took the lead in initiating implementation by learning about it and figuring out how it applied to their organizations and practice. The idea of having a policy champion within an organization was also highlighted in the literature as a way to create organizational support in implementing a policy and in creating clear roles and lines of accountability for the process. Future policy makers might consider identifying a policy champion in as many organizations as possible to ensure that there is a person in charge of localizing the strategy if need be and of ensuring that the policy is implemented within the organization.

This study also found that a clear network of implementing actors was not identified for Rising to the Challenge. This would need to happen as well in order to identify who the policy champions would be and in order to specify the implementation roles of the members in this network. The literature highlighted how this is a particular challenge for the mental health system because of the fragmentation that exists, the overlap between different programs and organizations, and the different funding models and priorities (Lester and Glasby, 2010). While this is a challenge, the complexity of the system makes doing this even more important if a policy is aiming to have more than just a symbolic effect. For future policy makers who are seeking to implement policies with clear goals, outcome variables, and specific actions, the network that will be needed to play a role in the implementation process will need to be

identified, as well as their responsibilities and accountabilities. Policy makers will also need to create a communications system so all departments, sectors, and organizations impacted by mental health policy will be informed.

The findings of this study highlighted some of the barriers that front line workers experienced with the implementation of this strategy. It was clear how time constraints and a lack of guidance impeded their ability to understand and be able to implement the strategy. The literature highlighted how time constraints and a lack of managerial support can lead to front line workers not adopting a policy (Barry, 2007; Lester & Glasby, 2010; McCollam, 1999; Nilsen et al., 2013). The literature also showed that having an implementation plan that includes tangible resources and materials that can help policy actors understand their role in implementation can serve as facilitating factors (Hogwood & Gunn, 1984; Pressman & Wildavsky, 1984; Sabatier & Mazmanian, 1981). This implies that it would be useful for future policy makers to create educational materials so that front line workers do not have to struggle as much with the time it takes to learn about the policy on their own, and this will help them learn their role in implementation in a timely way.

This study also found that the lack of resources that were available for this strategy's implementation, both in terms of financial and human resources, was a major barrier. In terms of financial resources, there was not enough funding allocated for the strategy to accomplish all of the activities it set out to accomplish. The literature also highlights how financial barriers play a significant role in reducing the ability of a policy to be executed into practice (Barry, 2007; Flisher et al., 2007; McCollam, 1999; Shera & Ramon, 2013b). In terms of human resources, the turnover that was experienced in the steering committee alone impacted the implementation by reducing the amount of leadership and commitment among the top policy makers for this

strategy. While turnover may be hard to control, future policy makers should make attempts to ensure that planning committee positions are filled so that there is a strong core of leadership guiding the policy's implementation. It is also recommended that financial resources be identified prior to the strategy's development so that the actions that are taken are developed accordingly, rather than planning a robust strategy that is out of the scope of available financial resources.

Finally, the study provides policy implications in regards to the time frame that was set for the implementation of the strategy. The five- year time frame was not enough time to allow for a process of policy oriented learning to occur. The literature (Heclo, 1974; Mazmanian & Sabatier, 1983; Sabatier, 1988; Sabatier, 1986; Weible et al., 2009; Weible & Sabatier, 2007) regarding the ACF clearly indicates that a period of ten years or more is needed to study policy change over time and to allow for policy oriented learning to occur. While setting a timeline of ten years or more for a provincial strategy is atypical, doing so would help policy makers create a more meaningful and thoughtful process where lessons can be learned and strategies can be revised to improve the outcomes of the strategy for Manitobans.

Social Work/Front-line practice.

The findings from this study also highlight important implications for social work practice and other front-line professions working in the mental health field. Front line workers are included among the street-level bureaucrats (Lipsky, 2010) who are responsible for putting policies into practice. By using the synthesis model of implementation front line workers can mediate some of the issues that they encounter. For example, policy divergence is often found when there is a conflict in interaction between agency preferences and street-level bureaucrat preferences, as when one respondent felt that the strategy was not directed towards the needs of

the clients with whom she was working. The discretion that social workers can use when implementing a policy that affects their clients may be different than the directions for implementation that are provided by their agency (Oosterwaal & Torenvlied, 2000). Rather than having this lead to implementation failures, front line workers can work with the various actors in the policy network to reformulate the policy over a significant period of time. In this way conflict will be able to be used productively to learn from and reformulate policy.

The mental health policy implementation literature provides recommendations to effectively carry out this process. These recommendations also have implications for front line workers. These facilitating factors can be organized into four core areas: policy, political, system, and organizational factors. The policy specific facilitators found in the literature included adopting new ideas from ground level while maintaining core elements of policy and undertaking ongoing revision of mental health policies (Awenva et al., 2010; Barry, 2007; Flisher et al., 2007; McCollam, 1999; Shera & Ramon, 2013). While front line workers may not often find themselves working at the policy development level, they can still ensure that they play a role in developing and implementing effective policy. Front line workers can get involved in policy and advocate for what needs to be considered based on their perspectives gained from working on the front lines with the people who are most impacted by the policies being developed.

With regard to political facilitators for implementation, this study's findings also suggest that having political support is a significant factor in facilitating the implementation process. This point is also highlighted in the literature (Barry, 2007; McPherson, 2011; Shera & Ramon, 2013a). This may also seem like a recommendation outside of the scope of work that front line workers generally find themselves doing; but their contributions as informed members of the

public at this level can significantly impact political support. This is another opportunity for front line workers to be advocates for their clients' needs in the development of policy. Provincial legislatures, like Manitoba's, for example, have committee meetings prior to a Bill being passed where members of the public can voice their opinions on a particular piece of proposed legislation (Government of Manitoba, 2016a). This is a great opportunity for front line workers to use their experiences to gain political support, influence the policies that will be implemented through their work, and to maintain contact with political decision-makers after a bill is passed to focus on the adequacy of its implementation.

Another strategy for gaining political support for policy is to gain public support, since this is an important element for influencing politicians. The need for public support was highlighted by a number of respondents in this study. Front line workers can help build support by increasing mental health awareness and education. As was related in the discussion about stigma and definitional ambiguity of mental health, there are still widespread misunderstandings about mental health. In order to carry through a major policy to effect social change, a strategy to inform and educate the public to gain its support would be required (McCollam, 1999). It would also be beneficial to direct education and awareness campaigns towards policy makers and professionals in the field so that any misconceptions or negative attitudes can be addressed among those developing and implementing these policies.

Mental health system specific recommendations from the literature include functioning as a multidisciplinary team, providing consultation to organizations, collaboration, reviewing the fidelity of the implementation plan, and developing health research through awareness of its importance, and funding (Awenva et al., 2010; Bollini et al., 1988; Fears & Höschl, 2011; Ingram et al., 2014; McCollam, 1999; (McPherson, 2011); Mechanic et al., 2014; Shera & Ramon, 2013).

Front line workers also play an important role in implementing policy at the system level.

