IMPLEMENTATION IN MENTAL HEALTH SYSTEMS

HOW DO SYSTEMS ACHIEVE THEIR GOALS? THE ROLE OF IMPLEMENTATION IN MENTAL HEALTH SYSTEMS IMPROVEMENT

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A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy

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Lay Abstract

People with mental health and substance use problems face many barriers that can affect their ability to participate in society. In order to make a positive impact on mental health, changes need to be made in a number of different areas such as health, education and justice. There is now research evidence about programs and policies that are effective, but there is a lack of understanding of how to get those changes into policy and practice so that people can benefit from them – a process called implementation. This thesis answers questions about implementation in mental health systems to help fill this gap. It contributes: 1) a new theory of implementation from the perspective of a policy goal; 2) insights about the infrastructure needed to support large-scale implementation; and 3) an understanding of how citizens and other stakeholders contribute to implementation by examining Ontario's mental health and addictions strategy.

Abstract

Effectively addressing mental health and substance use problems are important challenges faced globally. People experiencing such problems encounter many societal barriers that can affect their ability to participate as full members of society and have life expectancies much shorter than the general population. Policies to address mental health and substance use problems require the mobilization of multiple sectors, such as health, education, and justice. While there is strong evidence for programs and services that work, and there are policy directions aimed at achieving better service experiences and improved health and social outcomes, there is a lack of knowledge about how to get these policies and programs embedded effectively into daily practice – a process called implementation. The objective of this dissertation is to advance the understanding of implementation strategies for addressing such complex challenges through five original scientific contributions. The first is a critical interpretive synthesis of existing literature to generate a theoretical framework of the implementation process from the perspective of a policy goal by integrating findings from the public policy, implementation science and knowledge translation fields. Next is a two-part comparative case study exploring how policy implementation was structured and the strategies used in large, well-developed mental health systems. Last is a two-part in-depth examination of mental health policy implementation efforts in Ontario, Canada, beginning with an analysis of the development and implementation of the province's mental health strategy, followed by an examination of the role that citizens and other stakeholder groups played in its implementation. Together these studies contribute theoretical, substantive and methodological insights toward understanding the effective implementation of policy

directions for complex social challenges. Better implementation means more citizens can benefit from effective policies and programs that are needed across populations.

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Table of Contents

1. Introduction....1

2. Understanding the implementation of evidence-informed policies and practices from a policy perspective: a critical interpretive synthesis 19

3. Developing structural supports for policy implementation: The placement of intermediaries in mental health systems.... 87

4. An examination of current implementation efforts and the 'intermediaries' that support them in New Zealand, Ontario, Canada and Sweden: A comparative case study 123

5. A fresh approach to reform? A policy analysis of the development and implementation of Ontario's mental health and addictions strategy.... 175

6. Why stakeholders matter in policy implementation: An examination of citizen and stakeholder engagement in the implementation of Ontario's mental health and addictions strategy 199

7. Conclusions .... .243

List of Figures and Tables

Chapter 1 - Introduction

Figure 1. Fields of research being integrated into this dissertation 8

Table 1. The lens through which implementation is viewed and the goal of implementation by field of research 9

Table 2. Overview of key components of the thesis studies and the links among them 13

Chapter 2 – Understanding the implementation of evidence-informed policies and practices from a policy perspective: a critical interpretive synthesis

Table 1. Search terms 61

Figure 1. Literature search and study selection flow diagram... 62

Table 2a. Overview of included conceptual literature 63

Table 2b. Overview of included empirical literature... 67

Table 3. Policy-related strategies and examples of those strategies for implementation according to type of target 69

Table 4. Determinants of implementation from a policy perspective and the factors that characterize the determinants 73

Table 5. Types of policy actors identified in implementation 77

Figure 2a. Process model of implementation from a policy perspective depicting the process at one policy level 82

Figure 2b. Process model of implementation from a policy perspective depicting the process across policy levels.. 83

Figure 3. Determinants framework of implementation from a policy perspective...... 84

Figure 4. Characteristics, relationships and the context of policy actors important for implementation.. 85

Figure 5. Modified Interactive Systems Framework for Dissemination and Implementation (M-ISF) 86

Chapter 3 - Developing structural supports for policy implementation: The placement of intermediaries in mental health systems

Table 1. Summary of qualitative interview findings regarding the presence of intermediaries supporting policy implementation and their placement in the system by country 118

Table 2. Intermediary structures in New Zealand, Ontario and Scotland........ 120

Chapter 4 - An examination of current implementation efforts and the 'intermediaries' that
support them in New Zealand, Ontario, Canada and Sweden: A comparative case study

Figure 1. Graphic depiction of implementation support infrastructure by case 156

Table 1. Case selection criteria by jurisdiction 157

Table 2. Timelines of events leading up to the establishment of the intermediaries for each case 158

Table 3. Factors that influenced the decision to create intermediaries, drawing from Kingdon (1995) 161

Table 4. Structure and organizational characteristics of intermediaries........ 165

Table 5. Implementation strategies used by intermediaries by target and by case 169

Table 6. Interest-, ideational- and institutional-related factors that explain the avoidance of particular implementation strategies 172

Appendix 1. Interview guide for stakeholder interviews........ 173

Chapter 5 – A fresh approach to reform? A policy analysis of the development and implementation of Ontario's mental health and addictions strategy

Figure 1. Timeline of key activities and documents related to policy formulation and policy implementation of Ontario's Mental Health and Addictions Strategy 198

Chapter 6 – Why stakeholders matter in policy implementation: An examination of citizen and stakeholder engagement in the implementation of Ontario's mental health and addictions strategy

Figure 1. Structures that supported the *Strategy* implementation process, including the policy network and horizontal governance approach 226

Table 1. Policy actors involved in the implementation of the second phase of the *Strategy* and their roles.. 227

Table 2. Interests, institutional, ideational and external factors that influenced the implementation of the *Strategy* 231

Table 3. Factors related to actor relationships and actor context and their influence on the implementation of the *Strategy*.. 236

Appendix 1. Interview guide for semi-structured interviews 240

List of Abbreviations

3I+E – Institutions, interests, ideas and external factors

CAMH – Centre for Addiction and Mental Health

CIS – Critical interpretive synthesis

CoECYMH – Centre of Excellence for Child and Youth Mental Health

EIPPs – Evidence-informed policies and practices

IKT – Integrated knowledge translation

IIMHL – International Initiative for Mental Health Leadership

ISF – Interactive Systems Framework for Dissemination and Implementation

MCYS – Ministry of Children and Youth Services

MED – Ministry of Education

MOHLTC – Ministry of Health and Long-Term Care

NGO – Non-governmental organization

PSSP – Provincial System Support Program

SALAR – Swedish Association of Local Authorities and Regions

SMH ASSIST – School Mental Health ASSIST

Te Pou – Te Pou o te Whakarro Nui

WHO – World Health Organization

Declaration of academic achievement

This thesis presents five original research studies (chapters 2-6), as well as introductory and concluding chapters (chapters 1 and 7). Each of these original research studies is co-authored and I am the lead author of all five. I was responsible for conceptualizing the area of focus of the thesis and for its design, as well as for executing the data collection, analysis and preparing the written chapters. My supervisor, Dr John N. Lavis, provided input to the design, contributed to analysis and synthesis, and provided feedback on the written chapters. Committee members – Dr Michael G. Wilson and Dr Gillian Mulvale – provided feedback on various drafts, which were incorporated into the final version of the thesis. Dr Julia Abelson provided input to the design, contributed to the analysis and provided feedback on chapter 5. Details of the specific contributions for each study are outlined in the preface to each chapter.

Chapter 1. Introduction

This dissertation presents an original body of scientific work that consists of five research chapters related to the role of implementation in mental health systems improvement. In this introductory chapter, I begin with an overview of the current state of mental health policy, what has led to this state and why more scholarly attention on implementation is required. My focus starts at the global level and narrows to the context in Ontario, Canada where I conducted some of my studies. I draw my observations mainly from the academic literature, but I also reflect on my own experience working in the area. I then outline the aims of this thesis and the approaches taken to address each aim. The chapter concludes with an overview of the anticipated substantive, methodological and theoretical contributions of this work.

Current state of mental health policy

Mental health is a key component of health,[1] affecting at least one in four people within their lifetime, but until relatively recently, it has been neglected as a policy issue.[2] Fortunately, over the past two decades, mental health has risen dramatically on the policy agendas of jurisdictions around the world. This rise can be partly attributed to a better understanding of the scope of the problem and how far reaching the burden of disease is on mortality and quality of life. Most notably, the World Health Organization reported that mental and neurological conditions account for 31% of all disability in the world and 13% of the global burden of disease, surpassing the burden attributable to cardiovascular disease and cancer.[2-4] However, many policy gaps remain, and in 2011 only about 62% of WHO member countries

had a policy specific to mental health.[5] Even among those that have a policy, 40% had not been updated since 1990,[6] and therefore do not reflect recent advances in how the issue is understood as well as the new approaches to treatment and support.

Compounding the problem, the level of investment in mental health across countries is disproportionately small relative to the burden the conditions impose on citizens. For example, more than one third of the global population reside in countries that allocate less than one percent of their total health budget to mental health.[7] Across all countries, global spending in 2011 was less than $3 US per capita and the spending that does occur is unevenly distributed and spent largely on services that serve relatively few people, such as long-term hospital stays.[5] Furthermore, financing mechanisms often rely heavily on out-of-pocket payments or private insurance[7] creating differential access based on means. Resources for mental health can thus be characterized as scarce (not enough investment according to the burden imposed), inefficient in the allocation of service mix and inequitable (distribution based on means rather than need).[6]

Despite these challenges, there is an ever-expanding number and variety of evidence-informed programs and treatments designed to address mental health conditions and to prevent them from occurring. This is good news for governments as they now have a strong evidence base from which to develop sound policy.[1] Even as early as 2001, the WHO identified several areas where the evidence warranted action across jurisdictions and identified specific actions according to the level of resources available[2]. However, getting

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[1] Most of the evidence generated comes from high-income country settings and therefore there is still a lack of evidence for effective and cost-effective programs and treatments in low- and middle-income settings (Mackenzie 2014)

these effective programs and treatments to citizens at a scale in which to achieve socially significant outcomes remains a challenge. According to the Lancet Global Health Group, while up to 30% of the global population has some form of mental disorder, at least two thirds receive no treatment.[8] This finding holds for all countries, including those with the most resources.[9] For example, 31% of U.S. citizens are affected by a mental health condition every year but 67% of them do not receive treatment (and this number rises to 90% in some countries).[10]

This represents a significant treatment gap by all accounts and begs the question: if this gap is not caused by insufficient evidence about the size and scale of the problem, the effects of mental health problems, or their effective treatment, then what precisely is the problem and what can be done about it? Patel and colleagues[11] suggest that the gap can be attributed to barriers operating at all levels of the health system, ranging from global policies to local health-care provision. They classify these into four action areas: 1) human rights (to address violations that constitute a global crisis); 2) the lack of resources (to scale-up care, and investments for those particularly vulnerable such as children and youth, the elderly and those with co-occurring developmental disabilities); 3) a need for more effective implementation of evidence-based care in real-world settings; and, 4) a need to better address mental health in the context of conflict and natural disasters.

This dissertation concentrates on the third action area – the implementation of evidence-informed policies and practices in mental health systems. It examines implementation in the context of high-income settings with large, well-established mental health systems that face a unique set of challenges when compared with those in low- and middle-income settings. Because four of the five studies in this thesis either include, or focus

specifically on, the province of Ontario in Canada, the following section provides a high-level overview of the mental health system in Ontario within the country context of Canada.

Mental health policy in Ontario, Canada

As a country, Canada has lagged behind other G8 nations and was the last country to develop a national strategy for mental health. Mental health as a national policy issue rose in visibility just after the turn of the century. It was during this time (2004) that the Standing Senate Committee on Social Affairs, Science and Technology undertook a review of mental health and mental illness chaired by Senator Michael Kirby, with Deputy Chair Wilbert Keon. This very visible and influential process led to their final report: *Out of the Shadows At Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada.*[12] The review undertaken by the senate and the resulting report was seen as a turning point for mental health in Canada, bringing much needed attention to the issue and endorsement by senior leaders in government. One key recommendation that came from the report was a proposal to develop a mental health commission that would maintain a national focus on the mental health and take forward many of the report's recommendations.

The Mental Health Commission of Canada (the Commission) was established by the Government of Canada in 2007 and one of its key thrusts was to develop a national mental health strategy. The process included the development of a framework for the strategy[13] that was informed by thousands of stakeholders across the country. The national strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*[14] was built on this framework and published in 2012. While the development of the national strategy has been important, as noted in the strategy itself: "Although there are several population groups and

policy areas for which the federal government has important mental health responsibilities, the organization and delivery of health care, social services and education in Canada largely fall to provincial and territorial governments." (p.8). This is why it is important to look beyond the federal level and to the provinces and territories to gain a true understanding of how mental health policy in Canada is shaped and implemented.

Before turning the focus to Ontario, it should be noted that substance use problems have traditionally received separate consideration at the national level. A separate agency, the Canadian Centre on Substance Use and Addiction acts in a similar role to the Commission and supports activities aligned with *National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada,*[15] which is a national consensus document.

Ontario is Canada's most populated province with approximately 14 million residents. It also has a relatively large geographic footprint of 1.076 million square kilometers, making it Canada's second largest province and larger than France and Spain combined. Despite its scale, the population is unevenly distributed with most citizens concentrated in the south and within two hours drive to the US border. The size and scale of the province, coupled with the uneven distribution of its population, makes implementation challenging for any new policy, and mental health is no exception. Policy authority for mental health rests mainly within the Ministry of Health and Long-Term Care (MOHLTC), although increasingly other ministries – including those focusing on education, children, community and social services, and justice – are playing a role in creating and implementing mental health-related policies. Within MOHLTC, mental health and addictions are treated as one policy area and are not separated as they are at the federal level.

The Ontario government has been relatively prolific in its production of policy documents related to mental health. Since 1983 it has produced at least 22 policy documents on mental health or a specific policy area therein.[16] While this level of attention could be interpreted as a signal of "health" in the policy area, it could also be indicative of the challenges the province has faced as it tries to make progress on mental health. A cursory look at the system problems identified in these documents and the recommendations for necessary changes and their almost eerie consistency over time, suggests the latter. Policy analysts have also noted the lack of progress toward better outcomes and have contributed several pieces to the explanatory puzzle. For example, Hartford and colleagues identified the effects of the policy legacy created by the drastic reduction of inpatient beds and the size and number of the provincial psychiatric hospitals as well as the rights revolution that influenced the legislation regarding compulsory treatment and the establishment of a psychiatric patient advocacy office.[17] Similarly, Mulvale and colleagues examined the policy legacies created by psychiatric hospital policy, as well as the introduction of public health insurance.[18] Furthermore, the role of consumer participation in shaping the Ontario mental health system was explored by Grant.[19] Less has been done, however, to unpack the implementation processes related to these policy documents to identify salient features that could improve the implementation process and create a better connection between the policy goals and mental health and social outcomes for citizens. One notable exception is the work of Wiktorowicz[20] who explored how welfare state restructuring explained why community sector reforms have lagged behind the institutional downsizing completed in the early 2000s. She identified several obstacles related to the delay: 1) a number of arm's-length government processes with varying levels of authority; 2) an absence of political will necessary to allocate

funds to community services and devolve decision-making authority regarding care coordination to local networks; and 3) insufficient engagement of the policy network in implementation. This dissertation explores mental health policy implementation 10+ years after Wiktorowicz and continues the pursuit of unpacking the implementation process in Ontario and elsewhere.

Situating the author

I come to this research as someone with 15+ years working in the field of knowledge translation and implementation in policy and service delivery environments. The majority of this time was spent focused on mental health. This has certainly motivated me to undertake this dissertation and influenced my choice of research topics, but also means I have many pre-existing relationships with those involved in mental health policy implementation activities in Ontario and internationally. Given my history with the field, I anticipate some of these individuals will be partners in my research and/or participants in some of the studies. Furthermore, I anticipate my "lived experience" as an implementation practitioner will act as a lens through which the studies are designed, analyzed and interpreted. I see this mainly as a strength, but also something I will be interrogating throughout the thesis to ensure it does not unduly influence the findings. Finally, it is important to note that the first person singular ("I") is used in the introduction and concluding chapters of this thesis, however, each of the empirical chapters was done in collaboration with co-authors, and these collaborators and their contributions are noted in the chapter prefaces.

Scholarship informing this thesis

The research in the following chapters has its roots in three discrete but overlapping fields of scholarship: political science/public management, knowledge translation and implementation science. Each field has unique insights to offer regarding the policy implementation process but as yet, there has been relatively little overlap among them, as Nilsen and colleagues[21] aptly point out. This may mean each field is missing out on important advances in the other. Conceptually, the field of political science/public management focuses on realizing policy decisions, the field of knowledge translation focuses on improving the use of research evidence in policy and practice and the field of implementation science is focused on creating sustainable improvements in the delivery of services. Figure 1 and Table 1 below depict these unique contributions and situates this thesis at the point of intersection among all three fields.

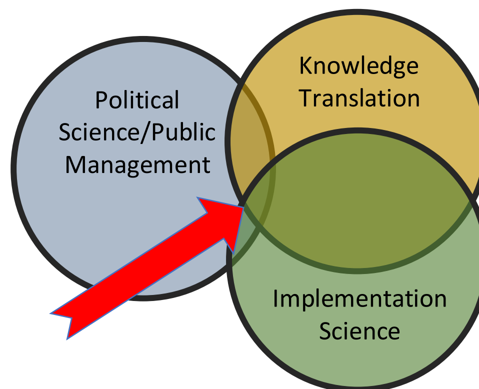

Figure 1 – Fields of research being integrated into this dissertation

Table 1 – The lens through which implementation is viewed and the goal of implementation by field of research

Field	Lens	Goal of implementation
Political science/public management	Policy	Realizing policy decisions
Knowledge translation	Research evidence	Improving the use of research evidence in policy and practice
Implementation science	Practice	Creating improvements in the delivery of services and interventions

Aims and approach

This thesis addresses the gaps in understanding related to the effective implementation of evidence-informed policies and practices (EIPPs) at scale in mental health systems. Its main objective is to advance the understanding of implementation for addressing such complex challenges with a focus on the following three aims:

1. To generate a novel theoretical framework of the implementation of evidence-informed policies and practices from a policy perspective (Chapter 2);
2. To explore how mental health policy implementation is structured and clarify the role of intermediaries in large, well-developed mental health systems (Chapters 3 and 4);
3. To critically examine Ontario's most recent effort at implementing a provincial mental health strategy to understand how it was structured and what contributed to the process and outcomes (Chapters 5 and 6).

Unpacking the implementation process and what contributes to success will be helpful to policy and system leaders and those supporting implementation to inform future systems change efforts.

I address these aims through five related but original scientific contributions. A summary of the specific objectives, designs, outputs and the links between chapters is

summarized in Table 2 below. This table will be used throughout the thesis to orient the reader and support wayfinding through the various chapters.

Chapter 2 presents a critical interpretive synthesis (CIS) of the literature to understand implementation of EIPPs from a policy perspective. It draws from the three distinct but overlapping areas of scholarship identified above: political science/public management, knowledge translation and implementation science. This research casts a wide net in terms of the topics of study to glean insights from areas beyond health and mental health, including areas such as justice and climate change, among others. The resulting theoretical framework has multiple components including a novel process model and a novel determinants framework. It also presents a modification to existing theory to demonstrate how these findings can be used to ensure policy is well-considered in implementation theory. In later chapters, elements of this theoretical framework are used to inform analyses, thereby also demonstrating its potential applications.

Chapter 3 is the first in a two-part examination of the mental health policy implementation infrastructure in large, well-developed mental health systems. The specific objective of this study is to understand the puzzling variation in the placement of intermediaries in systems (organizations or programs that support the implementation of EIPPs at scale) based on an observation made during the sampling phase of a larger comparative case study that intermediaries were situated in vastly different system locations. This study examines three intermediaries that vary in their system placements, located in three different socio-political systems (New Zealand, Ontario Canada, and Scotland U.K.). Drawing from institution theory and using a combination of document analysis and key informant interviews as data sources, the study identifies factors that explain the placement

of intermediaries in different systems and the importance of the institutional landscape in determining system placement.

The second part of the examination of mental health policy implementation infrastructure is a comparative case study examining the role of intermediaries supporting the implementation of EIPPs in the mental health systems of New Zealand, Ontario, Canada and Sweden (Chapter 4). The study specifically examines: 1) Why the intermediaries were established; 2) What structures and strategies they used to support the implementation of policy directions; and 3) Why some strategies were avoided. Established explanatory frameworks and implementation theory are used to frame the analysis.

Both Chapters 3 and 4 draw on the same sample pool of socio-political systems but use different sampling criteria. The studies were conducted in partnership with the International Initiative for Mental Health Leadership (IIMHL) – an international collaborative that focuses on improving mental health and addictions services in nine countries, using an integrated knowledge translation (IKT) approach.

Chapter 5 is the first in a two-part exploration of the development and implementation of *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (the *Strategy*)[22]. It analyzes the policy development and implementation process to identify features of the process that might distinguish it from past efforts and that may lead to better outcomes. The findings are the backdrop for Chapter 6, which uses a single case study design to examine the roles that citizens and other stakeholder are playing in implementation of the *Strategy* and how their involvement is contributing to systems change. Chapter 6 aims to describe citizen and other stakeholder involvement using stakeholder mapping, as well as explain how their involvement contributes to the process of implementation using several

explanatory frameworks. Similar to Chapters 3 and 4, it also uses an IKT approach but this time the partner was the Mental Health and Addictions branch at MOHLTC.

Table 2 – Overview of key components of the thesis studies and the links among them

Chapter	Study Objective	Design (and select methods)	Outputs/Contributions	Links
2.	To generate a theoretical framework of the implementation process from a policy perspective by integrating findings from the political science/public management, knowledge translation and implementation science fields ***Theoretical goal***	Critical interpretive synthesis • Compass question: how is policy currently described in implementation theory and processes and what aspects of policy are important for implementation success? • Grounded and interpretive approach to analysis	1. Novel process model 2. Novel determinants framework 3. Supplementary modification to existing theory (Wandersman et al.'s Interactive Systems Framework)	Theory (determinants and modified ISF) used to support Chapter 4 analysis Policy actor component used in Chapter 6 analysis
3.	To understand the puzzling variation in the system placement of intermediaries supporting mental health policy implementation (including their proximity to government) ***Descriptive + explanatory goals***	Comparative case study • Intermediaries were purposively sampled in three jurisdictions: New Zealand; Ontario, Canada; and Scotland, U.K. • Data were derived from published literature and public documents as well as key informant interviews • Qualitative content analysis was used to analyze data, drawing from political science theory (institutional theory)	1. Factors that explain the placement of intermediaries in different systems (e.g., the institutional landscape including the political structures, the public/private mix of mental health service delivery, and the differing administrative capacities of mental health systems)	Background underpinning Chapter 4 *Note: case selection criteria differed for Chapter 4*
4.	To explore how policy implementation is structured, the use of intermediaries and the	Comparative case study • Three jurisdictions were purposively sampled: New Zealand, Ontario, and Sweden	1. In-depth understanding of structures supporting implementation &	Chapter 3 & 4 used same sample pool of jurisdictions

	methods they use in large well-developed mental health systems. It examines whether features of the political system impact how implementation is structured and the strategies that are employed ***Descriptive + explanatory goals***	• Data were derived from semi-structured interviews and public documents • Directed content analysis was used to analyze, drawing from existing theory (Kingdon & 3I+E) and theory resulting from Study 1 • Study conducted using an integrated KT approach, in partnership with the International Initiative for Mental Health Leadership	similarities/differences across systems 2. Identification of factors that explain structures within individual cases, and factors that explain variation across cases 3. Practical feedback and guidance to systems on how to design/enhance implementation supports	Modified ISF and novel determinants framework from Chapter 2 provided theoretical lens for analysis
5.	To analyze the formulation and implementation of the policy: *Open Minds, Healthy Minds, Ontario's Comprehensive Mental Health and Addictions Strategy* guided by the question of whether there is something in particular about this policy process that increases the prospects of it leading to transformative change. ***Descriptive + explanatory goals***	Qualitative policy analysis using interpretive description • Analysis of key documents of the policy process, drawing on policy network and horizontal governance theory • Focus on a) describing the policy process, and b) identifying key features distinguishing it from past policy efforts	1. Further insights into the policy that has been the backdrop for much of the activity in the mental health and addictions system in Ontario for the past decade 2. Identification of features that set the policy process apart from previous reform efforts	Background underpinning Chapter 6
6.	To examine the roles that citizens and other stakeholder played in implementation of the	Single case study • Case is the implementation of the *Strategy*	1. Network map of citizen and other stakeholder involvement in	Chapter 2 determinants framework (actors and

	Strategy and how their involvement is contributing to systems change. ***Descriptive + explanatory goals***	• Analytic frameworks include 3I+E and policy actor determinants • Methods include qualitative interviews and mapping of citizen and other stakeholder involvement • Study conducted using an integrated KT approach in partnership with MOHLTC's mental health and addictions branch	implementation of the Strategy 2. Identification of factors that explain how involvement contributes to process and outcomes 3. Practical outputs for MOHLTC	attributes) informs analysis + policy networks and horizontal governance theory from Chapter 5

Anticipated contributions

I anticipate this suite of studies will contribute theoretical, methodological and substantive advances to the scholarly literature regarding implementation efforts in mental health systems. Collectively, they represent a novel exploration of what is often referred to as the "black box of implementation". From a **theoretical perspective**, I expect this thesis will generate a new theory on implementation that better integrates policy considerations, thus filling a current gap. This theory will then be tested for its 'usability' and explanatory power in two of the other studies.

Next, there are three anticipated contributions from a **methodological perspective.** First, the intentional integration of the political science/public management, knowledge translation and implementation science literature throughout the thesis will provide a unique lens through which implementation in mental health systems is explored. Second, this thesis will attempt some novel applications of theory from political science, and these applications will present an opportunity to explore the contributions and limits of these frameworks when studying implementation (as opposed to other aspects of the policy process such as agenda-setting or policy development). Finally, the research involving primary data collection will be conducted using an integrated knowledge translation approach. While IKT is not new, it is not often undertaken at the graduate level (unless it is already part of a broader program of research) nor used in two separate studies with two unique IKT partners.

The expected **substantive** contributions of this thesis are also three-fold and are ordered here from general to specific. First, it will provide policy-related insights into the implementation process and identify policy determinants of implementation success. Second, it will contribute a better understanding of the role of intermediaries in mental health

systems, with evidence drawn from several well-developed mental health systems around the world. Third, it will identify key features of the approach taken when developing and implementing Ontario's most recent mental health and addictions policy that distinguish it from past efforts and explore how and why citizens and other stakeholders contribute to the implementation process. My greatest hope, however, is that this thesis will produce new insights that are relevant and usable for policy-makers and those looking to implement EIPPs in mental health systems and other complex policy areas.

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Chapter 2. Preface

Policy-makers and researchers interested in bridging the gap between policy intentions and policy outcomes can benefit from a better understanding of the process of implementation and how to structure it effectively. However, the evidence concerning implementation is spread across three somewhat independent fields of scholarship including political science/public management, knowledge translation and implementation science. This makes it challenging for policy-makers and scholars to draw from theory and empirical studies that adequately reflect their implementation efforts. This study begins to address this gap by using both systematic and interpretive methods to develop a novel integrated theoretical framework of implementation from a policy perspective. It also demonstrates how the insights gleaned from the critical interpretive synthesis can be used to improve existing theory. Our findings offer a new way of thinking about implementation processes and determinants at the systems level.

I was responsible for conceiving of the focus and design of the study with my supervisor (Dr John N. Lavis), and for completing all data collection, analysis and interpretation. Dr Lavis also contributed to the analysis during ongoing iterative cycles of interpretation and synthesis that led to the development of the final theoretical model. Ashleigh Miatello independently assessed a sub-sample of the documents for eligibility and worked with me to refine the inclusion criteria. I drafted the manuscript, and Dr Lavis, Dr Michael Wilson and Dr Gillian Mulvale provided comments and suggestions that were incorporated into revisions. All of these individuals are co-authors on the manuscript.

Using Table 2 from the Introduction as a guide (see excerpt below), this study is the first of the five included as part of this dissertation and is the only one with the primary objective of building new theory. The theory is then used to inform the analysis of Chapters 4 and 6.

Chapter	Study Objective	Design (and select methods)	Outputs/ Contributions	Links
2.	To generate a theoretical framework of the implementation process from a policy perspective by integrating findings from the political science/public management, knowledge translation and implementation science fields ***Theoretical goal***	Critical interpretive synthesis • Compass question: how is policy currently described in implementation theory and processes and what aspects of policy are important for implementation success? • Grounded and interpretive approach to analysis	1. Novel process model 2. Novel determinants framework 3. Supplementary modification to existing theory (Wandersman et al.'s Interactive Systems Framework)	Theory (determinants and modified ISF) used to support Chapter 4 analysis Policy actor component used in Chapter 6 analysis

Understanding the implementation of evidence-informed policies and practices from a policy perspective: a critical interpretive synthesis

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Keywords: implementation science, public policy, evidence-based health care, systematic review, critical interpretive synthesis

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Abstract

Context: The fields of implementation science and knowledge translation have evolved somewhat independently from the field of policy implementation research, despite calls for better integration. As a result, implementation theory and empirical work do not often reflect the implementation experience from a policy lens nor benefit from the scholarship in all three fields. This means policy-makers, researchers and practitioners may find it challenging to draw from theory that adequately reflects their implementation efforts.

Methods: We developed an integrated theoretical framework of the implementation process from a policy perspective by combining findings from these fields using the critical interpretive synthesis method. We began with the compass question: how is policy currently described in implementation theory and processes and what aspects of policy are important for implementation success? We then searched 12 databases as well as grey literature and supplemented these documents with other sources to fill conceptual gaps. Using a grounded and interpretive approach to analysis, we built the framework constructs and used our findings to consider improvements to existing theory.

Findings: A total of 7850 documents were retrieved and assessed for eligibility and 34 additional documents were identified through other sources. Eighty-two unique documents were ultimately included in the analysis. Our findings indicate that policy is described as: 1) the context; 2) a focusing lens; 3) the innovation itself; 4) a lever of influence; 5) an enabler/facilitator or barrier; or 6) an outcome. Policy actors were also identified as important participants or leaders of implementation. Our analysis led to the development of a two-part conceptual framework, including process and determinant components. We also used our findings to modify existing theory.

Conclusions: This framework begins to bridge the divide between disciplines and offers a new way of thinking about implementation processes at the systems level.

Background

From a policy perspective, implementation is the process through which policy goals become realized in society as results, making it an important part of the policy cycle. "What" is implemented to achieve those goals is often one or more evidence-informed policies, programs or practices (EIPP). And while implementation has continued to capture the attention of public policy scholars from well before the publication of Pressman and Wildavsky's book *Implementation* in 1973[1], implementation remains relatively under-theorized and under-studied relative to the agenda setting or policy formulation stages of policy making. The reasons for this are many, as discussed in great detail by Hill and Hupe[2], and include challenges with isolating implementation from other parts of the policy process and a lack of agreement about conceptual underpinnings (commonly referred to as the "top down" versus "bottom up" debate). This then leads to challenges in identifying relevant explanatory variables and analysts often must resort to a "long list of variables that are potentially useful". Even once decisions regarding these challenges have been made, the complex, multi-level and multi-faceted nature of implementation creates difficulties designing and conducting high quality empirical research that can offer useful generalizations to those interested in improving the process of implementation and thus achieving better policy results.[2]

While this scholarly debate has continued to unfold in the public policy and management field, implementation has come to the attention of scholars from a completely different perspective. Knowledge translation and implementation science are two related fields of scholarship focused on improving the use of research evidence in policy and practice. Implementation in these fields emerges from scholarship in the social sciences conceptualizing the types of research utilization[3] and from the evidence-based medicine

movement,[4,5] and thus focuses mainly on fostering the uptake of evidence (usually in the form of an evidence-based practice or evidence-informed innovation) within organizations and by individuals to improve services and ultimately, the health and social outcomes of service users. This scholarship has also extended to policy through the seminal contributions of Jonathan Lomas and others.[6] Conceptual work on implementation from these fields has increased at a seemingly exponential rate to the point where there is a great deal of focus on sorting and classifying the many frameworks, models, and theories and providing guidance toward their use.[7-10] The empirical literature is also rapidly increasing. A quick search of a database of systematic reviews for health systems (www.healthsystemsevidence.org) revealed well-over 2,500 systematic reviews on consumer-targeted implementation strategies and almost 1,350 systematic reviews focusing on provider-targeted implementation strategies in the health field alone.

Despite the large number of models, theories and frameworks being generated in the knowledge translation and implementation science fields, the role of policy in the implementation process appears to be under-theorized. When policy is included in conceptual work, it is often identified as a contextual variable[11,12] rather than being central to the implementation concept itself. It is also often presented as a broad category of "policy", rather than as a variable that is specific and therefore measurable in empirical work. This lack of conceptual clarity and empirical work about policy and other policy-related structural constructs has been noted by several researchers. For example, in their systematic review of measures assessing the constructs affecting implementation of health innovations, Chaudoir and colleagues[13] make specific reference to the "relatively few" measures available to assess structural constructs, which they define as "political norms, policies and relative

resources/socioeconomic status”. [3] As a result, the field of public policy appears to have on the one hand, a challenge of too many policy-related implementation variables, and on the other hand, the fields of knowledge translation and implementation appear to have too few.

In recent years some researchers have recognized these silos in scholarship and have called for more implementation research that integrates public policy, knowledge translation and implementation science perspectives. For example, Nilsen and colleagues published a debate article that identified similarities and differences between the fields and suggested that while differences exist, the two fields can and should learn from one another.[14] Moreover, honing in on the opportunity for both theoretical and empirical advancements in human services, Staffan Johansson’s analysis concludes that implementation problems could be better understood through the inclusion of research in public administration.[15] Specifically, they indicate that more focus on issues such as resource allocation, priorities, ethical considerations, the distribution of power between actors and organizational boundaries, which are more commonly addressed in public administration research, would provide a more holistic understanding of implementation.

In addition to these challenges, much of the seminal policy scholarship on implementation from both the public policy and knowledge translation and implementation literatures come from the United States.[16-19] This has resulted in a concentration of theoretical and empirical works that reflect the governance, financial and delivery arrangements that are particular to the US[20,21] and that may not always readily apply in other contexts. These differences are particularly marked when it comes to the policy domain of health given the differences of the US system compared to most others.[22] One notable exception to this is the “second generation” of policy scholarship on implementation, which

adopted the perspective of the target population and the service deliverers. It focused more on the contextual and field variables at the "bottom" or "coal face" of the policy implementation process and included key contributions from European scholars.[23]

In response to these challenges, the objective of our study was to develop an integrated theoretical framework of the implementation process from a policy perspective by combining findings from the public policy, implementation science and knowledge translation fields. By integrating knowledge from these fields using a critical interpretive synthesis approach, we specifically examine how policy considerations are described in implementation theories, frameworks and processes from existing published and grey literature. Our goal was to generate a theoretical framework that can foster an improved understanding of the policy contributions to implementation that can be used in future studies to generate testable hypotheses about large-scale system implementation efforts.

Methods

Study design

Given the broad goal of this study, the question of interest and the scope of potentially applicable literature from discrete fields that could inform this work, we selected a critical interpretive synthesis (CIS) approach. The CIS method was first described by Dixon-Woods and colleagues in response to the need to synthesize multi-disciplinary and multi-method evidence based on a broad, policy-relevant question about access to healthcare by vulnerable groups.[24] It is one of several more recent approaches developed by researchers in an attempt to synthesize qualitative research and to integrate it with quantitative research.[25] Drawing from the techniques of meta-ethnography combined with traditional systematic review

processes, CIS employs an inductive and interpretive technique to critically inspect the literature and develop a new conceptualization of the phenomenon of interest. Unlike traditional systematic reviews which focus on answering a question of interest such as "what works?", CIS is helpful in generating midrange theories with strong explanatory power.[26,27] This is suitable for our goal of developing a conceptual framework that better integrates findings from diverse fields and affords the opportunity to critically inspect both individual studies and the literature from each field as a whole in terms of the nature of the assumptions underlying each field, and what has influenced their proposed solution.[24] The method begins with a compass question, which evolves throughout the course of the review in response to the multidisciplinary range of perspectives uncovered in the process.[24,28] Our compass question was: How is policy currently described in implementation theory and processes and what aspects of policy are important for implementation success?

Review scope

Our review casts a very broad net in terms of implementation processes and theories. While our main focus is on large-scale implementation efforts in health, behavioural health and human services areas that are not specific to a particular condition, we also drew from other large-scale implementation theories and empirical work, such as from the field of environmental science, that may yield important insights toward a more integrated framework of implementation. We drew from two key sources of literature: (1) existing frameworks, models, and theories (public policy, implementation science and knowledge translation); and (2) empirical studies that report on specific implementation processes.

Given our interest in implementation processes from a policy perspective, we limited our review to implementation frameworks, models, theories and empirical reports that

describe implementation efforts at a community or systems level (for example, city, province/state or country) where policy considerations are most likely to be an important factor. Implementation of a single evidence-based practice (unless across a large-scale) or implementation in a single organization were excluded, as was research that focused on behavior change at the individual level.

Electronic search strategy

Using the compass question, and in consultation with a librarian, we constructed a table of Boolean-linked key words and then tested several search strategies (Table 1). After refining the search strategy, the initial search was conducted in January 2017 for the time period of January 2000 – December 2016 (the month prior to the search being conducted) using the following 12 databases: ASSIA, CINAHL (via EBSCO), EMBASE (via Ovid), ERIC, Health Star (via Ovid), MEDLINE (via Ovid), PAIS Index, PolSci, PsychINFO, Social Sciences Abstracts, Social Services Abstracts and Web of Science. The dates for the policy databases (PolSci and Social Sciences Abstracts) were extended to 1973 to ensure key conceptual articles would be retrieved, such as the seminal work by Sabatier and Mazmanian in 1980.[18] A grey literature search was also conducted using Health Systems Evidence (which indexes Canadian and international policy documents related to health system arrangements and implementation strategies, as well as systematic reviews) and Canadian Public Policy Collection. Similar search strings were used across all databases with minor adjustments to ensure searches were optimized. We prioritized sensitivity (comprehensiveness) over specificity (precision) in our search strategy.

Article selection

We excluded articles based on their titles and abstracts if they did not fit within the study scope (above) or if they were not conceptual or empirical works (e.g., brief commentaries, book reviews, etc). We created additional inclusion criteria that were based on the following questions: 1) Is there a moderate (or greater) chance that the article will shed light on the role of policy in an implementation process or on the outcomes of the process? 2) Does the article describe implementation efforts at a community or systems level (for example, city, province/state or country)? and 3) Does the article identify actors at the government, organizational or practice level such as policy entrepreneurs who may be central to policy implementation efforts? Any articles that did not meet at least one of these criteria were excluded.

Complementary to the formal search, and in keeping with the inductive strategies that are part of the CIS process, we also conducted hand searches of the reference lists of relevant publications and searched the authors' personal files to identify further articles and theoretically sampled additional articles to fill conceptual gaps as the analysis proceeded.

After completing the searches, an Endnote database was created to store and manage results. Once duplicates were removed, a random selection of two percent of the articles was independently screened by two reviewers (H.B. and A.M.) who were blinded to each other's ratings and used the same inclusion criteria. The reviewers classified each title and abstract as "include" "exclude" or "uncertain". Inter-rater agreement was determined using the kappa statistic. This process was undertaken to improve the methodological rigor by enhancing trustworthiness and stimulating reflexivity, not to establish a quantitative assessment per se.[29] Any discrepancies were then discussed between reviewers until consensus was reached. Next,

one reviewer (H.B.) assessed the remaining titles and abstracts. Articles classified as "include" or "uncertain" were kept for full-text review.

The full text of the remaining articles was then assessed by one reviewer (H.B.). Articles were excluded at this stage if they did not provide detailed insight into the compass question. Articles were also sorted according to whether they were a conceptual contribution (i.e., presented a model, theory, framework or theoretical concept on implementation) or an empirical contribution (i.e., used qualitative, quantitative, review or other research methods to present new findings or an analysis of implementation).