Through capacity building, social workers can build the mental health workforce to develop the skills that support the implementation of policy initiatives (Barry, 2007). Capacity can be built through teaching programs aimed at developing the mental health knowledge of those involved with policy development and implementation, through providing ongoing support and supervision to those responsible for the implementation, and through developing networks for mental health policy where practitioners can share their experiences and promote new projects and effective policy implementation (Lund et al., 2014). By involving themselves in teaching and learning opportunities, front line workers can ensure that policy implementation occurs within a system of knowledgeable mental health professionals.

System recommendations also suggest addressing the social determinants of mental health (National Collaborating Centre for Healthy Public Policy, 2014). Mental health is regarded as being the product of a number of social determinants, which suggests a need for a multi-disciplinary approach to policy development and implementation; one which focuses on public policies that favor mental health and address the social determinants, such as employment policies, poverty reduction policies, appropriate criminal justice policies, and educational access policies (Mantoura, 2014). Social workers, in particular, work at improving the social inequities that people face as the core of their profession. There needs to be recognition of the overlap between mental health and the various fields of practice that social workers and other front line workers find themselves in, like poverty reduction, health, justice, education, employment, or child welfare. Front line workers can ensure that mental health policy crosses these various social departments by working collaboratively on multi-disciplinary teams to identify how social determinants influence mental health and should be incorporated into mental health policy.

The organizational recommendations in the literature included training staff and applying learning immediately for increased retention, leadership, providing additional time, supervision, a culture of support, having people with implementation experience on board, identifying a policy coordinator in each implementing agency, and determining roles for all those involved (Awenva et al., 2010; Barry, 2007; Bollini et al., 1988; Deane et al., 2006; Fears & Höschl, 2011; Hogwood & Gunn, 1984; Lester & Glasby, 2010; McPherson, 2011; Pressman & Wildavsky, 1984; Sabatier & Mazmanian, 1981). Front line workers can also engage themselves in teaching and learning opportunities within their organizations to improve their own and their colleagues' knowledge on effective implementation.

They can also take a leadership role in their organization, which was found to be a facilitating factor to implementation in this study. Strong leadership has been found to be effective in implementing mental health policy. Some regard this as mattering most in translating plans into actions and argue that leadership capacity needs to be developed from the macro level of policy to local levels of implementation (Barry, 2007; Lund et al., 2014). Strong leadership provides direction and accountability, which are important within a system comprised of so many different organizations and stakeholders. With so many varied stakeholders involved in this process, roles and responsibilities are recommended to be emphasized in implementation planning. Policy players need to clearly define the roles and responsibilities of key stakeholders in implementing the policy and indicate how the capacity to enact these roles will be built (Lund et al., 2014). Front line workers can ensure that they have a clear understanding of their roles and responsibilities in order to contribute to increasing direction and accountability in implementation.

Relationship of Findings to Literature

The findings of this study relate well to the existing literature on mental health policy implementation. One of the findings of this study was that while an implementation plan began to create more specific goals, specific actions were not specified. The strategy document as it was first presented also did not include goals, objectives, and strategic actions that were specific enough to support implementation. In this sense, the strategy appeared to some as more of a symbolic response than an intentional policy response.

As was described in the literature (Barry, 2007; Shera & Ramon, 2013a), there are a considerable number of mental health initiatives and policies that offer positive sounding plans and ideas to improve mental health; however, they lack a transparent approach to putting these ideas and policies into practice. As found in this study, the policy itself was well informed by stakeholders and research and offered positive sounding ideas. However, the approach taken to putting this policy into action was lacking in terms of identifying who would be responsible for implementation and how implementation would occur. A significant amount of time and resources often go into publishing policy and strategy documents without being accompanied by an implementation plan (Barry, 2007). This may explain why the policy was referred to as “fizzling out” once it got to the implementation stage.

The literature also illustrated how necessary it is to ensure clear roles and responsibilities for those involved so that implementation actors know how they are expected to contribute to the outcomes of policy objectives and increase the chances for successful implementation (Hogwood & Gunn, 1984; Pressman & Wildavsky, 1984; Sabatier & Mazmanian, 1981). While the roles and responsibilities of the steering group seemed clear among these policy actors, the roles and responsibilities of the working groups and the organizations responsible for further implementing

the strategy were not clear. The literature would suggest that this would have been a significant barrier to this strategy's implementation.

The literature also described that what often occurs as a result of this inadequate implementation planning is that local agencies are expected to figure out how to implement new policies. This can be difficult in the social work and mental health fields, given the busy caseloads of front-line workers (McCollam, 1999). We saw this with the initiative taken by some of the front line workers and the policy maker who became aware of this policy and looked for their own ways to implement it into their practice; which was also noted as being difficult given their busy caseloads. The lack of clarity in specific implementation plans for this policy created a large gap in making improvements to mental health; the respondents indicate that the policy fell short and seems to have turned this into more of a symbolic policy rather than a set of solutions.

The literature also reflected the challenge found with the design of Rising to the Challenge with its five-year time frame. It expressed how comprehensive mental health system change is a long-term undertaking that is usually composed of gradual incremental changes (Lester & Glasby, 2010; McCollam, 1999). With this strategy's broad system wide goals that essentially involve moving from the entrenched bio-medical model to a new recovery oriented model, a five year time frame does not allow for the gradual changes that need to occur to move us towards the policy's goals. However, the five-year time frame allotted for this strategy does not necessarily reflect the policy makers' recognition of the reality of these changes. There are often limits to these time lines that have to be taken into account. These limits may be as a result of short-term or time limited funding arrangements (McCollam, 1999), more manageable evaluation periods, time lines being based within terms of office, or changes in government. It may not have been possible or realistic, given the circumstances in which this policy was made,

to propose a longer time line; it may have been more realistic to create simpler objectives that could be achieved within a shorter time frame or an assessment of partial objectives. But, generally speaking, long-term time lines should be considered for implementing broad system wide mental health policy changes in order to account for gradual changes and enough time to evaluate the policy's progress and reformulate the policy, if needed.

This study's findings also included evidence of the policy being implemented and the lessons learned from those instances. The front line workers who took the initiative to learn about the strategy and figure out how it applied to their practice were good examples of this. Strong leadership was a recommendation in the mental health policy implementation literature (Barry, 2007; Lund et al., 2014; Ward et al., 2017). It was related to the need for having an organizational culture of support. Leadership is needed in each organization in order for those working there to both understand and feel supported in their roles in implementing the strategy. While a couple of respondents reported feeling somewhat supported by their organizations in adopting the strategy, there did not appear to be a committed policy champion ensuring that the policy was being followed through and implemented effectively. One administrator who demonstrated leadership skills to implement the policy provided the most evidence of implementation in practice, hiring procedures, and decision-making. Aside from that story, leadership consisted of workers adopting the strategy's principles on an individual basis and creating examples of how others working in their organizations could implement the strategy.