Data analysis & synthesis

Our data analysis proceeded in four stages. First, while screening and assessing the articles for inclusion, we noted some general observations of how policy was incorporated in the literature from each field of interest (policy/public administration, implementation and knowledge translation). Second, we classified articles according to how policy was portrayed in implementation theory and processes. Third, we constructed a data extraction template for conceptual and empirical studies that included: 1) descriptive categories (the author(s), the name of the model, theory or framework (if provided), year of publication, author location, focus of the article and whether a graphic or visual aid was included); 2) content from the article that addressed the compass question regarding how policy is portrayed and what aspects are important for success; and 3) interpretive categories including "synthetic constructs" developed by the review team from the article and additional notes on how the article contributed to the development of the conceptual model. Additionally, the data extraction form for the conceptual articles included a classification of the type of framework according to Nilsen's taxonomy of implementation models, theories and frameworks.[7] Nilsen

identifies five types of conceptual works in the implementation literature: 1) process models, 2) determinant frameworks, 3) classic theories, 4) implementation theories, or 5) evaluation frameworks.

In the fourth and final stage, we initially focused on the conceptual literature and used it as a base from which to build our integrated conceptual model. We developed the synthetic constructs by reviewing the content from each article that addressed the compass question and interpreting the underlying evidence using a constant comparative method to ensure that the emerging synthetic constructs were grounded in the data, similar to a grounded theory approach.[30] These synthetic constructs were then used to begin to build the conceptual model and an accompanying graphic representation of it. We then critiqued the emerging constructs to identify gaps in the evidence and emerging constructs.

Using this emerging model, we purposively sampled additional conceptual literature to fill the gaps that we identified and to ensure we incorporated as many relevant concepts as possible. We did this by consulting reviews of existing models, theories and frameworks[2,7-10] to identify additional relevant concepts not captured by our search strategy and by hand searching the reference sections of some seminal conceptual papers.[11,31] Once saturation of the conceptual literature was reached, we purposively sampled a subset of the empirical literature and used this subset to "test" the model and add additional detail to the theoretical constructs gleaned from empirical report. We used a similar data extraction template with the exceptions of removing the descriptive category of model or theory name and the interpretive classification using the Nilsen taxonomy[7], but adding the descriptive category of "methodology". If our model did not capture findings from the empirical studies, we revised

it and re-tested. This process continued until saturation was reached and additional empirical studies yielded no further insights into our model.

The methods reported here are based on a protocol developed prior to initiating the study (available upon request). The methods differ from the protocol in the following ways: 1) we took the additional step of assessing inter-rater agreement for inclusion; 2) the data extraction forms were modified to include the additional categories of: how documents were retrieved (search or other), the focus of the article, existence of a graphic or visual aid, how policy was portrayed in the article, and a place for author notes and how it contributed to theory building. We also removed the academic discipline category, which we felt was less relevant than the categories we added; 3) we did not formally undertake the analytic strategy of negative case analysis as part of our efforts to increase credibility as we felt this was covered through working to saturation; and 4) article quality was assessed less formally due to the difficulties encountered in finding the required information based on the diversity of disciplines and fields of scholarship and related publishing expectations.

Results

Search results and article selection

Our search of electronic databases retrieved 11,412 documents and 7,850 unique documents once duplicates were removed. The review of titles and abstracts was completed independently by two reviewers on a random sample of approximately two percent (n = 171) of the documents. The Kappa score was 0.72 indicating substantial agreement. Figure 1 provides a flow diagram outlining the full search strategy. Following these criteria for the remaining titles and abstracts resulted in 1,084 documents included for full text review. The

full text review excluded an additional 821 documents leaving 261 potentially relevant documents (excluded conceptual documents and the rationale for exclusion are available upon request). Of these, 22 conceptual documents and 241 empirical documents were included for the data extraction and analysis phase. We sampled and extracted data on all of the conceptual articles. For the empirical articles, we chose a maximum variation sampling approach based on the subject matter and article topic with an initial sample of 10% of the articles. We also noted that nine of the articles related to a large, multi-year national implementation study of evidence-based practices for people experiencing serious mental illness focusing on the state-level activities and outcomes.[32-40] Because this was the largest and most comprehensive account of the role of policy in large-scale implementation efforts identified through our search, we included these as a sub-group for data extraction. This approach led to data extraction for 34 empirical articles.

In addition to these two approaches we sampled articles that filled in conceptual gaps as our model developed (see above). This process resulted in the retrieval of an additional 25 conceptual articles and 3 empirical articles. In total, 82 unique documents were included with two of these documents used in both the conceptual and empirical data extraction. Tables 2a and 2b provide an overview of the included conceptual and empirical articles. The majority of studies were conducted in the US by US researchers (n = 55), with the others coming mainly from other Western countries (the United Kingdom (n = 8), Netherlands (n = 7), Australia (n = 5), Canada (n = 2), Sweden (n = 2), Germany (n = 1), Europe (n =1) and China (n = 1)). Articles covered a range of topics including health and health care, public health, mental health and addictions, children and youth, social care, justice, and climate change, among others. The conceptual documents included all of the categories of theories,

models and frameworks identified by Nilsen[7], with the Determinants Framework type being most common. The empirical articles employed a wide array of methods that fall into the broad categories of qualitative, quantitative and mixed methods.

General observations

Through the process of article selection we noted several general observations regarding the characteristics of existing literature. In terms of the scholarly disciplines included, most of the implementation science literature focused on the organizational or service provider levels with an emphasis on changing practice, often by introducing an EIPP. The knowledge translation literature included policy-makers as a target audience for research evidence, but the focus was on the agenda setting or policy formulation stages of the policy cycle, as opposed to the implementation of an EIPP. Here, the scholarship focused on strategies to increase the use of evidence in policy decision-making. The public policy literature included theory describing "top-down", "bottom-up" and integrated approaches to implementing an EIPP. The object of implementation in this area was the policy itself, rather than a specific program or practice. There was often no clear articulation of independent and dependent policy-related implementation variables across any of fields, although many articles did partially address this.

How policy is described in implementation theory and processes

Our coding based on the compass question resulted in the following characterization of how policy is described in implementation theory and processes:

Policy is described as:

1. Context in which implementation occurs (i.e., only briefly citing a policy or mandate as the reason for implementation)

2. Focusing lens, signaling to systems what the priorities and foci should be (i.e., referring to policy statements or attention by policy-makers as being an important signal about what is important and what organizations should prioritize in their work)
3. Innovation itself – the implementation object (i.e., the "thing" being implemented is a policy, such as new legislative policy on tobacco or the environment. The policy package can include both the "what" and the "how")
4. Lever of influence in the implementation process (i.e., policy is identified as at least one of the factors influencing the implementation process)
5. Enabler/facilitator or barrier to implementation (mediating variable) (i.e., while policy is identified as being external to the implementation effort, it is later found to be a barrier or facilitator to implementation)
6. Outcome – implementation process identifies need for policy changes (i.e., the success of the implementation process is at least partially defined and measured by a change in policy)
7. Policy actors as important participants or leaders in implementation

Theoretical framework

Our approach to developing the theoretical framework was two-fold. The findings from our analysis suggested constructs that addressed both the process of implementation and the factors underpinning the success or failure of implementation. We therefore first chose to develop a process model. Process models in implementation are described by Nilsen[7] as the steps in the process of translating research into policy and practice, including the implementation and use of research and practical guidance in the planning and execution

of implementation endeavours and strategies to facilitate implementation. Next, we developed a determinants framework, which specifies the types of policy determinants (independent variables) that affect implementation outcomes (dependent variables). This two-part theoretical framework achieves two goals: 1) the process model is most useful in describing the process of implementation from a policy perspective, and 2) the determinants framework is most useful for understanding and explaining policy-related influences on implementation outcomes.

Part 1 – Process Model

Figure 2a depicts this novel process model focusing on one policy or system level. Figure 2b depicts the same process model across policy and system levels.

Policy is shaped as it moves through systems. What is at the implementation stage at one level of a system may be at the formulation stage at another. The process through which policy travels from one level to another is known as policy transfer.[41-43] Each policy level is nested in a context that includes existing ideas (values, evidence, etc.), interests (interest groups, civil society, etc.), institutions (existing rules and institutional structures) and external factors (natural disaster, change in economic conditions) that affect the interpretation of the policy package.[44,45] This context affects how a problem is defined, whether it has the attention of decision makers and whether it is up for active decision-making. This aligns with the "problem definition" and "agenda setting" stages of the policy cycle but is also described as part of the exploration phase of most process models in implementation science.[16,46] Once a decision has been reached that something should be done to address a given issue, attention shifts to the "policy development" stage of the policy cycle, which aligns with the

"adoption decision and preparation" stage of implementation. It is during the policy development/adoption decision and preparation stage that the policy package gets developed.

Policy package

A policy package usually includes a mix of policy levers or instruments that are "the control knobs" of policy. Policy levers can be classified in many ways,[47] however, for the purposes of our model, we describe them as: legal and regulatory instruments, economic instruments, voluntary instruments, or information and education instruments.[48] Legal and regulatory instruments include acts and regulations, self-regulation regimes (e.g., health professions) and performance-based regulations. Economic instruments include taxes and fees, public expenditure and loans, public ownership, insurance schemes, and contracts among others, and are by far the most common type of instrument in the implementation literature and usually described as "funding". Voluntary instruments can include things like standards and guidelines and both formalized partnerships and support for less formalized networks. Finally, information and education instruments are usually targeted to citizens in general or specific groups and can be an important instrument when a behavior change of the public or the workforce is needed.[49]

The policy package can also include some implementation guidance. The level and specificity of which varies extensively but can include: a description of the overall implementation strategy architecture, the major streams of activity, timing of events and milestones, and, roles and responsibilities.

The level of ambiguity of the policy package in terms of its goals and means of attaining them, and the amount of conflict among actors with respect to the policy package

are important to understand in order to characterize the implementation process and also to explain its outcomes. According to Matland[50] the consideration of ambiguity and conflict leads to four types of implementation processes: 1) Administrative implementation occurs when there is low policy ambiguity and low policy conflict (e.g., eradication of small pox); 2) Political implementation occurs when there is low ambiguity but high levels of conflict (e.g., public transit); 3) Experimental implementation occurs when there is high ambiguity but low conflict (e.g., Head Start programs for pre-school aged children); and 4) Symbolic implementation occurs when both ambiguity and conflict are high and policies only have a referential goal and differing perspectives on how to translate the abstract goal into instrumental actions (e.g., establishing youth employment agencies).

Implementation process

The policy implementation process can start at any level, move in any direction and can "skip" levels. Power also shifts as implementation proceeds through levels.[34,51] The level currently focused on implementation tends to have the most power. This is true not only for different levels of governance, but as implementation cascades across organizations, through "street level bureaucrats"[17] or service providers and on to the end-user or target population (the "recipient") of the implementation process. Policy decisions at one level become context for the current level and implementation at other levels can exert either direct or indirect effects on the current level. The context surrounding each level (prevailing ideas, interests, institutions and external events) influences the acceptability and ultimate success of implementation.

In addition, the implementation focus and approach may need to shift over time in response to a constantly evolving context. For example, Bax, de Jong & Koppenjan[52] found

that shifts in the implementation approach for an evidence-based road safety policy were necessary in response to a shift from centralized policy authority for road safety to distributed responsibility across multiple ministries and policy areas.

Outcomes

The process of implementation is undertaken in order to lead to outcomes, which can be separated and measured at different levels. Proctor and colleagues[53] identifies three separate outcomes: 1) implementation outcomes (i.e., acceptability, adoption, appropriateness, costs, feasibility, fidelity, penetration and sustainability[13,53]); 2) service outcomes (i.e., efficiency, safety, effectiveness, equity, patient-centredness, and timeliness[53]); and 3) recipient-related outcomes (i.e., satisfaction, function, symptomatology[53]). Along with these outcomes, our model includes policy and systems level outcomes. These can be evaluated according to the policy outputs (i.e., enforcement variables, change of perspective of street-level staff, etc.), policy outcomes (i.e., unemployment levels, life-expectancy of population, crime levels, etc.) or indices of policy system change (i.e., administrative re-organization, privatization, etc.).[51] While the measures and levels will vary depending on the size, scale and focus of implementation, there is broad agreement that outcomes should be clearly defined a-priori and measured as precisely as possible through evaluation efforts. Evaluation findings regarding outputs and outcomes can dynamically feed back into the implementation process as it unfolds as well as when the implementation process is complete. This creates feedback loops and the process becomes very dynamic and multi-directional. In both version of the model, the policy package moves and can shift in any direction to another level.

Part 2 – Determinants framework

Figure 3 presents an overview of our determinants framework and the relationship among the determinants. Our findings point to several sets of policy-related factors that affect the process, outputs and outcomes of implementation: 1) policy instruments and strategies; 2) determinants of implementation; and 3) the policy actors, including their characteristics, their relationships and context. Collectively, these feed in to the process of implementation that proceeds in an iterative fashion along the stages: exploration, installation/preparation, initial implementation, full implementation/sustainment.[16,46] The types of policy influences vary according to the stage of implementation.[16] The process of implementation leads to a variety of outputs and outcomes as described above.

Policy instruments and strategies

Policy instruments and strategies are the most common set of factors mentioned in the literature (particularly the implementation science and knowledge translation literatures) and we found evidence for each of the instrument types described above, although with varying levels of detail. Depending on the system, policy instruments can be applied to implementation in differing ways, often with two or three levers used concurrently to implement a single initiative or strategy, as Grace and colleagues found in their analysis of policy levers used to implement mental health reform in Australia.[54] These instruments are applied to particular policy-related strategies used in implementation. In order to classify these strategies in a meaningful way, we drew on and adapted elements of a mutually exclusive and collectively exhaustive framework that identifies key features of health and social systems[44] and honed in on strategies that are particularly important for implementation. These include strategies focused on the governance arrangements, financial

arrangements, service delivery arrangements and implementation-related supports in systems. We then divided these strategies according to the intended "target" of implementation. Common targets of implementation from a policy perspective include the system as a whole (extra-organizational), organizations, the workforce or service providers, consumers and the innovation itself (the policy, program or practice to be implemented). Below we highlight some of the most common strategies found in our synthesis. We wish to note, however, that because policy-related variables have not necessarily been treated with the same specificity as other types of implementation variables, the most common strategies do not reflect the full array of strategies that *could* be employed. The full list of policy strategies and examples according to the type of target are outlined in Table 3.

Common policy-related strategies targeting the system include those focused on the accountability of the state sector's role in implementation. Developing system-wide performance indicators or targets, monitoring performance, evaluation, public reporting of results and considering the use of enforcement strategies (e.g. legal action for non-compliance) were strategies that were identified repeatedly. Funding system infrastructure, such as dedicating resources for intermediaries or technical assistance centres, was another commonly identified strategy.

A large number of strategies targeting the organizational level were reported in the documents included in our synthesis. The strategy of "funding organizations" was perhaps the most commonly reported strategy overall and reflects the recognized role of policy in funding implementation through organizations in systems. Specific examples include providing service grants or contracting with organizations, providing targeted payments or penalties based on performance or outcomes, or shifting the organizational funding models.

There are, however, several other governance-, financial-, service delivery- and implementation-support-related strategies that should not be overlooked (Table 3).

The service-providing workforce is another policy-related target for implementation and here the commonly reported strategies spanned those addressing professional authority (such as changing licensure requirements or scope of practice to support implementation) and remunerating providers (such as reimbursement for program participation or changing the way providers are reimbursed to encourage implementation).

Consumer-targeted strategies were less commonly identified overall in our synthesis, however, some documents addressed consumer and/or stakeholder involvement in implementation and monitoring and others identified mechanisms to incent consumers directly to change their behaviors (through altering consumer fees or providing subsidies).

Finally, some policy strategies targeted the innovation that is being implemented. The most common innovation-targeted strategy in our review was purchasing products or services (for example, changing the list of covered or reimbursed services or products or changing restrictions or caps on coverage for the EIPP and related supports).

Determinants

Beyond the specific instruments and strategies used in implementation, there were eight categories of determinants identified (see "Determinants" box and elsewhere in Figure 3). Interestingly, the policy implementation literature was much more likely to focus on these. We began with the determinants developed by Hill & Hupe[51] based on their extensive review of the policy implementation literature and we altered or created new synthetic categories through our analytic process. Each of these categories represents a suite of factors that are hypothesized to independently affect implementation outcomes. These determinants are

described briefly below and Table 4 provides a more fulsome description of the determinants and the factors that characterize them.

I – Characteristics of the Evidence-Informed Policy or Practice (EIPP) - It is not possible to predict the success or failure of a particular policy package based on its intrinsic characteristics alone.[51] Instead it is important to examine questions such as whether the policy selected is an appropriate "fit" with the problem[55] and aligned with existing context.[16,56]

II - *Policy Formulation Process* - Policy formulation roughly equates to the Exploration stage identified in implementation science. It is described as the shape given to a policy by the initial formation processes.[51] This includes who in government is responsible for formulating the policy, their legitimacy and the extent to which there is opportunity to provide feedback, how much feedback is given and the responsiveness in terms of adjustments made.[51]

III – Vertical Public Administration and Thickness of Hierarchy - Vertical Public Administration is the term used to identify the layers in the policy transfer process. It refers to separate governments exercising their authority with relative autonomy.[51] Policies generated outside of a socio-political level may be more or less acceptable to that level. Within a given layer, a particular policy area may require the mobilization of any number of institutions, departments or agencies and these agencies must act in a coordinated, interdependent fashion. Hill and Hupe refer to this as the thickness of the hierarchy.[57]

IV – Networks/Inter-organizational Relationships - This group of determinants reflects the existence and nature of the relationships between parallel organizations who must collaborative in order to achieve effective implementation and who do not have a hierarchical relationship.[51]

V – Implementing Agency Responses - The factors affecting the responses of implementing agencies can be divided into issues related to the overall characteristics of the agencies and the behaviour of front-line or street-level staff.[51]

VI – Attributes and Responses from Those Affected by EIPP - The attributes and impact of the responses from those affected by the EIPP is another set of determinants. In terms of attributes, the diversity of target group behaviour and the target group as a percentage of the population are key.[18] Responses include thing like impacts on workforce stability.[16]

VII – Timing/Sequencing - We added timing/sequencing as a new category of determinants because it was apparent from our review that the chronological ordering and sequencing of activities exerted an independent effect on implementation. In Figure 3, Timing/Sequencing is placed outside of the Determinants box but inside the hatched line area because it is important to consider across all of the other elements. This is perhaps not surprising given that implementation is a process that unfolds over time and does not always align with the cycles to which they are subject and the time constraints inherent therein.[58,59] Additionally, the external context in which implementation occurs is ever changing and "quintessentially unstable", and success hinges on the ability to perceive those changes and take the necessary actions to adjust along the way.[60]

VIII – External Environment or Policy Context - Most, if not all of the literature that we reviewed identified factors outside of the policy area of focus that may influence implementation. This determinant is placed outside the hatched line area in Figure 3 to reflect this. Many authors referred to this generally as the "political and social climate", as unmodifiable or macro "context" or as "socio-economic conditions".[13,18,61-66] We organized this determinant using: 1) the 3I+E framework,[67] and 2) a taxonomy of health and social system arrangements.[68]

In general, these categories of determinants should be viewed as interactive and not completely discrete[51] and the inter-relationship among the determinants is key.[42]

Policy actors

Our analysis revealed a wide-range of policy actors who are important for implementation. Some articles refer to these roles as "responsible authorities"[69] or "policy-makers"[43,70-73] but these categories are too broad to be analytically useful. Other articles are quite specific about the policy actors making them context-dependent. For example, state and local health and mental health departments were frequently mentioned, particularly in the literature from the U.S.[32,33,39,74-76] In some instances, specific roles were identified, such as a state commissioner[39] or the senior staff at a local health board.[58] In an attempt to create a category of variables that is analytically useful across contexts, we first divided the types of policy actors into the broad categories of: political actors, bureaucratic actors, special interests and experts, adapting a classification used by Dente.[77] To provide more specificity, we further divided these into a non-exhaustive list of actor sub-types that were frequently mentioned in the literature and included examples of the types of roles they tend to assume in implementation (Table 5). While many of the sub-types are commonly identified in other phases of the policy cycle, some receive particular attention in the implementation literature. These include two types of Special Interests: 1) Implementing Agencies - organizations or programs that are responsible for implementing the EIPP (e.g., hospitals, schools, child welfare agencies, industry, etc). These are the location(s) in systems where the majority of the implementation effort takes place; and 2) Street-Level Bureaucrats who, due to the relatively high degree of discretion in their jobs, and therefore discretion over the dispensation of public benefits or sanctions to citizens, can be critical to realizing any large-scale

implementation efforts. There are also three Expert sub-types that are particularly visible during implementation: 1) Field or Practice Leaders (often referred to as "champions") who can be influential in supporting practice change amongst professionals; 2) Innovation Developers/Disseminators who have developed the EIPP to be implemented and who may contribute or adapt tools and other types of support to encourage successful implementation; and 3) Intermediaries/Technical Assistance Providers who are organizations, programs or individuals that work "in between" policymakers, funders, and frontline implementers, to facilitate effective implementation drawing on expertise in implementation.

Beyond the type of policy actor, there are three additional categories of actor-related variables that are important in implementation: 1) actor characteristics; 2) actor relationships; and 3) the context in which the actors are embedded (presented as an overview in Figure 3). Figure 4 provides additional detail regarding these actor-related variables. First, the characteristics of the policy actors (either individual- or organizational-level) such as their knowledge of the implementation context, their legitimacy, power and control, and their leadership in the context of the implementation effort are often cited as being critical to the success in large-scale implementation initiatives. Second, the relationships policy actors have with other actors, such as the level of shared values and beliefs or the coordination and alignment of actors and their activities, can be predictive of successful implementation. Finally, the context of the actors, such as the sustainment of political will and commitment and the stability of the actors themselves can predict the long-term success of implementation (see Figure 4 for full list of actor characteristics, relationships and context).

Improving Existing Theory

Implementation science, knowledge translation, and political science already offer a wide range of conceptual models, theories and frameworks from which to draw.[7-10,51] While we have argued for the need for additional theory that better incorporates policy in implementation concepts and have attempted to fill that gap with this new theoretical model, we also saw value in using the findings of our CIS to improve existing frameworks, models, and theories. We drew upon the Interactive Systems Framework for Dissemination and Implementation (ISF) to provide an example of such improvements.[78,79] Initially developed as a heuristic to help clarify how new knowledge in the field of violence prevention moves from research development to widespread use and the systems and processes supporting this movement, the ISF has been widely cited and applied across a number of fields[80-84] and has been particularly helpful in clarifying the capacities required to support the implementation process at a systems level.

The ISF specifies the three systems needed to carry out dissemination and implementation functions: 1) Synthesis and Translation System, 2) Support System, and 3) Delivery System. The Synthesis and Translation system encompasses the functions associated with distilling theory and evidence, translating it into usable formats and ensuring that people who could benefit from the evidence have access to it. The Support System works with both the Synthesis and Translation System and the Delivery System to ensure innovations are implemented with quality and to increase the likelihood that the innovation will lead to desired outcomes. Finally, the Delivery System includes individuals, organizations and communities who carry out the innovations developed by the Synthesis and Translation System. The Delivery System is where implementation takes place and where social benefits are realized. Each system is connected through bi-directional relationships and the systems

are embedded within a context that includes macro-policy, existing research and theories, climate (defined as the level of emphasis placed on accountability for practitioners), and funding. For a full description of the ISF, see Wandersman and colleagues[78] and Wandersman, Chien, & Katz[79].

While the ISF has broad use and applicability and has found purchase among researchers and evaluators looking to design, describe and evaluate implementation efforts at scale, the framework has not been particularly sensitive to the policy considerations that are an important part of implementation in public systems and go beyond "macro policy" as part of the context in which implementation occurs. Our results can be used to build on the ISF by adding a Policy System to better capture the role of policy in implementation and the interactions between the Policy System and each of the three previously identified systems (Figure 5). The Policy System includes public policy at all levels (municipal, provincial/state, national and supra-national levels) as well as organizational policy, with each type of policy having influence on the other Systems to bridge the research to practice gap. Policies can also be EIPP-specific (e.g. legislative mandate for a particular practice or model of care), or reflective of the broader context in which the innovation is embedded (overall governance (e.g., relative centralization of authority), financial (e.g., financing and reimbursement structures), and delivery (e.g., where care is provided) arrangements of the system that might need adjustment to embed the EIPP). The activities and outputs of other Systems can also feed back into the Policy System with the potential to shape subsequent policy cycles. Additionally, an implementation effort can bypass the other Systems and be conceived of, and implemented directly from, the Policy System. An example of this is direct payments to citizens (e.g. child benefits) to encourage particular behaviours (in the case of child benefits,

to offset the additional costs of raising children in order to minimize the risk of future costs of children raised in poverty).

Discussion

Our study represents one of the first comprehensive attempts to answer the call of scholars to integrate the fields of implementation science, knowledge translation and policy implementation in an effort to build a more comprehensive and accurate understanding of implementation. By integrating conceptual and empirical works from all three fields, the resultant two-part theoretical framework provides additional clarity regarding the process of implementation viewed from a policy perspective and identifies a number of policy-related determinants that can be tested empirically in the future. Our study also sought to improve existing theory by applying our findings to Wandersman and colleagues' Interactive Systems Framework,[12,78] which resulted in the addition of a "Policy System".

A key strength of our study was the methodological approach we took to theory building. First was the comprehensiveness of the search strategy, which aimed to identify scholarship from more than one academic discipline and across wide range of topics beyond health. The literature identified through the search process revealed some interesting parallels and unique differences between the fields that made it clear to us the extent of the lack of integration up to this point. Perhaps not surprisingly, the area of public health seemed to be the most fertile ground for integration. This is likely due to their focus on population-level concerns requiring system-wide implementation of EIPPs and a diverse implementation ecosystem. The search strategy was part of the mixed methods approach of the CIS, which blended the rigor of a systematic search methodology that is explicit and replicable, with the

inductive, iterative and purposive sampling techniques from qualitative review methods to build mid-range theory. The result is a theoretical framework that is clearly linked to the literature, which should instill some confidence in the academic community regarding its grounding. Critical interpretive synthesis is a relatively new approach but is growing in popularity for these reasons.

Another key contribution is that our work did not stop with the generation of a new conceptual framework but also recognized existing theory and built upon it with our findings. As we mentioned, there are a plethora of models, theories and frameworks from implementation science and knowledge translation leading some to question whether more theory is needed. Our modification of the ISF is an example of an attempt to strengthen the excellent theoretical works that exist rather than just create something new.

Despite the merits of our approach, we did identify some challenges. First, we believe the literature from public policy may be underrepresented for several reasons: 1) search terms did not retrieve as much from those fields (it could be that there are terms used more commonly in those fields that would have increased yield); 2) the disciplinary approach to the scholarship in public policy often means the articles were less explicit about methods and this meant that more were excluded as not being "high yield"; 3) more of that scholarship is captured through other media (e.g., books and book chapters) and while some of these were included, our approach was not as sensitive to retrieving these types of documents. We also did not include all of the empirical articles for data extraction, which means we may have missed a key theme or framework component. While we believe this is unlikely because we continued to sample until saturation was reached, it is still possible something was missed.

As a result of this research, policy-makers and practitioners looking to use a conceptual model to guide their implementation activities have two additional options that they can be confident draw from existing theory and empirical works. Large-scale implementation endeavors or those that have started small and are looking to scale-up should at least be mindful of the critical roles of policy during the process and what policy-related factors may be important for success. Those planning implementation activities can consider the elements presented in the framework as factors that may require consideration and adjustment prior to implementing something new. Our work supports thinking beyond the program or practice levels and unpacks policy considerations that may have influence on, or affect the effectiveness of, a program or practice. Furthermore, the inclusion of policy-related outputs and outcomes in our framework offers policy-makers and practitioners the option of additional indicators of success on which they can measure and report.

Like any new theoretical contribution, our framework would benefit from further refinement and testing by the research community. Future research could adopt the process model to guide a policy-intensive implementation effort and test it to determine its usefulness in such efforts. Researchers could also select particular framework elements and unpack them further for additional precision and clarity, drawing from multiple fields of scholarship. Our framework also offers some much needed policy variables that have been lacking in the implementation science and knowledge translation fields, which could be incorporated as part of a suite of variables in implementation research. More generally, our study represents an early effort at integrating the fields of public policy, implementation science and knowledge translation. We have learned through this work that there is indeed a great deal that each of the fields can learn from the other to advance our understanding of

policy- and systems-level implementation efforts. It is our hope that these efforts are followed by more interdisciplinary research in order to truly bridge this divide.

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Table 1 – Search terms

Implementation Terms		**Government Level**		**Organizational Level**		**Practice Level**		**Evidence Terms** (with and without dashes)
implement*		policy		organizational polic*		"clinical guideline"		"evidence-based practice*"
"knowledge translation"	**AND**	strategy	**OR**	policy and procedures manual	**OR**	"practice guideline"	**AND**	"evidence-informed practice*"
"knowledge mobili*"		"action plan"		procedures manual		scope of practice		"evidence-informed policy"
								"evidence-based policy"

Figure 1 – Literature search and study selection flow diagram

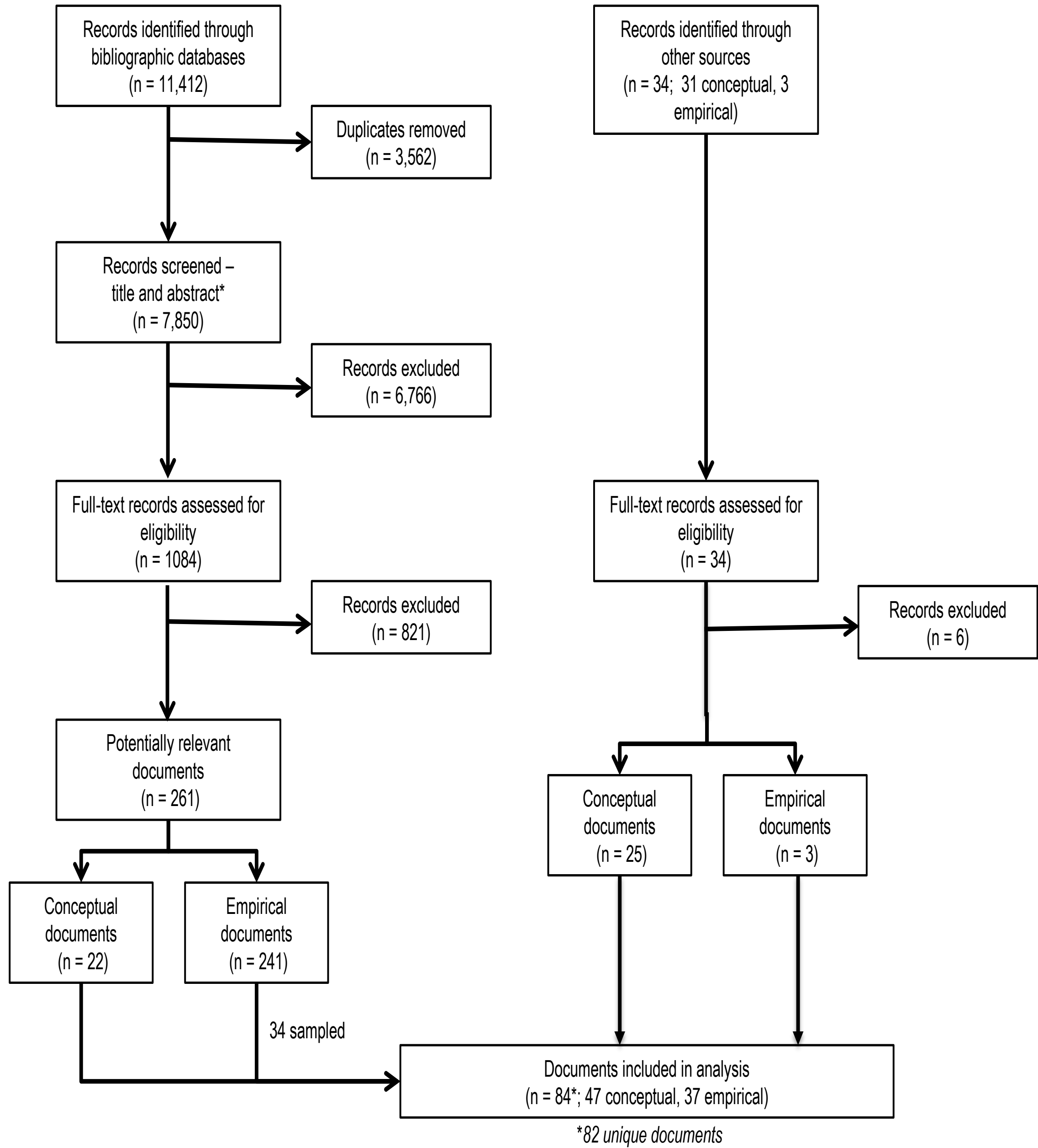

Table 2a – Overview of included conceptual literature

Author	Year	Author Location	Topic Area	Focus	Name of Model/Theory/Framework	Framework Type (Nilsen 2015)
Aarons et al[16]	2011	USA	Public services for children & families	Implementation	Conceptual model of global factors affecting implementation in public service sectors	Determinants framework
Bauman et al[43]	2006	Australia (majority)	Physical activity	Supra-National	A Six-Step Framework for International Physical Activity Dissemination	Process model
Bowen et al[85]	2010	USA	HIV	Organizational/ program	Rogers-Rütten Framework	Determinants + evaluation framework
Bowen & Zwi[62]	2005	Australia	Public health	Knowledge translation	Evidence-informed Policy and Practice Pathway	Determinants framework
Bruns et al[86]	2008	USA	Children & youth	System (state)	No name per se but addresses dimensions of state EBP implementation effort	Determinants framework
Burris et al[63]	2012	USA	Public health	System (law)	No name per se but unified framework integrating public health law and public health systems and services	Determinants framework
Chaudoir, Dugan & Barr[13*]	2013	USA	Health	System (measures of determinants)	A multi-level framework predicting implementation outcomes	Determinants framework
Cherney & Head[87]	2011	Australia	Evidence-based policy/practice	System	Components of a Support Delivery System: '9Cs'	Determinants framework
Chin & Goldmann[88]	2011	USA	Health	System	A Conceptual Model for Specifically Addressing Disparities 6 Key Levels of Influence	Implementation theory

Damschroder et al[11]	2009	USA	Health	Organizational	Consolidated Framework for Advancing Implementation Research (CFIR)	Determinants framework
Domitrovich et al[89]	2008	USA	Schools	Implementation quality	No name per se but identified as factors that can affect implementation quality: a multi-level model	Determinants framework
Evans & Davies[42]; Dolowitz & March[41]	1999 2000	UK UK	Policy transfer	Policy	Policy transfer	Determinants framework
Feldstein & Glasgow[90]	2008	USA	Healthcare	Research to practice implementation	PRISM (Practical, Robust Implementation and Sustainability Model)	Process model
Fleuren, Weifferink & Paulussen[56]	2014	Netherlands	Healthcare	Organizational/ program	No name per se but "Framework representing the innovation process and related categories of determinants"	Determinants framework
Godfrey[91]	2011	USA	Mental health	System	Hypothesized factors that influence ACT implementation	Determinants framework
Green et al[70]	2006	USA	Physical activity	Knowledge translation	Push-Pull Capacity Model	Process model
Greenhalgh et al[31]	2004	UK	Healthcare	Organizational	Diffusion of Innovations in Service Organizations	Determinants framework
Greig, Entwistle & Beech[92]	2012	UK	Healthcare	Implementation activity/practices	Activity Theory	Classic theory
Harris et al[64]	2012	USA	Health promotion	Organizational	Health Promotion Resource Center Dissemination Framework	Process model
Harvey & Kitson[93]	2016	Australia	Health services	Implementation	Integrated Promoting Action on Research Implementation in Health Services (I-PARIHS)	Determinants framework

Hendriks et al[94]	2013	Netherlands	Public health (childhood obesity)	Policy	Behavior Change Ball	Implementation theory
Hill & Hupe[57]	2003	UK & Netherlands	Policy implementation	Policy	No model/theory or framework but discussed 'the multi-layer problem'	N/A
Hill & Hupe[51]	2002	UK & Netherlands	Policy implementation	Policy	N/A (book)	Determinants framework
Hodges & Ferreira[95]	2013	USA	Children & families	Policy (local)	Multilevel framework for local policy development and implementation	Determinants framework
Howlett[47]	2004	Canada	Policy implementation	Policy (instruments)	N/A	Other (most closely resembles Classic Theory)
Hupe[96]	2011	Netherlands	Policy implementation	Explaining policy implementation	Thesis of incongruent implementation	Determinants framework
Hupe & Hill[97]	2016	Netherlands & UK	Policy implementation	Policy	N/A	N/A
Jansen[98]	2010	Netherlands	Public health	Disconnections between policy, practice and research	3 niches of public health	Process model + determinants framework
Jilcott et al[99]	2007	USA	Public health	Evaluating policy implementation	Applying the RE-AIM framework to assess the public health impact of policy change	Evaluation framework
Johansson[15]	2010	Sweden	Human services	Policy	N/A	N/A
Leeman et al[100]	2012	USA	Obesity prevention	Policy	Center TRT's evaluation framework	Evaluation framework
Lipsky[17]	1980	USA	Social services	Policy & individual	Street-Level Bureaucracy	Implementation theory

Matland[50]	1995	USA	Policy implementatio n	Policy	Ambiguity-Conflict Model of Implementation	Implementation theory
Mendel et al[101]	2008	USA	Mental health	Organizational/ community	Framework of Dissemination in Health Services Intervention Research	Process framework (2nd)
Michie[69]	2011	UK	Behaviour change (EBPs)	Individual	The Behaviour Change Wheel	Implementation theory + determinants framework
Pettigrew & Whip[60]		UK	Business	Organizational/ firm	Understanding strategic change: three essential dimensions (Warwick Framework)	Classic theory
Proctor et al[53]	2011	USA	Mental health	Implementation outcomes	Conceptual Model of Implementation Research	Evaluation framework
Raghavan, Bright & Shadoin[65]	2008	USA	Mental health	Policy	A Policy Ecology of Implementation	Determinants framework
Rutten et al[102]	2003	Germany/ Europe	Health promotion	Policy	Determinants of policy analysis	Determinants framework + classic theory
Sabatier & Mazmanian[18]	1980	USA	Policy implementatio n	Policy	Framework of Analysis for the Implementation of Public Policy	Determinants framework + process model
Schoenwald et al[103*]	2008	USA	Mental health	System	Conceptual model for the MacArthur research network on youth mental health child STEPs initiative on evidence based practice in clinics and systems	Determinants framework
Shortell[104]	2004	USA	Health care	System	N/A Levels and associated assumptions about change	Implementation theory
Spoth et al[105]	2013	USA	Public health/ prevention	Population	Translation Science to Population Impact (TSci Impact) framework	Process model

Strehlenert[66]	2015	Sweden	Health and social care	Policy	Conceptual Model for Evidence-Informed Policy Formulation and Implementation	Process model
VanDeusen Lukas et al[106]	2007	USA	Heath care	Organizational	Framework for Organizational Transformation	Classic theory
Wandersman et al[107]	2016	USA	Empowerment evaluation	Innovation & system interface	Getting to Outcomes	Process model
Wisdom et al[61]	2014	USA	Innovation adoption	System	N/A	Determinants framework

* *also included in empirical literature*

Table 2b – Overview of included empirical literature

Author	Year	Author Location	Topic Area	Level of Focus	Methodology
Bax, de Jong & Koppenjan[52]	2010	Netherlands	Road safety	System	Policy analysis
Beidas et al[73]	2016	USA	Mental health	Stakeholder	Qualitative interviews
Browdowski et al[71]	2013	USA	Child abuse prevention	System	Descriptive case study
Brownson et al[76]	2015	USA	Public health	System (state + local)	Cross-sectional survey
Chaudoir, Dugan & Barr[13*]	2013	USA	Health	System (measures of determinants)	Systematic review & criterion-validity assessment
Cheadle et al[108]	2009	USA	Physical activity promotion	Community	Evaluation – uncontrolled prospective design
Culotta, Wiek, & Forrest[59]	2016	USA	Climate change	Regional	Case study/policy analysis
Evans[58]	2013	UK	Health	Policy	Mixed methods survey & in-depth interviews
Fleuren et al[56]	2014	Netherlands	Prevention child health care/schools	Innovation determinants	Systematic review + Delphi study
Gotham et al[109]	2008	USA	Addictions	System (state)	Case study
Grace et al[54]	2015	Australia	Mental health	Policy	Policy analysis (document analysis)
Grundy & Smith[55]	2011	Canada	Employment	Policy	Policy analysis
Hargreaves et al[110]	2013	USA	Home visiting	Systems	Mixed methods
Haug et al[111]	2010	Europe	Climate change	Policy	Literature review
Horner et al[74]	2014	USA	School behavioral supports	Multi-state EIPP	Descriptive evaluation
Monroe-DeVita et al[75]	2012	USA	Mental health	EIPP	Literature Review
Painter[112]	2010	USA	Mental health	Policy	Single case study (document analysis + secondary data analysis of single provider)