The literature described how leadership capacity needs to be developed from the macro levels of policy to local levels of implementation (Barry, 2007; Lund et al., 2014) which coincides with responses in the data that described needing this capacity at policy, organizational, and front line levels. It was made clear in the literature that leadership provides

much needed direction and accountability within a system. These factors are very important to create an organized approach to implementation, especially considering how complex and fragmented Manitoba's mental health system is.

The findings of this study regarding the conflicts or complications that emerged in this implementation process also relate to the literature on mental health policy implementation. The definitional ambiguity of mental illnesses and mental health problems is well articulated in the literature that highlights how different characterizations of the concepts involved in mental health have been seen to be a barrier to implementing mental health policies (Mechanic et al., 2014; Shera & Ramon, 2013a; Ward et al., 2017). Having different ideas of what recovery means and different ideas on the best model of intervention clouds the interpretations of the problem and the justification of proposed policy solutions (Mechanic et al., 2014). The definitional ambiguity of mental health in Manitoba's mental health system and of the concepts used in *Rising to the Challenge* hindered its implementation process.

Another challenge that was found in the literature was mental health system fragmentation (McCollam, 1999; Mechanic et al., 2014; Ward et al., 2017). Across Canada there are complex systems involved in mental health that are similar to the various government departments, sectors of service providers, and informal support networks that have been identified within Manitoba. According to the literature, the challenge to implementation comes with coordinating this complex system and avoiding fragmentation to ensure system wide policy implementation (McCollam, 1999; Mechanic et al., 2014). It appears that some degree of a coordinated response was used in the development of *Rising to the Challenge* since the Branch assembled a variety of stakeholders to inform the document. However, this coordinated response did not seem to continue to the implementation of the strategy. This can be seen with entire

organizations being unaware of the strategy; as well as mental health front line workers employed within the public mental health system that developed the strategy.

This also relates to the need for clear roles and responsibilities of those involved in implementing mental health policy as expressed in the literature on implementation (Hogwood & Gunn, 1984; Lester & Glasby, 2010; Lund et al., 2014; Pressman & Wildavsky, 1984). Across service providers in Manitoba roles and responsibilities were not defined or allocated, which was made evident by the lack of knowledge of this strategy's existence. Since many service providers in this study were not given clear roles and responsibilities they could not determine how to effectively contribute to this policy's implementation. The lack of clear roles and responsibilities also created a barrier to implementing this strategy.

Another major complication that was found in this study was a lack of resources. The literature on mental health policy implementation highlighted how important resources are to a policy achieving its goals (Barry, 2007; Canada. Parliament. Senate of Canada. Standing Committee on Social Affairs, Science and Technology., 2004; Flisher et al., 2007; Lund et al., 2014; McCollam, 1999; Shera & Ramon, 2013b). Policy implementation is often challenged when there is not an organized health system in place, when an organization does not have the financial resources, or, if the staff does not have the capacity to see the policy through (Barry, 2007; Flisher et al., 2007). These challenges were evident in the implementation of the strategic plan. While there was not as much of an issue with having an organized health system in place aside from the fragmentation and complexity noted earlier, the lack of financial resources, lack of training plans for current staff, and mental health professional shortages minimized the likelihood of positive outcomes from this policy response.

The literature contains recommendations for resources to be allocated and planned for in the implementation process and one suggested way to do this was to use a mental health transition fund to shift resources from institutional settings to community settings (Lund, Caldas de Almeida, Whiteford, & Mahoney, 2014; Canada. Parliament. Senate of Canada. Standing Committee on Social Affairs, Science and Technology, 2004; Shera & Ramon, 2013). This would certainly be helpful with this policy's goal to shift from the reliance on the bio-medical system towards recovery-oriented services, but this, of course, is much easier said than done. This need was recognized by respondents. They suggested the need for advocacy for more mental health funding, including a mental health transfer fund from the federal government.

A lack of political support was also seen as a complication as it limited the amount of financial resources for the strategy. Political support was identified as a challenge in the mental health policy implementation literature, as well (Barry, 2007; Mechanic et al., 2014; Shera & Ramon, 2013b). Historically, there has been a lack of political support for addressing mental health issues, which has continued to push them further down the priority list (Barry, 2007; Shera & Ramon, 2013). Sources in the literature also describe how mental health usually only becomes a priority when a policy window opens in which the problems presents themselves in an undeniable way while at the same time converging with the policy and politics streams; a change often being led by a policy champion, which puts pressure on authority figures to act (Kingdon, 2003; Mechanic et al., 2014). As the interview respondents note, this policy window often occurs as the result of tragic events highlighted in the news. If someone, for example, has a mental illness and commits a horrific crime, mental illness becomes an issue of great concern that needs to be addressed. However, while it is clear to some that this means investments need to be made in mental health services; there is a balance between that thought and the stigma that arises in the

public at the same time. It is important to address the problem through policy or programming, but it is challenging to do so while taking the public's stigmatic views into account and without looking like you are, as one respondent described, "*sympathizing with the devil*".

Another issue that was highlighted in the literature is how quickly these issues recede into the background. Policy windows quickly close as soon as the next day's load of news stories enters into the forefront. If a more politically attractive issue comes into public view, the short term interests of political parties will often lead to choices to address that rather than an issue as complicated and as negatively viewed as mental health is (Shera & Ramon, 2013). This is one of the reasons why a public and political support are so important. With advocates highlighting how important mental health issues are and the need for investment continuously, it will be harder for the public and for the government to ignore. Activism is needed to keep that policy window open longer, or at least to open it up more often.

Stigma was also noted as a barrier in the mental health policy implementation literature. It is extremely influential as public opinion and cultural beliefs play a large role in guiding policy (Mechanic et al., 2014). While there certainly have been significant improvements in reducing stigma (Goldner, Bilsker, & Jenkins, 2016; Mental Health Commission of Canada, 2017; Stuart, Patten, Koller, Modgill, & Liinamaa, 2014), it still exists in the public and in politics (Saraceno et al., 2007). People are starting to speak out about their experiences, but we are not seeing the organized social outcry that we need to challenge the government in its responses to mental health. Stigma greatly affects how much attention mental health issues receive and the characteristics of a given policy. We can see this with the fact that *Rising to the Challenge* did not receive a lot of attention and that many people working in the mental health system were completely unaware of its existence. We also see this with the lack of funding attached to the

strategy. We are starting to see political parties put mental health issues on their platforms (Manitoba Liberal Party, 2011; Manitoba New Democratic Party, 2011; Progressive Conservative Party of Manitoba, 2011), which is certainly a positive step forward; however, the funding often does not follow through and the platform becomes an empty promise. Mental health awareness and education needs to increase in order to reduce this barrier to public mobilization and political action.

It was also made clear through the findings of this study that specific outcome variables were not developed, there was not an evaluation plan put in place and it is not clear how the accomplishments that were attributed to the strategy were determined. All of this limited policy learning and subsequent changes to address any concerns. Enhancing the monitoring and evaluation procedures for mental health policies came as a recommendation in the literature. McCollam (1999) noted how most often, evaluation processes are applied in a fragmentary way rather than on a collaborative interdepartmental basis. This fragmentation was made clear through the inconsistent reports of what procedures were in place for evaluation; as well as how valuable these were seen to be. Some respondents saw evaluation processes in place, such as reporting to the Minister of Health and the development of the summary of achievement reports and saw these processes as legitimate indicators of measurement and evaluation, while others reported that there were no evaluation procedures put in place and that the summary of achievement reports were not an accurate reflection of the implementation of this strategy.

It was also noted in the literature that evaluation is more easily facilitated when the implementation plan has clear and measurable goals. These goals can be used as a sort of checklist to determine what has been accomplished and where further work needs to be done (Lund et al., 2014). As previously mentioned, the goals, objectives and strategic actions of this

strategy were not very clear, which may have hindered attempts at evaluating it. Some of the language used, such as “strengthen the capacity” or “maximize opportunities” did not set out a clear path for what work needed to be done and what would need to happen for it to be achieved. Also, while the activities on the summary of achievements reports could be categorized under one of the broad goals of the strategy, there were no clear links between the strategic actions and the actions that were said to have been accomplished by the reports.

The finding regarding the lack of identification of the implementing actors within Manitoba’s mental health system also relates to what was found in the literature. As was noted in the literature, there are important weaknesses in most national, regional, and local levels of government in designing, implementing, monitoring, and evaluating mental health policies, and that this capacity needs to be strengthened (Barry, 2007). This relates to some of the issues that were found with regard to this strategy in terms of collaborating with various departments and sectors that are impacted by mental health, addressing the social determinants of mental health in a collaborative way, and learning how to identify and address other departmental and jurisdictional policies that impact your own. The literature suggested that this capacity could be built by developing the mental health knowledge of those involved with policy development from other departments (Lund et al., 2014). By developing this capacity we can reduce the gaps between departments and determine what connects them and how to work together to develop and implement effective policies.

The importance of addressing the social determinants of mental health was also found as a recommendation in the literature. It suggests a need for a multi-disciplinary approach to mental health policy development and implementation, which focuses on public policy that addresses the social determinants, such as employment policies, poverty reduction policies, criminal justice

policies, and education policies (Mantoura, 2014). Respondents saw this as underemphasized in Rising to the Challenge and something from which the mental health system would benefit.

The challenges that were found in this study in regards to front line worker experiences in implementing components of Rising to the Challenge relate to the challenge found in the literature on the applicability of policy to front line practice. The literature outlined how implementation can be challenged when the policy or the implementation plan is not valued in the same way across various implementation actors (Lester & Glasby, 2010). There were many differences among front-line workers as to how they viewed recovery-oriented practices in their day-to-day work, how they thought the strategy should be used as a practical tool or as a guide, and in their inability to use the strategy depending on its conflict with organizational values or existing legislation.

There did appear to be some inconsistencies among respondents in how much they valued the strategy; a couple of respondents reported using the strategy in their practice, while the others did not see value in adopting it. The literature also suggested that this could lead to a lack of support or resistance to a new policy, which can reduce the likelihood of implementation (Flisher et al., 2007). This can help explain why this policy did not appear to be implemented broadly across the system and could help to explain why it was not widely communicated among professionals in the mental health system.

This relates to the challenge in policy design found in the literature. The literature showed how, when policies are designed with generalized goals or objectives that are not realistic given the resources, implementation can suffer (Flisher et al., 2007). Implementation was also shown to be particularly challenging for social work and mental health fields, given the busy caseloads of front-line workers because they are given an additional responsibility for figuring

out how they are expected to implement the policy into their practice (McCollam, 1999). This was seen in the narratives about how there was a lack of resources to help front line workers implement the strategy and a lack of discussion as to how they were expected to implement it. The limitation described in the literature regarding mental health and social work practitioners not having the time to consider the strategy's implications due to their busy caseloads was also expressed by the front line worker respondents in this study.

Having a strong culture of support in an organization was noted as a challenge in the literature. Certain characteristics were described that comprise this culture of support, which included leadership, clear objectives, and clear lines of upward accountability (Lester & Glasby, 2010). Many of these characteristics were evident in the participants' responses. Leadership did not appear to exist for respondents whose organizations did not promote or adopt the strategy. An example of leadership was seen with the front line worker who took the initiative to read the strategy and figure out how to use it in her practice, which led to at least one person's implementation of the strategy. Having this leadership on a wider scale within an organization would increase the organization's culture of support and improve implementation.

The lack of clear and measurable objectives in the strategy may have contributed to why organizations may not have expressed as much support towards it. Even the ones which did support it aligned with the broader, possibly easier to understand, principles of the strategy, such as recovery. It may be difficult for an organization to support a strategy when it is not sure what to do with it. Clear lines of upward accountability were also not evident as was seen with the lack of managerial support described in most front line workers' responses. Even for the workers who had heard about it through management, there were no guidelines, protocols, or follow-ups to ensure that front line workers were adopting the strategy into their practice.

Ensuring these characteristics of an organizational culture of support is especially important in the mental health system. As noted in the literature, the mental health system in Manitoba is incredibly complex and fragmented. There are a wide variety of sectors, departments, and stakeholders that require organizational commitment or a culture of support in order to organize an implementation response to a policy. It was noted in the literature that the actors involved in this system need to have clearly defined roles and responsibilities to increase implementation capacity (Lund et al., 2014), which would be highly unlikely to be defined if there was not an organizational culture of support. The organizational support of a policy would be evident if it included defined roles and responsibilities for those in a given organization.

This study also found that there were conflicting views about the policy's role and value across implementing organizations. These various perceptions of the policy's role relate to the challenge found in the literature with regard to the tensions between the policy making level and the local implementation level. Lester & Glasby (2010) described how implementation deficits could occur when the policy is not viewed the same way among the various implementation actors. We saw this challenge with the applicability of this policy to front line practice and how policy makers may not be in tune with the realities of front line practice and the challenges to implement policy in front line practitioners' day-to-day work. It is also evident in the divergence in viewing the policy as a directional planning document versus more of a measurable action plan. Just as a front line worker may not implement a policy if she or he does not see it as valuable or realistic for her or his work, a worker may not try to find ways to incorporate specific measurable actions into her or his practice if she or he sees this document as simply a philosophical guide. The more support and cohesion among policy actors in regard to what the

policy is intended for, how it is to be implemented, and who is responsible for what will increase the likelihood of an organized implementation response.

Limitations

The following discussion outlines the limitations that existed over the course of this study. To start with, there were limitations in using ‘Rising to the Challenge’ to study policy implementation. The fact that it is defined as a strategy as opposed to being defined as a policy or legislation leads to different perspectives on the extent to which a document like this can be implemented. Since it has no legal requirement for implementation, it could be argued that this would not be a good example for studying policy implementation. However, based on the document itself describing plans for implementation and the attempts to create specific goals, objectives, and corresponding strategic actions, it is clear that the strategy was meant to be implemented over the course of its timeline.