Author	Year	Author Location	Topic Area	Level of Focus	Methodology
Perla, Bradbury & Gunther-Murphy[113]	2013	US & UK	Healthcare	System	Scan of literature using modified Delphi technique
Powell et al[114]	2012	USA	Health & mental health	EIPP	Narrative review
Powell et al[115]	2014	USA	Mental health	EIPP	Systematic review
Powell et al[116]	2015	USA	Health & mental health	EIPP	Delphi process
Rhoades et al[72]	2012	USA	Prevention (of crime & delinquency)	System (state level)	Case description
Rieckmann[117]	2011	USA	Addictions	Policy	Mixed methods (survey & key informant interviews)
Rieckmann[118]	2015	USA	Addictions	Policy	Mixed methods (survey & key informant interviews)
Rubin[119]	2016	USA	Alignment of implementation & public systems	Systems	Intro to special issue (review of articles)
Schoenwald et al[103*]	2008	USA	Mental health	System	Structured survey (national sample)
Yamey[120]	2012	USA	Health in LMICs	System	Key informant interviews
Zhang & Marsh[121]	2016	China	Administrative policy transfer	Policy	Policy analysis
National Implementing Evidence-Based Practices Project articles (53 sites; 8 states), n = 9**					
Bond et al[32]	2009	USA	Mental health	System (multi-state)	Mixed methods
Finnerty et al[33]	2009	USA	Mental health	Policy/System	Instrument development & testing
Isett et al[34]	2007	USA	Mental health	System (multi-state)	Qualitative (interviews)
Isett et al[35]	2008	USA	Mental health	System (multi-state)	Case study (site visits + semi-structured interviews)
Jones et al[36]	2014	USA	Mental health	System (multi-state)	Semi-structured interviews (state leaders)
Mancini et al[37]	2009	USA	Mental health	Innovation (2 states)	Mixed methods (fidelity measurement + interviews, surveys & site visits)
Peterson et al[38]	2014	USA	Mental health	System (multi-state)	Longitudinal analysis (descriptive)
Rapp et al[39]	2005	USA	Mental health	System (multi-state)	Descriptive

Author	Year	Author Location	Topic Area	Level of Focus	Methodology
Rapp, Goscha & Carlson[40]	2010	USA	Mental health	System (state)	Descriptive

* *also included in conceptual **9 articles described individually in subsequent rows*

Table 3 – Policy-related strategies and examples of those strategies for implementation according to type of target

Target	Strategy	Examples	References
System	Policy authority (governance arrangement)	• Centralization/decentralization of policy authority (e.g., creating a regional infrastructure with some policy authority to oversee implementation) • Accountability of the state sector's role in implementation (e.g., develop system-wide performance indicators or targets, monitor performance and fidelity, evaluate, report results publicly, consider enforcement strategies) • Leadership for implementation (through the appointment of state sector leaders, dedicated resources, garnering support for innovation and its implementation) • Stewardship of the non-state sector's role in implementation (e.g., constructing formal opportunities for non-state sector in oversight of implementation; contracting with non-state sector for implementation-related activities; fostering networks and linkages across different types of organizations who are engaged in implementation)	11,16,32-36,42,61,62,86,116
	Funding system infrastructure (financial arrangement)	• Dedicate resources for system infrastructure to support implementation (e.g., intermediaries, technical assistance centres, backbone organizations, facilitators, etc) • Create funding sources that align with time needed for effective implementation and scaling	13,32,33,36,37,40,71-74,86,91,105,113,116
	Re-designing system to meet needs (delivery arrangement and implementation-related supports)	• Consider impacts of implementation on availability of care/service and plan for scaling-up across the geographical area or population • Assess possible impacts on other services (e.g., wait times, etc) in response to implementing innovation	11,18,31,39,70,85,93,94,104,109,112,116
	With what supports service is provided (delivery arrangement)	• Create or change system-wide record systems or information and communication technologies to support implementation	34,74,113,116

Organization	Organizational authority (governance arrangement)	• Management approaches in support of optimal implementation, including: developing data collection systems, developing and monitoring performance indicators, quality improvement plans, use of scorecards, or public reporting • Develop and deploy appropriate organizational leadership for implementation oversight and engagement • Include innovation as part of accreditation processes • Engage in networks/multi-institutional arrangements in support of implementation	11,39,103,109,113,116
	Funding organizations (financial arrangement)	• Provide service grants or contract with organizations to support implementation or to offset additional administrative costs of implementing an innovation (e.g., training, data infrastructure changes, workforce stability impacts, etc) • Prospective payments to cover lag-time costs when beginning to implement an innovation • Targeted payments or penalties based on organizational performance related to innovation (e.g. changing reimbursement rate structure so that providers of high fidelity receive modestly higher per unit rate) • Targeted payments or penalties based on client outcomes • Shift organizational funding models to support implementation (e.g., from fee-for-service to no-risk managed care arrangements)	16,33,34,39,40,65,74,103,106, 112,116,118,119
	Where service is provided (delivery arrangement)	• Adjust sites of service delivery in response to an innovation • Consider how the physical structure, facilities & equipment can support innovation during implementation and ensure appropriate supply (supply chain management) • Adjustments to the organizational scale in response to an innovation (e.g., number of beds, units of service, etc)	54,116
	With what supports service is provided (delivery arrangement)	• Change organizational record systems or other information and communication technologies to support implementation	113,116

	Organization-targeted implementation supports (Implementation-related supports)	• Develop educational materials, hosting educational meetings, training or outreach visits tailored to organizations • Develop and disseminate program or organizational service standards • Provision of technical assistance and other forms of implementation support • Support development and maintenance of inter-organizational collaboratives, communities of practice and other forms of inter-organizational communication/learning • Consider non-monetary awards, incentives and disincentives for organizations (e.g., exemplary program award)	11,13,33,34,40,59,64,73,93,101,116
Workforce/ Service Provider	Professional authority (governance arrangement)	• Create or alter training & licensure requirements • Change scope of practice to reflect innovation • Alter where providers can practice geographically and in what systems (public vs private, etc) • Continuing competence (e.g., provide training & continuing education unit credits for innovation or disallow certain courses for credit) • Professional liability (e.g., change liability laws) • Alter university curricula to include knowledge of innovation	32,33,39,65,75,103,109,116
	Remunerating providers (financial arrangement)	• Reimbursement for program participation, extra efforts in applying the innovation or lost time due to training • Increase reimbursement rate • Changing the way providers are reimbursed to encourage implementation (e.g., from fee-for-service to capitation) • Loan forgiveness • Targeted payments or penalties for performance • Targeted payments or penalties based on outcomes • Review and align fiscal and billing policies and incentives for providers • Make billing easier for providers	11,32,37,39,53,54,56,61,64,65,73,90,101,104,116,119
	By whom service is provided (delivery arrangement)	• Assess and improve workplace conditions for providers to foster implementation • Extend the role of a particular provider within their existing scope of practice	11,42,69,91,94,95,107,109,116

		• Shift tasks between types of providers • Optimize the performance of the workforce in their current roles by creating, disseminating and monitoring guidelines or standards of care for service providers	
	Workforce-targeted implementation supports (implementation-related supports)	• Develop educational materials, hosting educational meetings, training or outreach visits • Engage local opinion leaders • Reminders & prompts • Audit & feedback • Coaching • Develop either tailored or multi-faceted interventions to support implementation • Consider non-monetary awards, incentives and disincentives for workforce	33-35,39,65,71,86,101,109,116
Consumer	Consumer & stakeholder involvement (governance arrangement)	• Consumer protection (laws, complaints management, etc) • Consumer, family & stakeholder engagement in implementation & monitoring	65,103,109,116
	Incentivizing consumers (financial arrangement)	• Alter consumer/patient fees • Consider disincentives that may exist for consumers to be successful (e.g., some employment programs) • Subsidies for private health insurance	34,54,116
	Consumer-targeted implementation supports (implementation-related supports)	• Information or education provision • Behaviour change support • Skills and competencies development • Communication and decision-making facilitation	42,65,69,94
Innovation	Commercial authority (governance arrangement)	• Adjust licensure & registration requirements to support implementation • Consider pricing & purchasing • Establish voluntary agreements on advertising	69,94

	Purchasing products & services (financial arrangement)	• Changes to the scope and nature of insurance plans: extending or ending insurance coverage • Adjust list of covered/reimbursed services & products • Change restrictions or caps on coverage/reimbursement for innovation and related supports • Change mechanisms for billing • Prior approval requirements	37,65,75,76,91,103,107,109,116

Table 4 – Determinants of implementation from a policy perspective and the factors that characterize the determinants

Determinant	Description	Factors that characterize determinant

I. Characteristics of the EIPP	• Not possible to predict the success or failure of a particular policy package based on its intrinsic characteristics alone[51]
	• Need to examine questions such as whether the policy selected:
	  ○ is an appropriate fit with the problem[55]
	  ○ aligned with existing context[16,56]
		• Relative advantage[31,85]
		• Compatibility[31,85]
		• Complexity of goals and ease of implementation[31,85]
		• Obligations[31,85]
		• Resources[31,85]
		• Existing relationship with state and providers[118]
		• Level of ambiguity of the EIPP[50]
		• Level of conflict among stakeholders[50]
		• Interaction of policy characteristics with other determinants[51]

II. Policy Formulation Process	• Shape given to a policy by the initial formation processes has an impact on its implementation[51] • Depending on the implementation approach, the government may distribute responsibility for some or almost all of the policy formulation process to other stakeholders[16] • Level of involvement of service organizations, street-level bureaucrats and recipients may influence the confidence in, and support of, the policy decision and improve the chances for successful implementation[113]	• Government actors responsible for formulating policy[51] • Perceived legitimacy of government actors[51] • Extent to which there is opportunity to provide feedback[51] • Responsiveness of policy makers to feedback[51] • Level of involvement of non-governmental actors [16,113] • Adequacy of planning for implementation (consideration of resources for implementation)[113] • Constraints experienced during formulation[16,31]
III. Vertical Public Administration and Thickness of Hierarchy	Vertical Public Administration: • Term used to identify the layers in the policy transfer process • Refers to separate governments exercising their authority with relative autonomy[51]	• Number of socio-political levels[51] • Acceptability of policy generated outside of a particular socio-political level[121] • Appropriateness of socio-political level[59]

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<td>• Policies generated outside of a socio-political level may be more or less acceptable to that level
Thickness of Hierarchy:
• Number and complexity of institutions, departments or agencies at a particular socio-political level
• The thicker the hierarchy, the more managerial competence, professionalism and governance skills are required by public servants in order to support effective implementation[96]</td>
<td>• Thickness of each socio-political level (number and complexity of institutions, departments or agencies and their coordination and interdependence) [57]</td>
</tr>
<tr>
<td>IV. Networks/Inter-Organizational Relationships</td>
<td>• Reflects the existence and nature of the relationships between parallel organizations who must collaborative in order to achieve effective implementation and who do not have a hierarchical relationship[51]
• Better connections among stakeholders also increases the opportunity for rapid diffusion and informal spread of innovation, facilitating implementation</td>
<td>• Degree of coordination among:
o Systems[61]
o Organizations[59]
o Donors /other funders[70]
o Leaders[16]
• Formality (formal or informal)[103]
• Network type (e.g. policy or inter-organizational) [93]
• Coherence and strength of connections[122]</td>
</tr>
<tr>
<td>V. Implementing Agency Responses</td>
<td>• Factors affecting the responses of implementing agencies can be divided into:
o issues related to the overall characteristics of the agencies, and
o behaviour of front-line or street-level staff[51]
• Overall "health" of organizations and how front-line/street-level bureaucrats use their discretion and power impact implementation success</td>
<td>A) Overall characteristics of the agencies:
• Level of organizational control[51]
• Rate of staff turnover[56]
• Organizational decision-making processes[56]
• Extent of policy and behaviour-related change required[18]
• Attitudes of the agencies[18,90]
• Resources of the agencies (e.g. minimum "investment threshold" in implementation infrastructure [113] or cost-absorptive capacity of agency to absorb additional costs associated with implementation[16] or certainty of funding[91])</td>
</tr>
</table>

		• Impetus for change[106] (e.g. external mandates may increase an agency's predisposition (i.e. motivation), but not its capacity to adopt an innovation; mandates may divert activity away from other innovations or locally generated priorities[31]) • Perception of implementation approach (e.g. if approach is punitive, mandatory or "top down")[73] B) Behaviour of front-line or street-level staff • Level of discretion and level of relative autonomy from organizational authority affect the amount of interpretation of EIPP[17] • Power distribution between actors at the front-line, agency and political levels[35] • Personal characteristics including their knowledge, skills, and perceived support from colleagues[56]
VI. Attributes and Responses from Those Affected by EIPP	• The characteristics of the people affected by the EIPP, their response to it, and the impact of the responses • Most evident when those affected are powerful, such as in regulatory policy when those regulated are large organizations[51]	• Diversity of target group behaviour[18] • Target group as percentage of the population[18] • Impacts on stability of the workforce and responses to instability[16]
VII. Timing/ Sequencing	• Implementation processes at scale require adequate time, which doesn't always align with the cycles they are subject to and some authors have identified the lack of time or short-term opportunism as barriers to effective implementation[58,59] • The sequencing of activities and alignment of implementation with other cycles is also important	• Balance of predictability and adaptiveness to changing circumstances[60,111] • The simultaneous address of system levers (including policy changes, measurement systems, and regulatory mechanisms)[113] • Timing and pace of cycles, such as political, policy and funding cycles[119] • Specific aspects of time that impact implementation: ○ the phased structure of the implementation process [119]

		○ when and how the implementation efforts are initiated[119] ○ timeframes for funding and leadership support[119] ○ the need to demonstrate the impacts early ○ return on investment of time and money[119]
VIII. External Environment or Policy Context	• Factors outside of the policy area of focus may influence implementation • Can be referred to generally as the "political and social climate", as unmodifiable or macro "context" or as "socio-economic conditions" [13,18,61-66] • While most included articles did not address these determinants in depth, an overall examination of extracted data suggested two theoretical frameworks would be useful for classifying and understanding these determinants: A) 3I+E framework that identifies the Institutions, Interests, Ideas and External events that help explain what influences policy choices[67] B) Taxonomy of health and social system arrangements classified according to the governance, financial and delivery arrangements[68] • These broader context and system arrangements may be critically important in explaining implementation outcomes and these frameworks provide some logic and organization to potential variables	A) 3I+E framework • Ideas (e.g. the interplay between beliefs and values of policy makers and research evidence in a general way[62]) • Interests (e.g. the political culture and the depth of social cleavages[47]) • Institutions (e.g. relevant policies from other areas that "may represent potentially powerful contextual effects"[105]) • External factors (e.g. technology and technological changes,[18,63] economic forces operating in the overall society,[84] and environmental (in)stability[93]) B) Taxonomy of health and social system arrangements.[68] • Governance arrangements that are not specific to the EIPP being implemented but are still relevant to understanding implementation outcomes (e.g. centralization and power distribution of government[35,103] or the form of governance structures (omnibus/discrete)[103]) • Financial arrangements (e.g. private/public contractual relations, reimbursement rates and mechanisms,[103] and existing resource distribution[35]) • Delivery arrangements - referred to more generally in the health-focused articles as "health(care) system and services context"[62,66] or "medical delivery system"[63]

Table 5 - Types of policy actors identified in implementation

Actor	Sub-Type (non-exhaustive)	Role Description	Role in Implementation (non-exhaustive)	References
Political Actors	Politicians	• Represent citizens (in a democracy) through popular consensus. • Mandate to create laws and policies with varying levels of authority • Can be supra-national, national/federal, state/provincial, regional, local/municipal	• Most important level of elected officials is the level where most policy authority rests for area of implementation • Develop & pass laws/policies (e.g. mandating a particular EIPP) • Provide leadership and focus • Source of funding for implementation (organizations, providers, and/or consumer levels)	[39,43,61,70-75,94,98,100,101]
	Other Elected Officials	• Similar to elected politicians but mandate is limited to a particular policy domain and (often) limited geographic jurisdiction (e.g., sheriff, judge, school board trustee, etc)	• If policy authority rests at their level, they may develop & pass laws • Enforce laws/polices from other levels • Interpret/adapt laws/policies for their implementation • Provide leadership & focus • Source of funding for implementation (organizations, providers, and/or consumer levels)	[94]
Bureaucratic Actors	Executive Departments	• Departments or ministries who specialize in a unique area of government responsibility (e.g. health) • Responsible for carrying out the "vision" of an elected official with leadership for that portfolio (e.g. Minister of Health)	• Support policy development, including implementation considerations • Operationalize policy/law passed by politicians • May allocate tasks, responsibilities and define competencies for implementation • Monitor policy implementation and track outputs or outcomes	[39,73,76,98,109]

		• Not elected nor formally tied to a particular political party	• Source of funding for implementation (organizations, providers, and/or consumer levels)	
	Boards and Agencies of Government	• Often operate semi-independently from government but are appointed by them • In most cases, they deal exclusively with one particular sub-field of responsibility in which the demand for public services is especially high (e.g. food inspection agency, state mental health authority)	• Regulation & enforcement • Interpretation of policies/laws • Monitor policy implementation & track outputs or outcomes • May have the ability to apply penalties for non-compliance • May allocate tasks, responsibilities & define competencies for implementation	32,33,39,61,73,101
	Self-Governing Regulatory Agencies	• Bodies that regulate the conduct of their own members (such as admissions and discipline) and are empowered to do so by the appropriate level of government and their members (e.g., medicine, law, etc) • Regulators are drawn from the membership	• Can set or change: scope of practice, training & licensure requirements, or professional liability to support implementation • Develop/adopt guidelines or standards • Monitor quality and safety and continued competence of professionals during implementation	73
	Judicial System	• System of courts that provide a formal mechanism for interpretation and application of laws in the name of the state and resolves disputes	• Interpret/re-interpret laws through rulings that may affect how they are implemented • Define/re-define public policies through legal challenges	63
Special Interests	Implementing Agencies	• Organizations or programs that are responsible for implementing the laws or policies developed (e.g., hospitals, schools, child welfare agencies, industry, etc)	• Interpretation of policies/laws • Develop or adapt organizational policies & procedures to support implementation • Training & support for workforce • Provide or manage funds to support implementation	33,39,42,55,70-72,75,88,109

		• Location(s) where the majority of the implementation takes place	• Monitor & evaluate implementation at organizational level	
	Street-level Bureaucrats	• The schools, police and welfare departments, lower courts, legal services offices, and other agencies whose workers interact with and have wide discretion over the dispensation of benefits or the allocation of public sanctions[17] • Have 1) relatively high degree of discretion; 2) relative autonomy from organizational authority[17]	• Interpretation of policies/laws • Often the parties responsible for changing their behaviours or practices during implementation	[17,88]
	Insurers	• Organizations or government bodies that manage risk by pooling risk across a group of individuals and providing coverage to them for needed services • Managed care organizations are a specific type of insurer in health care that monitor and control the provision of care in an effort to increase quality through regulating the choices of providers and patients	• Have the ability to change the risk pool by insuring more or fewer people (scope and nature of insurance plan) • Can adjust the list of covered/reimbursed organizations, providers, services & products • Can change billing/reimbursement processes to facilitate implementation • Engagement & potential influence with political & bureaucratic actors (feedback loops) regarding implementation & scaling	[70,73,101]
	Donors/ Foundations	• Organizations that raise and allocate funds based on a specific mandate that they identify	• Funding and/or in-kind implementation supports (e.g. human resources) • May have funded an innovation and now have a vested interest in seeing it implemented or scaled (bring leadership & focus, implementation & scaling expertise, etc)	[120]