It is also acknowledged that due to the scope of this study, a full account of the policy implementation was not provided for the entire province. The focus on Winnipeg omitted how the policy had been implemented in other cities and rural communities, aside from a couple of document examples that described actions being taken in Manitoba’s north. Last, the complex nature of this policy with its high number of aspects presented some challenges. While there were inconsistencies in the way respondents commented about the strategy based on their interpretations of its purpose and whether or not it was something that was intended to be implemented, the inconsistencies were sources of important findings. The amount of data gathered also helped complement this by supporting the different interpretations that were presented.

It is also recognized that there were limitations in the methodology chosen. Using qualitative methods can be limiting due to their subjective and personalistic nature rather than more objective and generalizable methods (Stake, 2010). While there are also strengths to a more subjective approach, as described in the methods chapter, limitations may still have surfaced in my interpretations and analysis of the data. There are methods that have been developed to enhance the quality of qualitative research, which were used to strengthen the quality of this study. In a constructivist study, such as this, reality is seen to exist in the form of multiple mental constructions where people construct their own understanding of phenomena based on their interactions with their surroundings (Lincoln, Lynham, & Guba, 2011). There are two sets of criteria that constructivists use to assess the quality of studies, and these are trustworthiness and authenticity (Guba & Lincoln, 1994). The trustworthiness criteria depend on the quality and competency of data collection (Rodwell, 1998). The criteria include credibility, transferability, dependability, and confirmability (Guba & Lincoln, 1994). The authenticity criteria refer to the integrity and quality of the process of attaining multiple constructions based on context (Rodwell, 1998), which include fairness, ontological authenticity, and educative authenticity (Guba & Lincoln, 1994). These criteria are used throughout the remainder of this chapter as a means to describe methods to enhance the quality of this study.

It is recognized that there are limitations evident in using the case study approach. It is a method that requires extra diligence due to the researcher's bias that can occur in developing her or his chosen methodology, including how she or he designs interview questions, observation forms, and how she or he selects documents (Yin, 2014). In order to control for this as much as possible, the interview questions and document abstraction form that were developed were checked with my advisor and were reviewed by my thesis committee.

It is also acknowledged that, like qualitative research, case studies have historically been critiqued for a lack of their ability to support generalization from their findings; however, while results may not be generalizable to populations, they are generalizable to theoretical propositions (Yin, 2014) such as, those discussed in the synthesis and ACF theoretical frameworks. When predictive theories, such as these, are used to study a phenomenon, the case study can be used to test these theories just as well as more generalizable methods (Flyvbjerg, 2011). It has also been argued that when single case studies are added to the literature of other case studies on similar topics, it creates a new group of case studies through which we can modify old generalizations (Stake, 1995). The results of this study add to the theoretical generalizations in the literature and may be used in concert with other studies to capitalize on key similarities or differences.

It is also important to note here that while case studies have been widely critiqued for a lack of generalizability, this has recently been contested by those who see generalization as an overrated source of scientific development, expressing that generalization is only one of the practical skills for carrying out scientific work (Flyvbjerg, 2011). This side of the argument also includes refuting the belief that case studies cannot be generalizable. It has been noted in the literature that one can often generalize on the basis of a single case, especially in cases where a study aims to falsify a proposition (Flyvbjerg, 2011). While this study did not aim to falsify a particular proposition, it contributes to ‘falsifying’ any assumptions that may regard mental health policies as automatically implemented just because policy has been published.

This idea of generalization relates to the trustworthiness criterion of transferability, which judges the quality of a study on the basis of its ability to allow for the possibility that information learned in a particular context can also have meaning in another context (Rodwell, 1998). While broad generalizations may not be possible for this study, inferences may be drawn by readers that

may have applicability in their own context situations through the thick descriptions that were developed to provide clear levels of meaning (Lincoln & Guba, 1990). Thick description refers to describing an experience in detail, but also connecting it to theory (Stake, 2010). This was achieved by comparing my interpretations of the results of this study to the theory found in the literature review in order to increase the quality of this study and the likelihood that transferability can occur.

There were also recognized limitations in the data collection and analysis stages of this study. In terms of the use of documents, there are limitations in the selection process. I requested access to documents that I thought would be useful; however there may be other useful documents that I was not aware of and did not ask for. Since I was not granted access to private departmental documents, there are many documents that exist that I did not have access to. The private documents that were obtained from a working group member only provided evidence of the work of one of the working groups, which implies that similar documentation existed for the other five goal areas that could not be included. Another limitation that has been noted in the literature is that all documents are constructed accounts rather than a necessarily accurate portrayal of social reality (Coffey, 2014). However, with this study's use of the constructivist paradigm, the different biases that exist within different groups' organizational cultures help to describe the uniqueness of the various experiences.

There are also some limitations regarding the interviews that were conducted. The sample size of ten interviews is a relatively small number of respondents. While this did provide for an in-depth exploration of their experiences, it would be harder to draw more generalizable conclusions. It is also recognized that there are potential biases. People who took an interest in participating in this study may have been doing so out of frustration with the processes under

study; on the other hand, some respondents spoke more positively about the process, which may have been influenced by the positions they hold in attempts to create a positive reputation for this policy. However, these biases still contribute to the contextual experiences of each respondent, which was taken account of in the analysis.

These issues also relate to some of the criteria that were used to enhance the quality of this study. The trustworthiness criteria of credibility and dependability were utilized here. Credibility refers to whether or not a study has established a balance of the various views as well as an increased awareness of the complexity of the issue (Rodwell, 1998); dependability refers to how well a study demonstrates a representation of the multiple perspectives based on what is included in the data (Rodwell, 1998). For the purpose of this study, data from each respondent were included and reported on regarding particular themes that were discussed in order to understand the different perspectives of the participants included in this study and how these various perspectives contribute to the complexity of this issue.

There may also have been bias in my own interpretations while eliciting themes from the data. In order to control for this, I engaged in a process of member checking to insure that I made accurate representation of the participants' experiences. Member checking is a way to seek accuracy where a research participant is provided with a copy of an interview transcript in order to confirm the researcher's reporting (Stake, 2010). This process also helped enhance the quality of this study based on the trustworthiness criterion of confirmability, which refers to the extent that a study's findings are grounded in the data (Rodwell, 1998).

Finally, some of the informants who offered to participate in interviews about this policy were already aware of its existence. In my professional experience working in Manitoba's mental health system, it was clear that many professionals were completely unaware of this policy,

which is an important factor to consider in its implementation. Professionals working in the mental health system should be aware of a province-wide five-year strategic plan aimed at improving mental health for Manitobans. While some were aware of the policy, others were not and were introduced to the policy as a result of being invited to participate in the study. While this may have led to inaccuracies regarding the content and purpose of the strategy, their impressions of the strategy and the barriers that led to them not being aware of it were important to include in this study.

Other than the methods that have already been discussed to manage the limitations in this study, there are additional criteria that were used to enhance the quality of this study. In terms of the authenticity criteria mentioned earlier, there are three measures that were used to strengthen this study, fairness, ontological authenticity and educative authenticity (Guba & Lincoln, 1994). Fairness refers to the researcher presenting all value differences, views, and conflicts equally (Rodwell, 1998). This was taken into account so that the differences and similarities among all study participants are reflected. This was particularly important for this study because it described the implementation process from the perspectives of different stakeholder groups.

Ontological authenticity refers to how the research participants' conscious experience of the world becomes more informed or sophisticated as a result of reading the study (Rodwell, 1998). The results and discussion of this study aim to influence the conceptualization that research participants and readers may have of the implementation process for mental health policy. In order to achieve this, statements and descriptions of various participants' experiences are presented with the expectation that the vicarious experience of reading these descriptions will help research participants come to a better understanding of their own experience (Onwuegbuzie, Leech, & Collins, 2008). A summary of the findings that include descriptions of these various

experiences will be distributed to each of the research participants. Participation in the interviews will also have provided an opportunity to discuss these processes and to develop a stronger understanding of the various experiences and factors that were present during the implementation of this strategy.

Finally, educative authenticity refers to the reader's increased understanding and respect for the values of others as well as how these values frame other perspectives as a result of reviewing the study (Rodwell, 1998). Since this study is descriptive in nature, it is intended to increase readers' understanding of this process, along with the values and perspectives of others and how they influence mental health policy implementation. This was achieved similarly to the methods for achieving ontological authenticity, by presenting narrative descriptions of the experiences of various stakeholders. The values of these stakeholders were highlighted in the narrative descriptions and connected to the ACF's premise regarding the beliefs and value priorities of coalitions and how these affect a policy subsystem and the implementation of policy.

It should also be mentioned that there are limits to the authenticity of this study due to the parameters of thesis research. According to the University of Manitoba, the purpose of a thesis is to build or test theories through independent, scholarly research, which should establish a student's competence and expertise in a given subject area (Faculty of Social Work, 2014). While there certainly are contributions that this study can make to those involved in the research and the mental health community, as noted in the introduction, the purpose of building and testing theory is not particularly community focused. The research is directed at an academic audience who are more oriented towards the complexity that the theoretical basis of this study will produce. In terms of authenticity and the concerns regarding the impact of the study on research participants and the community, the study might not contribute a lot in terms of

practical knowledge. Establishing expertise in a particular field also gives a very specific focus to this research, which may not be translatable to those participating in the study who need to consider many more topics, aside from policy implementation, in their daily work.

There are also methods that were used to enhance the quality of this study's final product. In order to enhance this quality, the study had to meet specific criteria, which include resonance criteria and rhetorical criteria. Resonance criteria assess the extent that the case study report fits with the alternative paradigm that the researcher has chosen to follow (Lincoln & Guba, 1990). As mentioned earlier, this study followed the constructivist paradigm. This means that the case study report reflected the multiple realities constructed by the respondents involved in this study (Lincoln & Guba, 1990). There are a variety of ways to establish the resonance criteria in a study. This can be done by avoiding recommendations which can be interpreted as generalizations, taking into account the values of the various stakeholder groups, and including my own reflections of my personal experience while conducting the fieldwork (Lincoln & Guba, 1990). All of these approaches were taken into account during this study.

Rhetorical criteria were also used to enhance the quality of the final report. Rhetorical criteria refer to those related to assessing the form, structure, and presentational characteristics of the case study (Lincoln & Guba, 1990). There are a number of methods that were used in writing the final report to help meet these rhetorical criteria. These included organizing ideas to enhance the central themes, ensuring coherence and corroboration, ensuring simplicity and clarity in writing so that the report is accessible to many readers, ensuring craftsmanship by carefully writing the report, and ensuring that the study is written in a way that expresses an openness to negotiation and alterations to the ideas proposed in the report (Lincoln & Guba, 1990). By using

these methods, this study's quality in terms of the final product was enhanced, along with the criteria mentioned earlier to enhance the quality of this study's process.

Areas for Future Research

The findings of this study suggest several new areas for future research. These areas include building on the methodology that was used, testing and expanding on the implications found for the theoretical foundation, and further exploring some of the specific findings from this study. Future research areas could include the following.

One area of future research would be to examine how mental health policy in Manitoba has changed and been implemented over a ten-year period of time. Since this study assessed the implementation of a strategy over a five-year timeline, some of the concepts of the ACF were not as applicable, such as the ten-year time frame and the extent of policy-oriented learning that was possible. It would be interesting to investigate mental health federally and what has been implemented and changed over the ten-year period of time since the Mental Health Commission of Canada was created in 2007. Another way to apply the ACF in studying mental health policy change over time in Manitoba could be to study the subject more longitudinally, such as studying the changes in mental health policy from the time when deinstitutionalization began to our current state of attempting to prioritize recovery oriented services in mental health care. This would likely involve studying multiple occurrences of policy implementation over a longer period of time.

Another area of research could be developing a study like this with a wider geographic scope. One way this could be done would be to investigate how implementation unfolds in less populated areas of the province. The study of this policy's implementation focused on the processes that occurred within Winnipeg. Evidence was presented of initiative being

implemented in other areas of the province, but a detailed account of this was lacking. Given the lack of access to services that people in rural and northern communities experience, it would be useful to study the extent to which provincial mental health policies attempt to reach these communities. Another way to widen the scope in developing a study like this would be to include more participants. While studying the experience of ten respondents gave this study an in-depth view of implementation from each of their perspectives, having more respondents may help corroborate the evidence found in the respondents' statements.

Additional research could be conducted to study methods for incorporating recovery-oriented frameworks into predominately bio-medically operated mental health systems, including fee-for-service and hospital based services. One of the conflicts that was found in the implementation of this strategy was how it did not apply well to the bio-medical system that continues to dominate Manitoba's mental health system. Learning how to strengthen the relationships between these two systems, how to shift services, and how to encourage managerial and front-line worker adoption of recovery-oriented values would be helpful in guiding the implementation of a strategy like this and would help contribute more facilitating factors to implementation research in the mental health policy implementation literature.

Another area of research could be to explore the role that front line workers play in implementation and in the ACF. Most implementation studies examine this stage of the policy process only from the perspectives of policy makers and administrators. This study took it a step further to incorporate ground level implementation perspectives, which led to some interesting findings, such as how front line workers were implementing the strategy in ways they saw fit when policy makers assumed the strategy had just fallen off the table. It would be useful in

expanding the literature on this idea to include front line workers in future policy implementation studies in mental health and other fields of study.