			• Engagement & potential influence with political & bureaucratic actors (feedback loops) to support implementation & scaling	
	Government Corporations	• Organizations or businesses that are run independently from government but are still ultimately accountable to them	• Interpretation of policies/laws • Develop or adapt organizational policies and procedures to support implementation	
	Unions	• Organized associations of workers created to promote and protect their interests in the workplace	• Negotiate contractual relationships with implementing organizations on behalf of members (can influence the ease of implementation) • Engagement & potential influence with political & bureaucratic actors (feedback loops) regarding implementation & scaling	[39]
Experts	Scientists/ Researchers	• Individuals or research programs that systematically gather, analyze and use research and other evidence through processes such as theorizing, synthesizing, and hypothesis testing, to gain and share understanding and knowledge	• Share or contribute research expertise concerning the problem, the innovation, the implementation or the evaluation of the implementation effort & any expected outcomes • Engagement & potential influence with political & bureaucratic actors (feedback loops) to support implementation & scaling	[40,72]
	Field or Practice Leaders/ Champions	• Individuals who belong to a service providing community and are viewed as leaders or champions of an innovation and its implementation	• Share or contribute practice expertise concerning the problem, the innovation, the implementation or the evaluation of the implementation effort & any expected outcomes • Act as champions for implementation to members of their service providing community and to other policy actors	[36,62,87]

			• Engagement & potential influence with political & bureaucratic actors (feedback loops) to support implementation & scaling	
	Patients or Persons with Lived Experience & Families/Carers	• Individuals who bring personal knowledge or experience of a problem, condition, or service and who are the intended beneficiaries or ultimate "targets" of implementation, and/or • Individuals who are family members or carers to individuals who bring personal knowledge or experience of a problem, condition or service	• Share or contribute lived experience of the problem, the innovation, the implementation or the evaluation of the implementation effort & any expected outcomes	[33,40,42,71,88,95,116]
	Innovation/ Developers and Disseminators	• Organizations, programs or individuals who have developed a process, program or product to be implemented	• Synthesize knowledge about innovation & package it in ways that are "usable" • Actively seek opportunities for innovation to be adopted in policy and/or practice • Provide expertise about the innovation during implementation process • Adapt innovation and materials as needed during implementation process	[64,72]
	Intermediaries and technical assistance providers	• Organizations, programs or individuals that work "in between" policymakers, funders, and frontline implementers, to facilitate effective implementation drawing on expertise in implementation • Also known as purveyor organizations, backbone	• Translate policy intention for implementing agencies • Provide technical assistance to implementing agencies (e.g., guidance on implementation process, coaching, decision support, monitoring & evaluation) • Provide mechanism for communication between service delivery, policy systems and innovation developer (if applicable)	[13,36,42,59,71,72,87,89,93,109,116]

		organizations or central bodies charged with coordination		
Other	Media	• Individuals and organizations that communicate information through a variety of channels, including formal media outlets and social media outlets	• Monitor implementation and communicate facts or perceptions of the process and outcomes to the public • Provides feedback loop for political actors, bureaucratic actors, special interests and experts regarding implementation	[39,101]

Figure 2a – Process model of implementation from a policy perspective depicting the process at one policy level

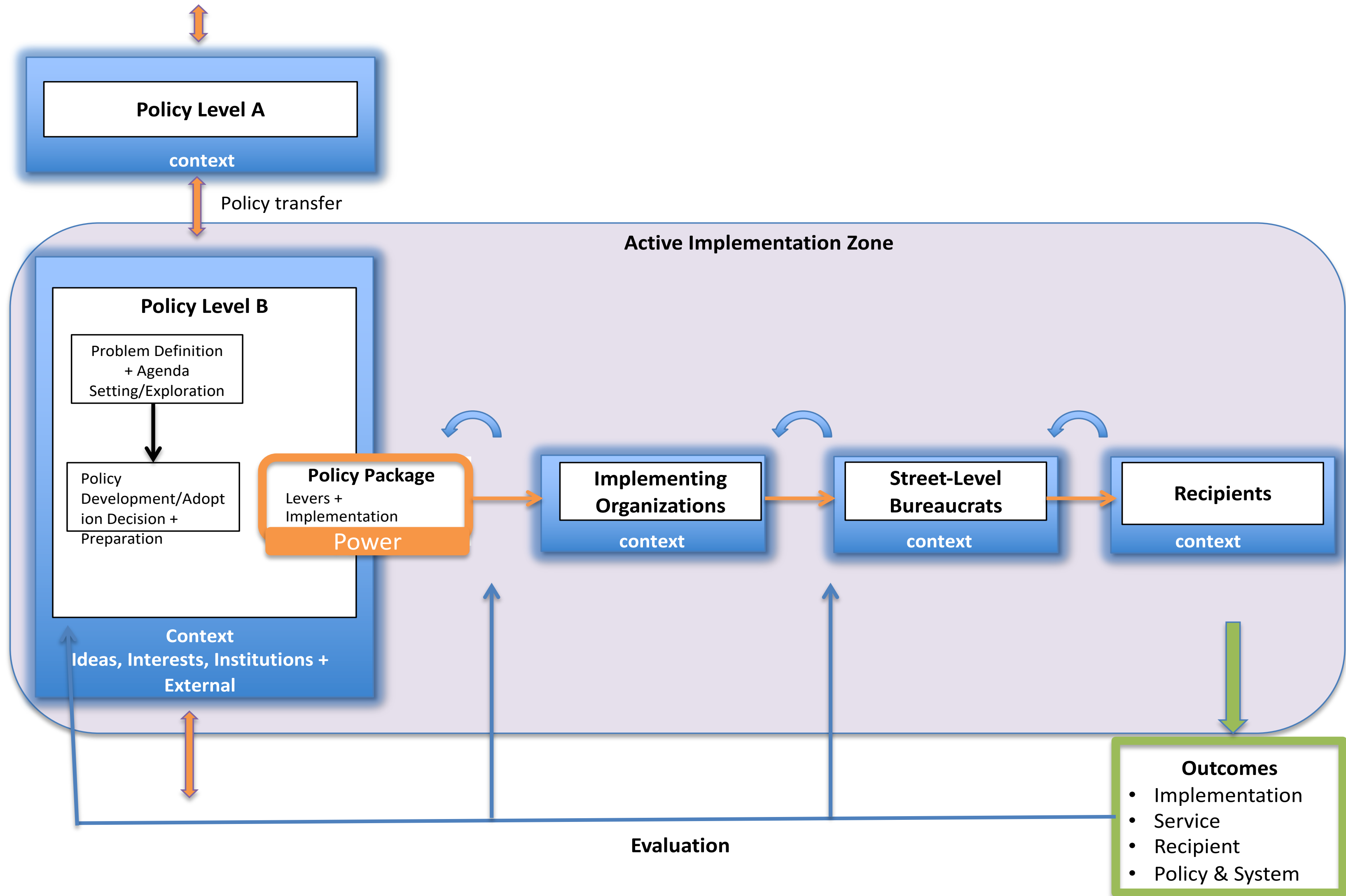


Figure 2b – Process model of implementation from a policy perspective depicting the process across policy levels

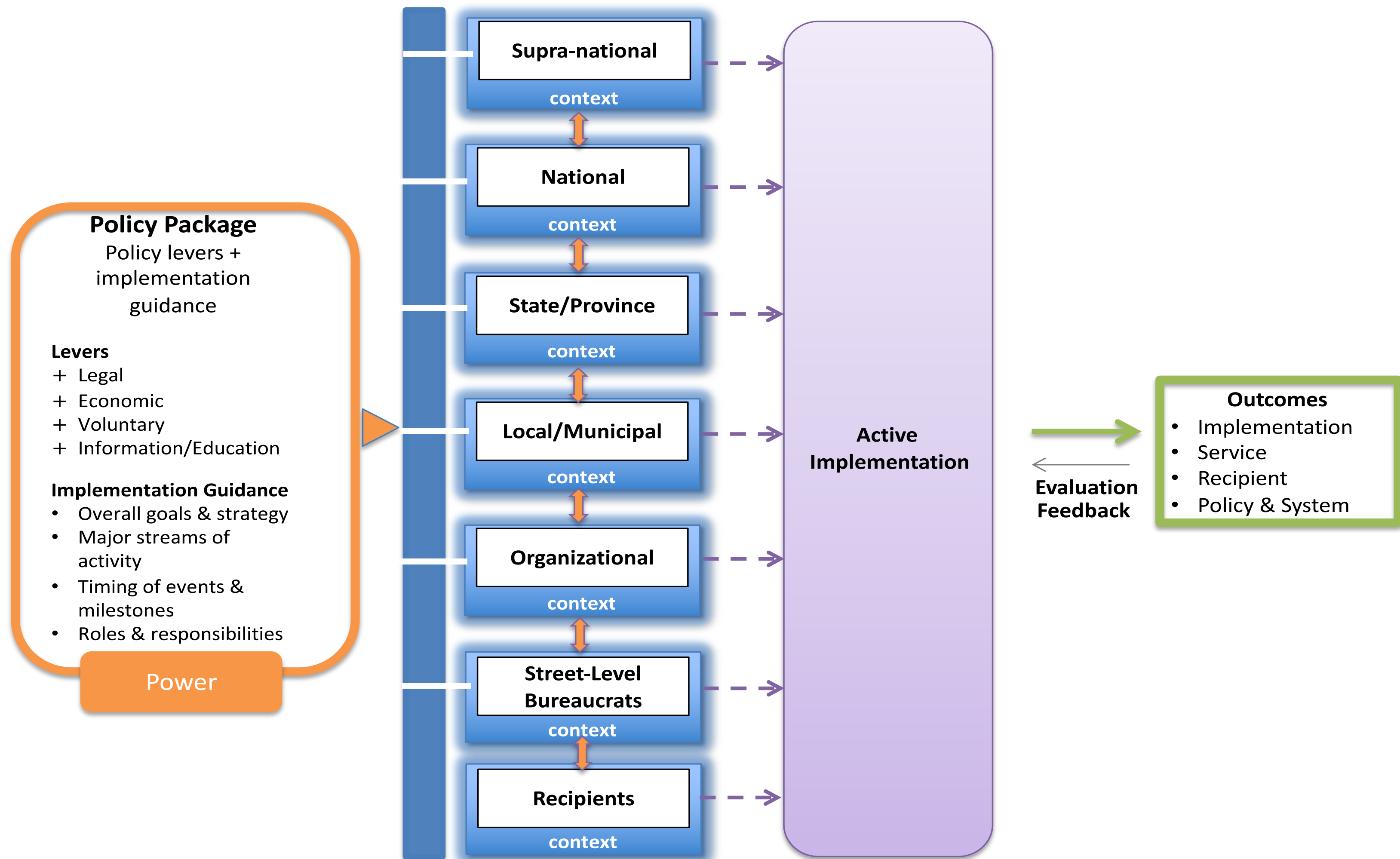


Figure 3 – Determinants framework of implementation from a policy perspective

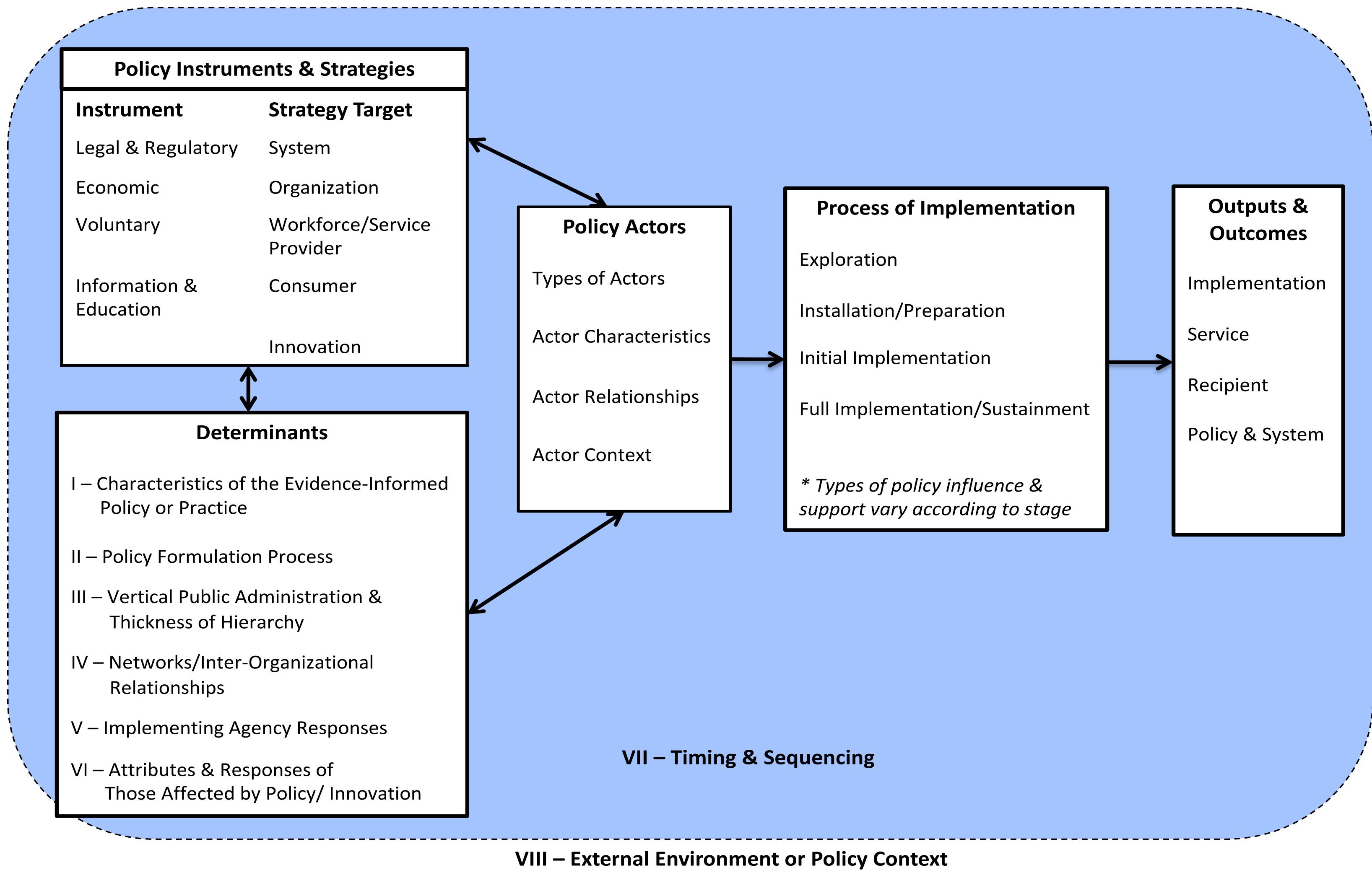


Figure 4 – Characteristics, relationships and the context of policy actors important for implementation

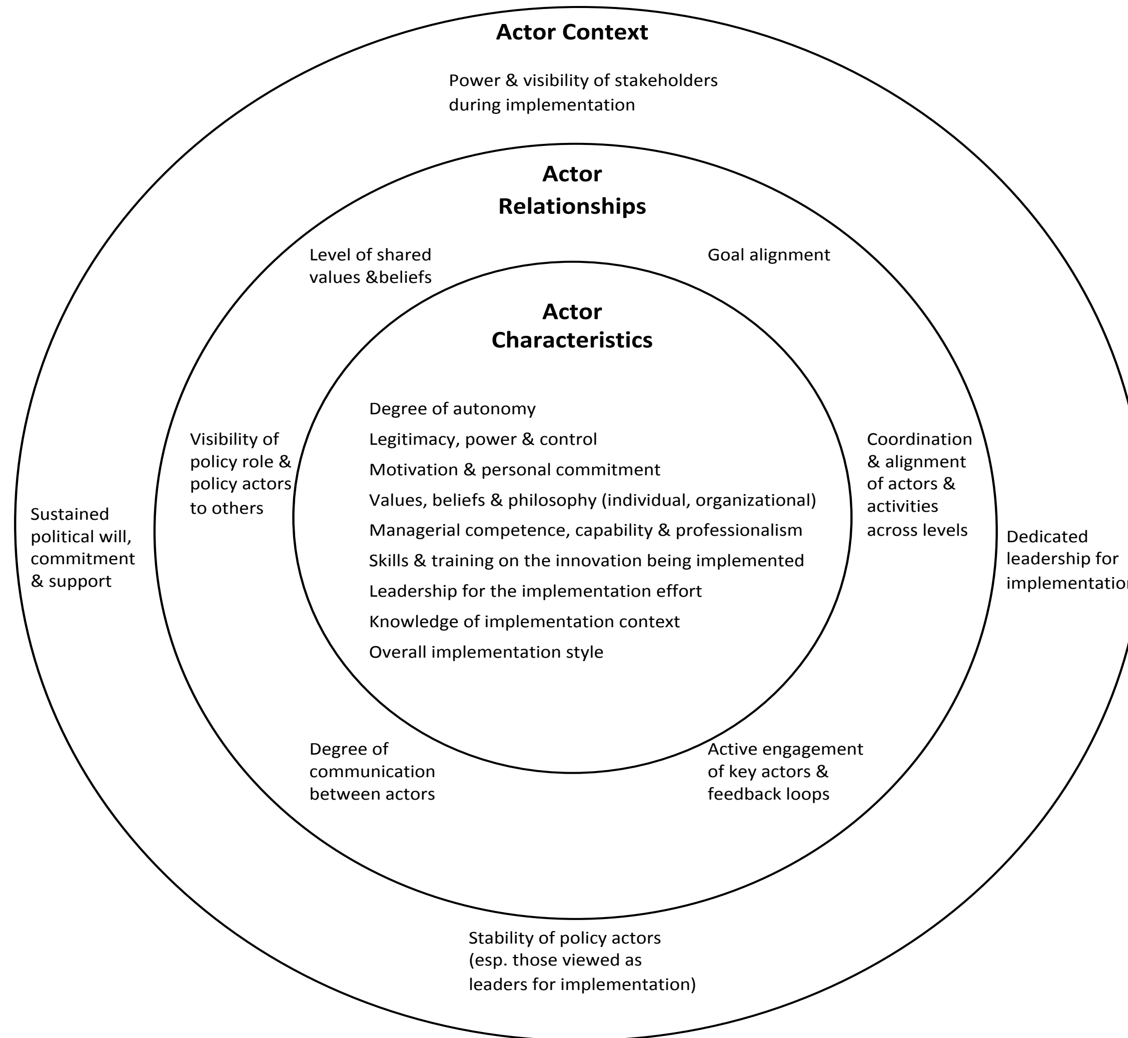
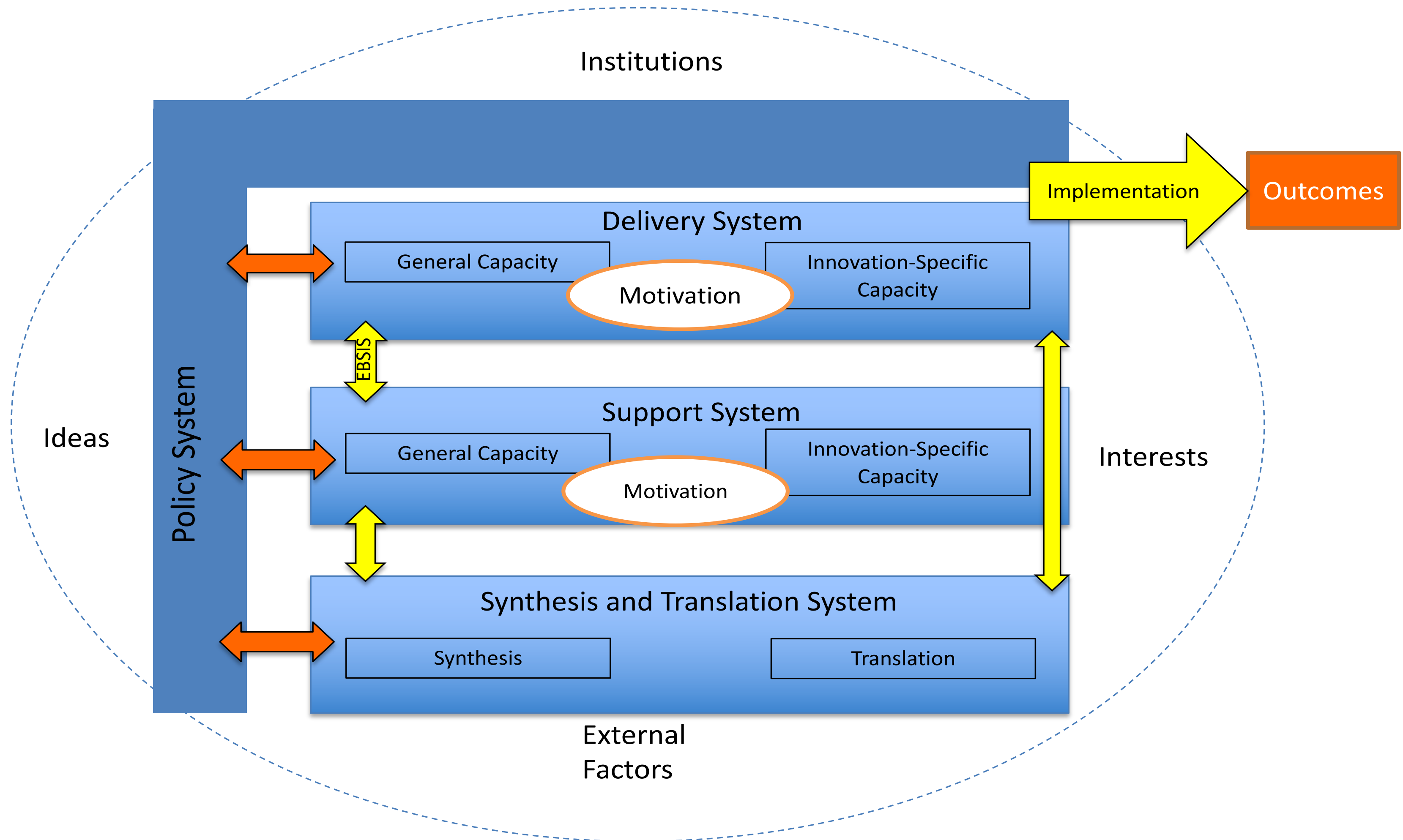


Figure 5 – Modified Interactive Systems Framework for Dissemination and Implementation (M-ISF)



Chapter 3. Preface

While there is an increasing understanding that attention must be paid to the implementation of evidence-informed policies and practices in order to achieve positive changes for citizens, there is still a lack of understanding of what is required to make implementation successful. This chapter contributes to the understanding about the infrastructure that is required to support implementation through an analysis of intermediaries (the organizations that work with policymakers and service providers to facilitate implementation). We use institutional theory to explain why there are differences in the placement of intermediaries in different mental health systems. Our findings help to foster a better understanding of intermediaries and encourage policy-makers to consider the infrastructure required to implement policy and the role intermediaries can play. To our knowledge this is the first-time theories from political science have been used to explain intermediaries in mental health or other areas of health or social care thus offering a unique academic contribution.