The findings regarding the experiences of front line workers also suggests further research to add to the theoretical literature. The ACF is an example of a synthesis model of implementation, which incorporates top down and bottom up approaches. However, the theoretical application of the ACF in the study was not completely able to incorporate the experiences of the front line workers. The questions that arose such as how are front line workers involved in implementation other than in the policy formulation stage, can the ACF incorporate all front-line worker experiences, what happens when front line workers cause policy divergence, and would every potential implementer in a given subsystem need to be directly aware of the policy, were not able to be answered. Further research in these areas could strengthen the articulation of the bottom up components of the ACF.

Further research into the advocacy coalitions that exist within the mental health subsystem would also be useful to explore. Advocacy coalitions and their relation to special interest groups could be included in this. As was indicated through this study, Manitoba's mental health system is very complex and fragmented. It also struggles with the definitional ambiguity of various concepts and treatment models. Since there were challenges in applying the ACF to this strategy's implementation, it would be useful to do further research into whether or not the ACF can apply to fields where the network of implementing actors and advocacy coalitions are not well defined. If so, how can advocacy coalitions be organized to include the complexity of the mental health system?

It should also be noted that while the ACF notes that coalitions are united through their shared belief systems, this might be more realistic in theory than it is in practice. With the

complexity of the mental health system, implementers may have different beliefs even within their coalitions that may cause them to perceive and implement the policy in different ways. For example, a social worker and a psychiatrist working in the bio-medical system are trained with different professional skills, theoretical frameworks, and philosophical orientations, which would likely cause them to view the needs and treatment plans of their patients differently. They may also have different professional association loyalties that could cause them to have quite different policy beliefs. Various implementers may have different material interests in terms of how their organizations are funded and whether or not they are paid through a salary or by a fee-for-service structure. This also leads to research questions regarding what happens when there are lasting deviations among the implementers with some taking the policy in different directions based on different beliefs and perceptions of the core principles. Further research is needed to study the belief systems within complex and fragmented systems, such as the mental health system in Manitoba.

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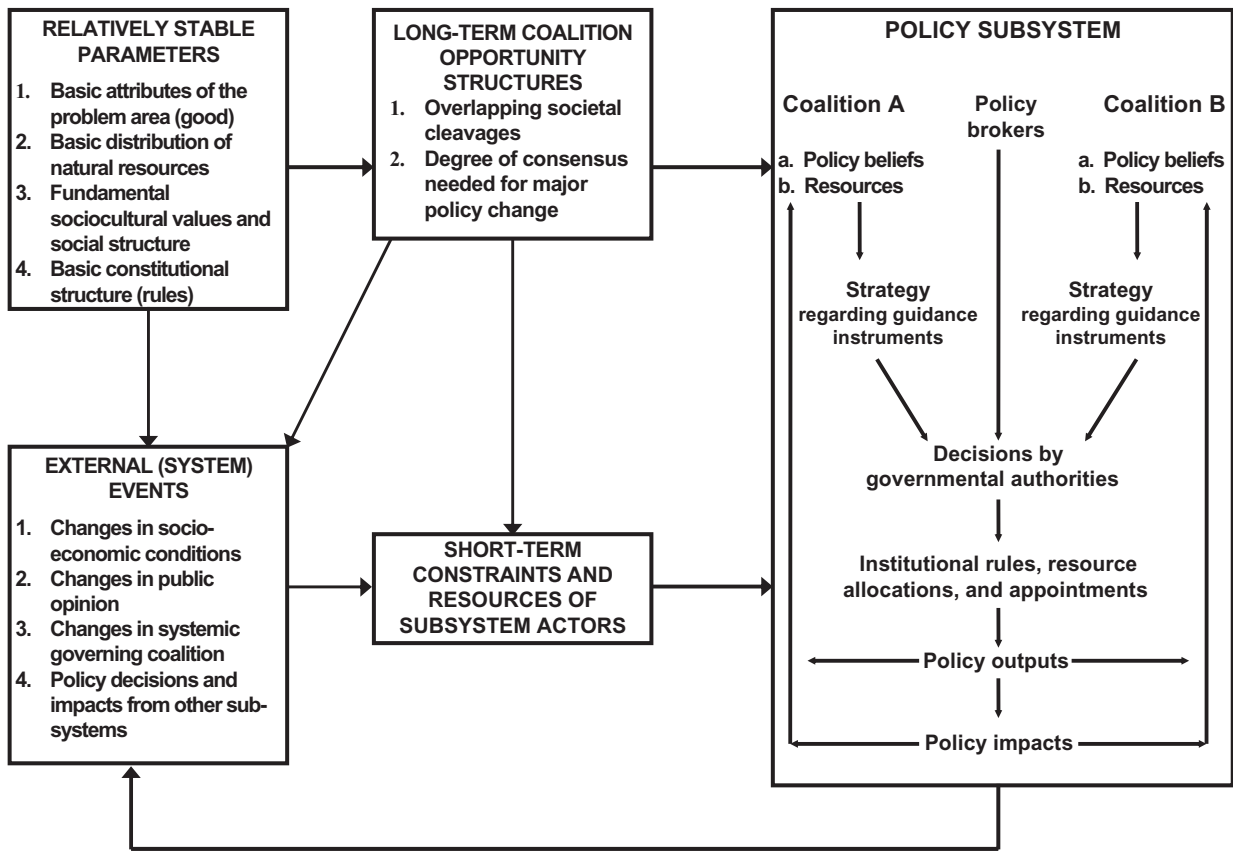
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Appendix A

Advocacy Coalition Framework



2007 Advocacy Coalition Framework Flow Diagram

(Weible et al., 2009)

Used with permission

Appendix B

Interview Participant Recruitment Letter

Date

Dear _____,

I am writing to you today regarding a research project that I am conducting for my Master of Social Work thesis through the University of Manitoba. My thesis is examining the implementation of Manitoba's mental health strategic plan "Rising to the Challenge: A strategic plan for the mental health and well-being of Manitobans". You have been identified by people with whom I have talked about the study as someone who may be involved in implementing this strategy, and your assistance would be very helpful and appreciated.

The study's purpose is to describe the implementation of Manitoba's strategic plan. A case study approach will be used in order to gather a detailed description of the processes involved. This description is aimed at determining the relevant factors related to the successes and barriers that have become apparent during the implementation process, along with the strengths and weaknesses of the approach that is being used.

I would like to learn more about your role in the implementation process and what your experience of it has been so far. Your participation in this study would involve meeting with me for a semi-structured interview that would last no longer than two hours. The interview will include a number of questions regarding the strategy itself, your role in implementing it, and various factors that might affect the implementation process. The interview will take place at a time that is convenient for you and off site of your employment agency in order to protect your privacy. Participation in this study is completely voluntary. You will suffer no consequences if you chose not to participate.

If you agree I will be tape recording your interview. The recording of the interview will be transferred from the audio recorder to an audio file that will be saved to investigator's personal computer. The audio file will be transcribed and saved as a Word document on the investigator's computer. One hard copy of the transcription will be printed for the purpose of data analysis. In order to protect your confidentiality, the audio file and the Word document will be stored on a password-protected computer and the hard copy of the transcript will be stored in a locked drawer in the investigator's home. I will not use your name or other personal identifiers in any presentation or research paper. All information containing personal identifiers, such as your consent form, will be destroyed by January 2016.