The manuscript presented in this chapter is (at the time of writing) under review at the journal *Health Research Policy and Systems*. I was responsible for conceiving of the focus and design of the study and for completing all data collection, analysis and interpretation. I also drafted the manuscript. My supervisor, Dr John N. Lavis helped conceive of the study and contributed to the analysis and refinement of the manuscript. We are both authors on the paper.

Using Table 2 from the Introduction as a guide (see excerpt below), this study is the second of the five included as part of my dissertation. The primary sources of data for this analysis were the interviews conducted and documents collected to support case selection for

Chapter 4. This study had the goals of: 1) providing a rich description of intermediaries in mental health systems, and 2) explaining how and why they vary in their placement.

Chapter	Study Objective	Design (and select methods)	Outputs/ Contributions	Links
3.	To understand the puzzling variation in the system placement of intermediaries supporting mental health policy implementation (including their proximity to government) ***Descriptive + explanatory goals***	Comparative case study • Intermediaries were purposively sampled in three jurisdictions: New Zealand; Ontario, Canada; and Scotland, U.K. • Data were derived from published literature and public documents as well as key informant interviews • Qualitative content analysis was used to analyze data, drawing from political science theory (institutional theory)	1. Factors that explain the placement of intermediaries in different systems (e.g., the institutional landscape including the political structures, the public/private mix of mental health service delivery, and the differing administrative capacities of mental health systems)	Background underpinning Chapter 4 *Note: case selection criteria differed for Chapter 4*

Developing structural supports for policy implementation: The placement of intermediaries in mental health systems

Authors: Bullock HL, Lavis JN

Keywords: intermediaries, implementation, mental health, behavioral health, health care, evidence-informed policy

Word count: 6237 (main text); 8310 (inclusive of abstract, references and exhibits)

Abstract

Background: Intermediaries are organizations or programs that work in between policymakers on the one hand and service providers on the other hand, to facilitate effective implementation of evidence-informed policies, programs and practices. Although still a relatively new phenomenon, a number of intermediaries now exist in well-established mental health systems.

Aims & Objectives: This research seeks to understand the puzzling variation in the system placement of intermediaries supporting policy implementation in the mental health systems of Canada (Ontario), New Zealand and Scotland, U.K.

Methods: The analytic goal was to compare intermediaries across jurisdictions and explain differences in their placement using explanatory frameworks from political science. Data for this analysis were derived from several sources, including: a literature search of published and grey literature on intermediaries and on policy implementation in mental health systems, a review of relevant policy documents and websites, as well as documents and websites relating to the various intermediaries and other interest groups within each system, and key informant interviews.

Results: Through the analysis, we argue that the placement of intermediaries supporting policy implementation can be explained through an understanding of the political structures, the policy legacies leading to the current public/private mix of mental health service delivery, and the differing administrative capacities of mental health systems.

Conclusions: This research contributes to our growing understanding of policy-related intermediaries supporting implementation at scale and how we might build appropriate infrastructure in systems to support the implementation of policy and achieve better outcomes for citizens.

Background

Governments are continually looking for better ways to achieve their policy goals. While policy implementation has been acknowledged as critical in filling the gap between policy promises and policy outcomes, the process itself is complex and multi-faceted and has yet to be well-understood. Policy implementation is generally defined as a series of activities undertaken by government and others to achieve the goals and objectives articulated in policy statements (1). Most works from this field focus on designing policy to be *implementable* or describing the factors that are important in the implementation process (2). The literature is scant, however, when it comes to understanding the how to build and harness the system infrastructure required to support the policy implementation process (3). Yet there is growing recognition that the capacity of existing system actors (such as those who deliver health or social services to citizens) requires additional expertise and support to implement changes, especially changes that are large-scale or complex in nature (4).

In the policy domain of mental health, a focus on implementation is particularly important in order to achieve change because of the complex and multi-faceted nature of the system. What is loosely known as the "mental health system" tends to be a suite of fragmented services delivered with varying levels of intensity and effect across services and sectors (3), making it challenging to achieve systemic change. A focus on implementation is also important because while there is an increasing supply of evidence-informed treatments for a wide range of mental health and substance use problems, a number of studies have found that the majority of people experiencing such problems receive care that is not based on the best available evidence (e.g. 5, 6-8). Ensuring that mental health policy is evidence-informed and facilitates the adoption of evidence-informed practices in service settings is

critical to addressing this gap and reducing the unnecessary suffering of people with mental health and substance use problems. A recent two-part review of implementation strategies in health and mental health by Powell and colleagues (9, 10) identified 73 discrete strategies that support effective implementation, however, they did not address who or what might support the delivery of these implementation strategies in systems. This is usually addressed through the implementation concept of change agency (11) or facilitation (12).

Change agents can be individuals (e.g. knowledge brokers or champions), teams (e.g. implementation teams), programs or organizations. Intermediaries are organizations or programs that have a direct role supporting the implementation of evidence-informed policies, programs or practices (EIPPs) through the use of specific implementation strategies and are one type of change agent.

Intermediaries work in between policymakers on the one hand and service providers on the other hand, to facilitate effective implementation of EIPPs. They play an important role as translators for policy and provide technical assistance to organizations and service providers that deliver services for citizens (13-16). There are many definitions of intermediaries (14, 17, 18) and there is no conceptual agreement on what they are or what roles they play beyond working in the "in between". This is likely because the scholarship that does exist comes from different fields (e.g. public management, social sciences, implementation science), the research focuses on diverse topics (e.g. education, environment, health, children and youth services, etc.), and intermediaries can also serve other purposes in systems besides implementation support.

Most of the work done to date on intermediaries has been descriptive, often focused on their specific functions in systems. Scholars have identified many functions of

intermediaries (19, 20) and some of the most commonly described functions include:

- educating and stimulating interest in a policy or program;
- assessing evidence and a policy or program's fit or feasibility in a certain context;
- linking knowledge generators and policy or program developers with service deliverers;
- ensuring effective implementation and fidelity systems are developed and maintained;
- building capacity to implement well and integrate efforts to implement multiple initiatives;
- promoting the spread and scaling up of effective interventions;
- enabling quality improvement and quality assurance processes; and
- supporting policy and systems development.

Furthermore, a recent study by Proctor and colleagues found that intermediaries focused on the implementation of specific evidence-based practices for children and youth used an average of 32 discrete strategies with many of them focusing on planning, education and quality improvement (21).

This work has been helpful in elucidating the important activities of intermediaries and how they can improve the capacity of service delivering organizations to implement changes. However, it is not often specific to mental health and the intermediaries described do not always have a direct role supporting the implementation of policy. Instead, many are focused on supporting the implementation of one or more specific evidence-based program or practice at an organizational level. While the organizational level goals are generally not in conflict with the government policy directions, these efforts can, and often do, proceed

without being tied specifically to the implementation of country or state/province-level policy direction.

As part of a broader program of research, we are interested in understanding the role of policy-oriented intermediaries in mental health systems who support the implementation of EIPPs at scale. Given this focus, for the purposes of this study we define intermediaries as: organizations or programs that have an explicit and recognized role to support the implementation of government mental health policy goals and employ specific methods of implementation support. These methods can range from quality improvement approaches to methods drawn from implementation science or knowledge translation. In order to achieve these goals, other actors in the policy system must understand and accept this role, including those in government.

Policy puzzle

This research is less concerned with the activities and strategies of intermediaries, focusing instead on why there is variation among them in terms of their placement in mental health systems. Although still a relatively new phenomenon, a number of intermediaries supporting implementation of EIPPs now exist in well-established mental health systems. Intermediaries seem to vary in their placement in two key ways. First, there is a mix of the types of organizations that have assumed this function. In our examination of intermediaries that support mental health policy implementation, those uncovered thus far exist in six different system settings: 1) government (often as discrete programs), 2) arms-length agencies of government (such as mental health commissions or quality agencies), 3) service delivery organizations, 4) non-governmental organizations (NGOs), 5) academic or research settings,

and 6) “peak organizations”, defined as an organization or association that represents a collective of like organizations. Second, the intermediary function is often segmented in two different ways. Segmentation seems to be based on the age of the target population (child and youth versus adult) or by the sector (education versus health/mental health) (see Table 1 for examples).

There are two traditional explanations that might predict the placement of intermediaries in mental health systems: 1) the prevailing values related to mental health in each jurisdiction (differing values drive differing placement); or 2) the specific policy directions at play (differences in the policy directions require different intermediary capacity). We examine each of these explanations in turn below and argue that there are too many similarities in the articulated values and policy directions in these jurisdictions to explain the variation in the placement of intermediaries in their mental health systems. We suggest that these factors may be necessary for intermediaries to arise, but not sufficient to explain the variation in their placement in mental health systems.

Turning to why values were ruled out, we first explored whether there were differences in the types of values at play in mental health in New Zealand, Ontario and Scotland (selection of which is explained in detail in the methods section). Indeed, a review of key policy documents from these jurisdictions for the years 2004 – 2016 addressing mental health reveal an ideational shift in the mental health sector toward an increased focus on quality, value-for-money, and achieving specifically articulated outcomes capturing measurable indicators. However, these ideas are consistent across jurisdictions. The strategies and reports articulate a need for services to be “evidence-based” (New Zealand and Scotland) or “evidence-informed” (Ontario) in order to deliver on quality objectives. These values are

likely a result of feedback from past policies in the form of policy learning that the policy goals were not being reached to a large extent and that the patchwork of services and supports available to citizens was variable in terms of quality and availability. This coincided with an increase in the understanding of governments, service providers, researchers and citizens about what services and treatments are effective in addressing particular mental health challenges (7). The shift toward ensuring there are higher quality, evidence-informed services and supports for citizens, and demonstrating measurable outcomes based on the identified goals, reinforces the need for jurisdictions to develop adequate supports for services to make these transitions. This ideational shift might therefore contribute to our understanding of why intermediaries exist but is not enough to explain where they are located in systems.

This leaves differences in the policy directions themselves as a potential explanatory factor for why intermediaries are found in different parts of the system. The idea being that certain policy directions might require specific capacities in certain parts of the system but not others. If the policy directions themselves can be linked to the location in the system where the intermediary is found, this might explain the observed variation. However, examination of the policy directions in the three jurisdictions once again shows remarkable similarity, albeit with some jurisdiction-specific priorities. For example, all three jurisdictions focus efforts on children and youth and combating stigma and discrimination. They also place a strong emphasis in the engagement of "people with lived experience of mental health problems" or "service users" and their families as partners in care as well as service design and policy development. Furthermore, they all recognize the need for efforts targeted to mental health promotion, prevention and early intervention. Finally, they all state that mental

health cannot be addressed from the perspective of the health system alone but requires an approach that spans multiple sectors and government ministries or agencies.

In terms of differences in the stated directions, the New Zealand documents consistently prioritize workforce development (see *Te Tāhuhu – Improving Mental Health 2005-2015* (22); *Blueprint 2* (23) and *Rising to the Challenge* (24)). Interestingly, the NGO (TePou) that is functioning as an intermediary in New Zealand is focused on workforce development lending some support to this theory. However, despite specific actions being identified for government in the Scottish strategy (see *Mental Health Strategy for Scotland 2012-2015* (25)), these actions are spread across the policy directions so it is difficult to make the connection between these patterns and an intermediary function for the Scottish government. Furthermore, in Ontario, the policy directions refer to a wide range of service delivery environments and there is no discernable pattern that would explain why the function emerged in the three service delivery organizations that are acting as intermediaries.

Research question

Our research seeks to understand this puzzling variation in the system placement of intermediaries supporting mental health policy implementation. We ask the question: what influences how intermediaries are positioned in the mental health systems of Canada (Ontario), New Zealand and Scotland, U.K. including their proximity to government?

Through this analysis, we argue that the placement of intermediaries supporting policy implementation in these three mental health systems can be explained primarily using an institutional framework. More specifically our analysis indicates that the placement of these intermediaries can be explained through an understanding of the policy legacies leading to

the current public/private mix of mental health service delivery, and the differing administrative capacities of mental health systems. We hope that answering this question will contribute to our nascent understanding of the relatively new phenomenon of intermediaries and how we might build appropriate infrastructure in systems to support the implementation of policy and the achievement of policy goals.

Methods

Sampling

We first looked for the presence of intermediaries in the mental health systems of eight high-income countries. The pool of potential jurisdictions included countries that are members of the International Initiative for Mental Health Leadership (IIMHL) - an international collaborative that focuses on improving mental health and addictions services in eight countries: Australia, Canada England, New Zealand, Republic of Ireland, Scotland, Sweden, and USA, which provided endorsement and facilitated access to key informants. Although England and Scotland are part of the United Kingdom, they are considered separate countries for this analysis because the governance authority for health and mental health rest with their respective National Health Services. They are all countries that have well-established health systems and their participation in the IIMHL reflects a commitment to mental health systems improvement and advancement. These countries provide adequate variation in terms of health service structures, including how mental health services are designed, managed and delivered. This sample pool also provides adequate variation in the factors that may impact successful implementation but enough similarity in the underlying

features of the systems (government spending per capita, etc) to ensure the analysis is sensitive to the variables of interest.

One or two leaders from each jurisdiction were invited to participate in a brief phone interview with the study team. The questions focused on four areas: (a) structures supporting implementation of mental health priorities (where implementation functions exist within their system, who is responsible for carrying out implementation and what skills they have); (b) methods for change being utilized (such as quality improvement, implementation science, etc); (c) how established these structures and methods are and whether they have evidence of their effectiveness; and (d) health system characteristics (to provide an overview of the key features of the mental health system in terms of governance, financial and delivery, such as mental health priorities currently identified, dedicated funding, etc.), and political system characteristics (such as institutional arrangements, interest group dynamics, dominant values, etc.). Key informants were asked for any supporting documents or websites that describe their system's characteristics or implementation structures or methods in detail. In total, nine interviews were conducted, with participation from all countries except for Scotland. A mix of leaders participated, including those in government, agencies of government, non-governmental organizations, and service providers who had roles related to implementation.

It is important to note that the focus of these interviews was to identify the *presence* of intermediaries using our definition rather than a comprehensive identification of all of the programs and organizations that have a role supporting implementation in a given mental health system. To keep it manageable, the goal was to identify intermediaries at the national level but we were open to identifying those at the state/province or municipal levels if no strong examples were identified nationally. This was the case for Canada and interviews were

conducted with leaders from two provinces: Ontario and Saskatchewan. Table 1 provides an overview of the countries, their general characteristics, and some general detail regarding the intermediaries identified.

TABLE 1 HERE

Case selection and justification

The criteria we used to select cases for this analysis included: 1) the presence of an intermediary that met our definition; 2) the intermediary(ies) was well-established with multiple data sources from which to draw, and 3) there was variation in the dependent variable (the system placement of the intermediary including their proximity to government). Based on these criteria we purposively sampled the jurisdictions of New Zealand, Canada (Ontario), and Scotland, U.K. for this analysis. New Zealand is a unitary state and authority and policy decision making for health care and mental health rests nationally and the intermediary function is also a national body. In Canada, Ontario was selected because it was the province with the most well-developed intermediary structure aligning with our definition, and despite it not being a national example, due to Canada's federalist structure, health care (mental health) is primarily under the jurisdiction of the provinces. Scotland was included despite there being no response to requests for interviews during the identification phase because they had the most well-developed intermediary structure located in government and there were many other publicly available data sources from which to draw. One of the authors also had informal conversations and heard formal presentations from members of the Scottish intermediary structure just prior to the study period. By selecting jurisdictions that share similar macro-system features, we reduce the possibility that variation

in these features alone can be the explanation for why there is variation in the placement of intermediaries.

Data sources

Data for this analysis were derived from several sources, including: 1) a literature search of published and grey literature on intermediaries using the terms "intermediar*", "intermediary organi*", "knowledge brokering organi*" and "backbone organization" using PubMed and PsycInfo; 2) a literature search of published and grey literature on policy implementation in mental health systems using PubMed and PsycInfo; 3) a review of policy documents (including presentations) and government websites, including current and past mental health strategies, targets and indicators, and background documents pertaining to their development; and, 4) a review of documents and websites relating to the various intermediaries and other interest groups within each system. These sources were supplemented with information derived from the key informant interviews with one mental health leader from New Zealand and one from Ontario who had knowledge of the intermediaries in their systems.

Analysis

First, data relating to the placement of intermediaries, their role in systems, and the methods they use from the interview transcripts and documents were extracted using qualitative description (26). Next, all data sources were analyzed again with an explanatory lens using directed content analysis (27) drawing on institutional theory to explain differences in intermediary placement and their proximity to government. The focus at this stage was comparing across jurisdictions. Ethics approval was granted by the Hamilton Integrated Research Ethics Board at McMaster University for this work.

Results

I - Description of the Intermediaries

Table 2 provides a fulsome description of the intermediaries in each jurisdiction. In New Zealand, Te Pou o Te Whakaaru Nui (Te Pou) is a NGO that acts as a national workforce development centre for mental health, addictions and disability that supports the implementation of the Ministry of Health's policy priorities. It receives funding from the New Zealand Ministry of Health. In Ontario, Canada, there are three intermediaries that play a large role supporting the implementation of the provincial government's policy directions. All three exist within the service delivery system. Two are located in hospitals (Ontario Centre of Excellence for Child and Youth Mental Health (OCoECYMH) at the Children's Hospital of Eastern Ontario and the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health), and one is located in a district school board (School Mental Health Assist at the Hamilton-Wentworth District School Board). Each one receives funding through a separate government ministry: Children and Youth Services, Health and Long-Term Care and Education, respectively. Finally, in Scotland, the government created the Quality and Efficiency Support Team overseen by a Mental Health Delivery Team comprised of individuals from the key national bodies with specific responsibility to ensure the delivery of commitments relating to measurement of progress and improvement support in mental health. This structure is part of the Scottish government.

What is interesting about these three jurisdictions is that their intermediaries are not new organizational forms. Rather, the function of policy implementation support has been built into existing institutional infrastructure. This can be best described as a process of

institutional conversion, which, according to Thelen occurs when "existing institutions are redirected to new purposes, driving changes in the role they perform and/or functions they serve." (28). In these cases, the conversion process is only partial in nature, since all of the initial institutional functions continue to be filled. For example, the NGO in New Zealand continues to do the workforce development work it was originally established to do, the hospitals in Ontario still continue to serve patients, and the government in Scotland still fulfills its other governmental duties. The conversion in this case consists of scaffolding a new function onto an existing organization rather than replacing the function outright.