The findings of my study will be disseminated through the thesis, subsequent articles in peer-reviewed journals and presentations at professional meetings. I can also send you a summary of results from the study in June 2016. If you have any questions about this study or your participation in it please feel free to contact me by telephone at 204-232-2268 or by e-mail at umdeblok@myumanitoba.ca. If you are interested in assisting me by participating in an interview, contact me to indicate your interest. Thank you for taking the time to read this and for considering my request.

This research has been approved by the Psychology/Sociology Research Ethics Board at the University of Manitoba.

Sincerely,

Karen De Blonde

M.S.W Student

Appendix C

Interview Informed Consent

Research Project Title: Implementation of Manitoba's Mental Health Strategic Plan: A Case Study Application of the Advocacy Coalition Framework.

Principal Investigator: Karen De Blonde, M.S.W. Student, Faculty of Social Work
204-232-2268 umdeblok@myumanitoba.ca

Research Supervisor: Dr. Sid Frankel, Associate Professor, Faculty of Social Work
204-474-9706 Sid.Frankel@umanitoba.ca

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

This study examines mental health policy implementation. Its purpose is to describe the implementation of Manitoba's mental health strategic plan, "Rising to the Challenge: A strategic plan for the mental health and well-being of Manitobans". A case study approach will be used in order to gather a detailed description of the processes involved. This description is aimed at determining the relevant factors related to the successes and barriers that have become apparent during the implementation process, along with the strengths and weaknesses of the approach that is being utilized.

You are being invited to be interviewed for this study as a result of your direct experience in implementing this particular mental health strategic plan. The interview will include a number of questions regarding the strategy itself, your role in implementing it, and various factors that

might affect the implementation process. The interview will last up to two hours and will take place off site of your employment agency in order to protect your privacy. I will request that the interview be recorded so that I can accurately transcribe what you have said during the interview. If you choose not to consent to the interview being recorded I will take notes during the interview by hand. In order to ensure the accurate depiction of your experience I will request that you review a copy of the transcribed interview with some of my interpretations within two weeks of the interview where you can respond in favor of the transcription and interpretations or request revisions.

Your choosing to participate in this study may also benefit you. The study may be beneficial in increasing your knowledge about the implementation process which may also help improve the implementation exercise under study. It should also be noted that there is a potential risk in your choosing to participate in this study. There is a possibility that those who know you may identify you based on particular comments that are made during the interview. However, the data and any quotations used will not be connected with your name. The only identifying feature that will be linked with your data is the implementation levels that you are involved in, that being policy makers, organizational administrators, and front-line workers. This is simply for the purpose of comparing the responses of participants from different implementation levels.

Consent forms will be stored in a locked drawer in the investigator's home separate from interview transcripts which will also be stored in locked drawers and in password protected computer files. All data will be destroyed within one year of the date it was collected. Attempts will be made to avoid identification of informants and those observed through dissemination by not including identifying details in the thesis and subsequent presentation and articles, and by disguising identities, where possible.

You are free to withdraw from this study at any time and there are no negative consequences for doing so. You may choose after reading this informed consent form that you would not like to participate or during the interview, at which point you can just let me know that you would like to stop and the data collected will be destroyed. If you choose to withdraw after the interview has been completed you can telephone or e-mail me to inform me of your request to withdraw from the study and the data collected from your interview will be destroyed.

The findings gathered in this study will be disseminated through my thesis, subsequent articles in peer-reviewed journals and presentations at professional meetings. Also, a brief summary of results will be provided to participants if they would like to receive it approximately in June of 2016. If you would like to receive the summary of results you can choose to have it mailed to your home address, work address, or an electronic version can be sent to an e-mail address of your choosing.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Psychology/Sociology Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 474-7122 or humanethics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

I agree to have the interview audio-recorded

Initials

Participant Signature

Date

Principal Investigator Signature

Date

Address or e-mail address that you would like the summary of results to be sent to.

Appendix D

Interview Guide

- How familiar are you with the Government of Manitoba's *Rising to the Challenge* strategy?
- What are your views on this strategy as a policy response for improving mental health in Manitoba?
- How would you relate your views on the strategy to others working in your organization?
- To what extent do you value this policy in terms of the goals that the government is trying to achieve and the strategies it is using to achieve those goals?
- What is your role in the implementation of this strategy?
- Can you describe for me the strategies you have used in your position to implement the policy?
- Can you describe any conflicts that have arisen as the policy has been implemented?
- What, in your view, has been learned as the policy has been implemented?
- What challenges have been experienced in implementing the policy?
- Can you describe any important factors in the environment that have affected the implementation of the policy? Here I am thinking about organizational factors, political factors, economic factors, public opinion, tragic events, and more.
- Can you describe for me how the process of implementing this policy has unfolded? What have been its stages and phases?
- Can you describe what human, financial and intellectual resources have been available to implement this policy?
- What has been effective in this implementation process?

- What adaptations have been made at your level to the policy through the way it has been implemented?
- What has been the level of agreement with the policy goals across organizations and levels of organizations?
- What has your experience been like in working collaboratively with the other organizations involved in implementation?
- What is the extent to which you feel that the provincial government is committed to this policy?
- Are there some challenges in implementing this policy that are not understood by others involved?
- What recommendations would you give for improving the implementation of this policy?

Appendix E**Document Abstracting Form**

Date
Document name
Organization
Description
Analysis
Code
Areas to find further data
Justification sampling decision

Appendix F

Research Ethics Board Approval Certificate



Research Ethics and Compliance
Office of the Vice-President (Research and International)

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone +204-474-7122
Fax +204-269-7173

APPROVAL CERTIFICATE

February 24, 2016

TO: Karen De Blonde (Supervisor: Sid Frankel)
Principal Investigator

FROM: Kelley Main, Chair
Psychology/Sociology Research Ethics Board (PSREB)

Re: Protocol #P2016:033
"Implementation of Manitoba's Mental Health Strategic Plan: A Case Study Application of the Advocacy Coalition Framework"

Please be advised that your above-referenced protocol has received human ethics approval by the Psychology/Sociology Research Ethics Board, which is organized and operates according to the Tri-Council Policy Statement (2). It is the researcher's responsibility to comply with any copyright requirements. This approval is valid for one year only and will expire on February 24, 2017.

Any changes to the protocol and/or informed consent form should be reported to the Human Ethics Coordinator in advance of implementation of such changes.

Please note:

- If you have funds pending human ethics approval, please mail/e-mail/fax (261-0325) a copy of this Approval (identifying the related UM Project Number) to the Research Grants Officer in ORS in order to initiate fund setup. (How to find your UM Project Number: <http://umanitoba.ca/research/ors/mrt-faq.html#pr0>)
- if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) in order to be in compliance with Tri-Council Guidelines.