It is also important to note that in each of these jurisdictions, some of the intermediary functions are fulfilled by other organizations or programs in other locations in the mental health systems. The intermediary role tends to be distributed across systems with different organizations contributing different types of expertise and fulfilling different but complementary functions. The focus here is on those that have the most direct and concentrated functions.

TABLE 2 HERE

II – Using an institutional framework to explain the placement of intermediaries in mental health systems

We propose that the placement of intermediaries in these three mental health systems can be explained primarily using an institutional framework. Health systems in general, and mental health systems in particular, need to adjust their policy implementation strategies to fit the contours of different institutional terrains. It is these differing institutional landscapes that explain the variation in system placement of the intermediaries. Our analysis indicates that

two factors in particular, the variation in public/private mix of mental health service delivery due to legacies from past policies, and the differing administrative capacities of mental health systems, collectively explain the differences in where intermediaries are located.

1. Policy legacies leading to a differing public/private mix of health and mental health service delivery

The public/private mix of service delivery due to policy legacies helps to shed some light on when we might see intermediaries within government – jurisdictions who have public delivery of mental health services with no alternative service streams – but it does not explain where intermediaries might be located if this is not the case. However, it does suggest that leading policy implementation may be a valuable function for other systems actors to take on since it could reinforce their role in the system and provide them with access to elites and additional financial resources.

The public/private mix of health and mental health service delivery can create different incentives or disincentives for system actors. Actively leading the implementation of policy is visible and traceable to a wide range of system actors and also to the public, depending on the specific direction being implemented (29). The visibility and traceability of policies and policy actions (including implementation) can convey important information to system actors that can influence their attitude and behaviours (30). While implementation success can lead to concentrated gains for those leading it, implementation failure is easily traced back to the leaders, causing concentrated losses. For government or any other actor, being actively engaged in the implementation of mental health policy is risky. Because of the complexity of the problem, the policy solutions are often complicated and multi-faceted, spanning a wide

array of system actors and different sectors. This increases the likelihood that implementation efforts may not achieve the intended results or results may take longer than in some other policy arenas. For governments that act as what Weaver (31) calls "blame avoiders", this may mean it is advantageous to "pass the buck" of mental health policy implementation to other system actors when feasible. Conversely, while other institutional actors also face the risks related to implementation, they do not face the same losses as government, such as losing the ability to govern through the electoral process. By leading the implementation of the government's policy directions, system actors can receive other benefits, such as increased access to government elites and financial resources, which secure or even increase the centrality of their place in the system.

In all three jurisdictions funds are raised for health care primarily through taxation and all have some form of universal insurance for citizens. Where they differ is primarily in the delivery of services and this difference, we argue, is important in explaining the placement of intermediaries to support implementation. When governments are directly responsible for the public delivery of services (as is the case in Scotland through the Scottish NHS) they are viewed by themselves and other system actors as having certain powers and authorities that would not be attributed to governments in other systems where service delivery is more 'divorced' from government. Scotland's mental health system constitutes the most centralized and government-concentrated form of service delivery of the three cases. In such a system, one might expect that the government could also be directly involved in the implementation of new policies because assuming the role of intermediary would be viewed as a logical role for them. They also have less opportunity for blame avoidance (32) because

there are fewer institutions in the mental health service delivery system to which they can shift responsibility.

Conversely, in Ontario, mental health delivery is more arms-length from government, provided mainly through private, not-for-profit community mental health agencies and hospitals. However, unlike most other areas of health care, there is also a goodly amount of private, for-profit delivery, including registered professionals such as psychologists and social workers operating in private practice and some private mental health and addiction residential treatment facilities. In this type of service delivery environment, many of the specific service delivery decisions are made by governing boards that follow the broad policy expectations and service contracts outlined by the provincial government and the regional health authority structure (Local Health Integration Networks, or LHINs). Implementation support related to new policy directions is not under the auspices of the government, which sees itself as a "steward" of the health system and less involved with the actual delivery of health (and mental health) services.

Somewhere in between these two cases in terms of public/private mix is New Zealand. The mental health service delivery system in New Zealand includes a mix of public, private, and NGO providers. The Ministry of Health flows funds to 20 District Health Boards (DHBs) that are responsible for providing some portion of services directly. District Health Boards also purchase services offered by NGOs, primary healthcare organizations, or other private providers. Non-governmental organizations account for approximately 30% of the mental health and addiction service delivery budget of DHBs (33). Citizens are also able to pay for private services directly, either out-of-pocket or through additional private insurance. This system might include more government capacity than Ontario to directly support the

implementation of policy directions, since it includes some portion of direct government delivery. However, its mixed model of service delivery from a range of provider types means that it is not necessarily an obvious place for an intermediary. Unlike Scotland, in both New Zealand and Ontario, there are other institutional actors that could be tasked with supporting policy implementation because past policy decisions have led to less centralized forms of mental health service delivery. These capacities would allow blame-avoiding governments to "pass the buck" to other system actors, who could take on this risky role. Furthermore, as mentioned, these other system actors operate with a different mix of incentives and are not subject to some of the concentrated costs that implementation failure brings government, making this role more palatable and in fact, potentially desirable.

In order to explain which system actors might assume this role, we must turn to another institutional feature of mental health systems.

2) Administrative capacities

Governments vary in the degree to which they possess the resources needed to implement policies and decision makers must consider not just the political constraints related to a given policy, but also the administrative and financial ones (34). We suggest that intermediaries are created in the system location that has the most administrative capacity to enact the functions required of them and that this capacity was built as a result of past policy decisions. Administrative capacities can be broken down into two sub-categories: 1) human resource capacity, or what Pierson called "loyal and skilled" staff, and 2) functional capacity, which refers to the practical ability of the system to support the intermediary function through the efficient flow of funds and other resources. Each of the jurisdictions examined here have

their own particular history, replete with past policy decisions that over time build and shape each system in a unique way. As Skocpol states "Because of the official efforts made to implement new policies using new or existing administrative arrangements, policies transform or expand the capacities of the state. They therefore change the administrative possibilities for official initiatives in the future, and affect later prospects for policy implementation" p.58 (35).

Implementation support delivered through intermediaries requires very skilled individuals that are able to work "in between" and understand both government and service delivery environments. They must also offer expertise in one or all of: quality improvement, implementation science or knowledge translation. Finally, they must be skilled communicators who are able to translate policy intention into change at a service level. This is similar to the role of policy entrepreneur described by Kingdon (36). Whereas policy entrepreneurs play a crucial function in coupling the problems, politics, and policy streams to bring an issue to the decision agenda, those working as intermediaries play a crucial role in facilitating implementation by working effectively with actors at the policy, managerial and front-line levels. Each jurisdiction will vary in terms of where such human resources are found or where this capacity can be built.

Functional capacity, on the other hand, is the capacity built from previous policy decisions around how funds can flow through the mental health system and to whom. Although a key function of government is to flow funds to other actors in their system, at any given time, governments are constrained in their ability to disperse resources to certain actors with whom they have no prior existing financial relationship. It is always easier and swifter to use existing administrative capacity that exists from past policies, allowing funds to

flow relatively rapidly and with little question about why from other system actors than to construct new financial arrangements. Governments then, have an important incentive to continue to use these preexisting pathways to achieve new policy implementation support.

New Zealand - The New Zealand government works closely with NGOs that receive 'significant funding' on the scale of two to four billion dollars per year for health, with funding to NGOs for mental health and addictions representing approximately one third of the total budget (37). The government also recently formalized this relationship with NGOs through the development of a Health and Disability NGO council and Network. This partnership supplements the government's capacity to provide mental health and addictions services and supports, but NGOs also play a key role in systems support, including workforce development, anti-stigma initiatives, and making service information and resources available for self-support (37). The NGO sector represents significant human resource capacity, with a skilled workforce constituting a diverse range of roles. Te Pou in particular has the type of human resources articulated above that are able to fulfill the intermediary functions. Furthermore, Te Pou's presence across the country and their existing relationships with the wide array of organizations delivering services means they have the functional capacity to play this role. Thus, the administrative capacity of the NGO sector in general combined with the specific human resource and functional capacity of Te Pou makes it a logical place for the intermediary function in New Zealand.

Ontario - The Ontario government adopted a stewardship model of governing in health in 2007, where it shifted its focus to providing overall direction and driving strategy and

performance and became less directly involved in the actual delivery of health care. It also devolved some decision-making authority to the newly created regional health authorities (LHINs) which have been mainly focused on service contracting. These changes have meant there is limited administrative capacity within government to support an intermediary function. While there are many interest groups within the mental health sector, including a number of NGOs, they are very limited in size and scale and tend either to play an advocacy role or are association driven, representing the interests of service-providing organizations and providing them with group insurance and other benefits. Although some of these organizations receive funding from government to support specific activities, and thus, have the functional capacity to receive funds from government to play an intermediary function, they tend not to have the mix of human resources with the right skills and supports to make them a logical site for an intermediary. Alternatively, the institutional service delivery sector in Ontario is robust and both hospitals and school boards are well recognized and trusted by government. They are also large in size and have a well-trained, highly skilled workforce. Additionally, these institutions have traditionally engaged in many activities that go beyond service delivery such as research, community development, and continuing education. Furthermore, the functional capacity exists for government to flow funds to these organizations directly. Logic then dictates that the system actors who would receive funds to develop the policy implementation support function in the form of an intermediary would be service-delivering organizations.

Scotland - As mentioned, Scotland's mental health system constitutes the most centralized and government-concentrated form of service delivery of the three cases. The Scottish

Government's direct involvement in the implementation of new policies is aided by their existing administrative capacity related to the delivery of services in the system, including a bureaucratic workforce with a diverse range of administrative skills and expertise from which to draw (29). Additionally, as part of a larger governmental thrust, Scotland has reshaped its mental health system around a focus on improvement through the creation of specific mental health improvement aims, targets, and improvement supports and more generally through the establishment of Health Improvement Scotland in 2011. Health Improvement Scotland represents a functional system capacity that can support the skilled members of the government workforce who work closely with the service delivery system by enhancing their expertise in improvement approaches. These administrative capacities combine to reinforce the intermediary function played by the current mental health delivery team within government.

Discussion

This analysis demonstrates that the placement of intermediaries in these three jurisdictions is explained by their institutional landscapes and in particular, the mix of public/private mental health service delivery created by policy legacies and the differing administrative capacities of their systems. A system such as Scotland, with public delivery and administrative capacity within the government, is more likely to have the intermediary function within that setting. When delivery is a public/private mix (like New Zealand) or primarily private (like Ontario), then the location of the intermediary is explained by where the administrative capacity exists in the system (NGO sector in New Zealand and service delivery system in Ontario).

A key strength of this paper is that it is an early attempt to combine theory on facilitation from implementation science with theories from political science and other social sciences to explain intermediaries supporting mental health policy implementation. By drawing on institutional theory, it offers an explanation for the placement of intermediaries in systems. This study also provides rich comparative descriptions of intermediaries in three different jurisdictions – something that is currently lacking in the literature – and an important building block to clarifying the phenomenon of intermediaries.

A limitation of this analysis is the lack of interview data from Scotland. It is possible that key informant interviews from that jurisdiction may have altered or served to enrich the analysis and conclusions that were drawn. However, the research team was in contact with key leads in Scotland just prior to the study period and was able to draw on presentation and other publicly available materials to mitigate this limitation. Additionally, this analysis did not include cases of intermediaries from the other three settings identified earlier (arms-length agencies of government, academic or research settings, or peak organizations). Intermediaries do exist in these settings and the inclusion of them could further test the institutional arguments forwarded here and increase the conceptual credibility of the conclusions. Furthermore, it is possible that locations of intermediaries were overlooked or misclassified. For example, research in the field of education examining 'knowledge mobilization intermediaries' identified four possible types: government, not-for-profit, for-profit, and membership (38). This classification diverges from that used here and identifies two potential other categories for system placement: for-profit and membership settings.

This analysis yields a set of testable hypotheses that can be used to examine the emergence and placement of intermediaries in other mental health systems or other areas of

health or social care. In particular, it would be interesting to compare jurisdictions where intermediaries exist with jurisdictions where they do not to explore what system features explain how and why they come about. Future research could also investigate whether the placement of intermediaries in systems affects the type activities they engage in or the relative weight of activities. One might predict that intermediaries in the delivery system would have a strong organizational-level focus and an emphasis on organizational-level activities. Those within government may be more focused on the implementation of policy goals and targets. Intermediaries in academic settings might have an increased focus on the purveyance of evidence-based practices or the translation of research evidence for policy and practice.

Conclusions

A better understanding of intermediaries is important for policy makers who must consider the infrastructure required to support the implementation of policy. This study offers them insights about where they might build such capacity and the types of intermediaries that are possible. It represents a unique contribution to the growing literature on intermediaries, but more work is required to truly understand how to harness systems more effectively to achieve policy goals.

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Table 1 – Summary of qualitative interview findings regarding the presence of intermediaries supporting policy implementation and their placement in the system by country

Country	Sub-Jurisdiction (if applicable)	Population (millions)	Welfare State Regime Type[1]	Does Intermediary Exist?	Intermediary's Methods Clear?	Intermediary's Name	Intermediary's Placement in System	Notable Feature(s) of Intermediary
Australia		23.13	Liberal	✓	✗	Orygen, The national centre of excellence in youth mental health	**Research** (University of Melbourne but has independent charitable status)	Youth focus
Canada	Ontario	13.60	Conservative	✓	✓	Provincial Centre of Excellence for Child & Youth Mental Health	**Service delivery organization** (Children's Hospital of Eastern Ontario)	Children & youth focus
						Provincial System Support Program	**Service delivery organization** (Centre for Addiction and Mental Health)	Adult focus
						School Mental Health Assist	**Service delivery organization** (Hamilton-Wentworth District School Board)	Education sector
	Saskatchewan	1.13	Conservative	✓	✓	I-team	**Government** (regional health authorities)	Mandate not renewed
England		53.01	Liberal Subgroup	✓	✗	IAPT implementation support	**Government** (NHS)	Initiative-specific; Mandate not renewed
Ireland		4.60	Liberal Subgroup	✓	✗	Centre for Effective Services	**NGO**	Mostly child & youth focused

								but has been expanding
New Zealand		4.47	Liberal Subgroup	✓	✓	Te Pou o Te Whakaaru Nui	**NGO**	Adult-focus Includes Matua Raki (addictions-specific)
Scotland		5.30	Liberal Subgroup	✓	✓	Quality and Efficiency Support Team & Mental Health Division of Scottish Government	**Government** (NHS)	
Sweden		9.59	Social Democratic	✓	✓	Mission Mental Health	**Peak organization** (Swedish Association of Local Authorities & Regions)	
USA		318.9	Liberal	✓	✓	National Technical Assistance Center for Children's Mental Health	**Research** (Duke University)	
					✓	Department of Defense, Defense Centers of Excellence	**Service delivery organization/ Government hybrid**	Serves military personnel and their families around the world
	New York City	8.55	Liberal	✓	✓	Mental health innovation lab	**Government** (NYC Department of Health and Mental Hygiene)	Public health approach with strong collaboration across multiple agencies

[1]Classification based on Bambra[39]

Table 2 - Intermediary structures in New Zealand, Ontario and Scotland

Intermediary Name	Placement in System	Year Est.	# Staff	Approx. Annual Budget	Funding Source	Location(s)	Structure	Description	Implementation Methods
New Zealand									
Te Pou o Te Whakaaru Nui (Te Pou)	Non-Governmental Organization (NGO)	2005	46	$20 million NZD	Ministry of Health (primary source)	• Auckland • Hamilton • Wellington • Christchurch Travel as needed across the country	• Part of Wise Group of community organizations Governance: • board of directors (7 members) • clinical sector reference group (26 members) provides advice to ensure clinical and sector partnership feedback is incorporated • 1 of 5 national workforce development centres for mental health	• national centre of evidence-based workforce development for the mental health, addiction and disability sectors • works with range of organizations and people including service providers (DHB and NGO), training and education providers, researchers and international experts support to improve their services	• knowledge exchange (e.g. *SPARK Evidence into Practice*) • decision support /data systems (collecting and reporting on outcomes and workforce information) • capacity building of system to: access, interpret and implement evidence • technical assistance (e.g. seclusion & restraint reduction) • strong focus on collaboration
Ontario, Canada									

Ontario Centre of Excellence for Child and Youth Mental Health (OCoE CYMH) Children's Hospital of Eastern Ontario (CHEO)	Service delivery system - hospital	2004	50	$5.9 million CAD	Ministry of Child & Youth Services	• Ottawa Travel as needed across province	Governance: • CHEO hospital board • strategic advisory council (12 members) provides advice, direction and input on strategic plans, partnership initiatives and high-level operations	• focus on increasing capacity in the child and youth mental health service delivery system to use evidence-based practices, evaluate their work, and to improve their ability to collaborate across systems with the goal of improving services	• implementation science approach (e.g. NIRN's Active Implementation Frameworks) • knowledge mobilization • quality improvement • performance measurement • evaluation
Provincial System Support Program (PSSP) Centre for Addiction and Mental Health (CAMH)	Service delivery system - hospital	2011	150	$19 million CAD	Ministry of Health and Long-Term Care & global hospital budget	Provincial office: • Toronto Regional offices: • Kenora • Thunder Bay • Sudbury • Barrie • London • Hamilton • Ottawa • Kingston • Toronto	Governance: • CAMH hospital board	• Works collaboratively across sectors to move evidence to action to transform mental health and addictions systems in Ontario	• implementation science (e.g. NIRN's Active Implementation Frameworks) • knowledge exchange • information management • evaluation • engagement & health equity

School Mental Health Assist (SMH Assist) Hamilton-Wentworth District School Board	Service delivery system – school board	2011	13 provincial staff 72 mental health leaders in schools	$2.2 million CAD (figure does not include funding for mental health leaders)	Ministry of Education	Provincial office: • Hamilton Regional offices: • In all 72 school boards	Governance: • Hamilton Wentworth District School Board (Director of Education)	• created to address critical gaps in the organizational capacity and conditions of schools and school boards to provide evidence-informed programming addressing mental health[40]	• implementation science approach, drawing from NIRN's Active Implementation Frameworks
Scotland, U.K.									
Quality and Efficiency Support Team & Mental Health Division of Scottish Government	Government	2009 (restructured in 2012)	12	N/A	Scottish Government	• Edinburgh Travel as needed across country	Governance: • Mental Health Delivery Team (12 people drawn from multiple agencies) • Scottish government	• focuses on elements of a quality improvement and outcomes framework • ensures the delivery of commitments relating to measurement of progress and improvement support	• quality improvement - adapted version of Institute for Healthcare Improvement's Model for Improvement[41] • monitoring of progress toward **H**ealth improvement **E**fficiency **A**ccess to treatment **T**reatment targets

Chapter 4. Preface

The implementation of evidence-informed policies and practices across systems is complex and multifaceted. In order to facilitate this process, policymakers, innovation developers and service deliverers are increasingly calling upon intermediaries to support implementation, yet relatively little is known about precisely how they contribute. This chapter continues the examination of the infrastructure required for large-scale implementation by comparing intermediaries supporting the implementation of evidence-informed policies and practices in the mental health systems of New Zealand, Ontario, Canada and Sweden. Using a comparative case study methodology and taking an integrated knowledge translation (IKT) approach, we draw from established explanatory frameworks and implementation theory to explore: 1) why the intermediaries were established; 2) what structures and strategies the intermediaries use to support the implementation of policy directions; and 3) why some strategies are avoided. Like Chapter 3, our findings help to foster a better understanding of intermediaries and encourage policy-makers and system leaders to consider the infrastructure required to implement policy and the role intermediaries can play. It uniquely contributes rich descriptions of the structures and implementation strategies used by policy-related intermediaries in three systems and offers novel explanations regarding why intermediaries were created and why they avoid particular strategies.

I was responsible for the study focus and design and for completing all data collection, analysis and interpretation with assistance from my IKT partners. I also drafted the manuscript. My supervisor, Dr John N. Lavis, helped conceive of the study and contributed to the analysis and refinement of the manuscript. Committee members, Dr Michael Wilson

and Dr Gillian Mulvale, reviewed the manuscript and provided detailed feedback on earlier drafts, which was incorporated into the final version of this chapter.

Using Table 2 from the Introduction as a guide (see excerpt below), this study is the third of the five included as part of my dissertation. The primary sources of data for this analysis were the interviews conducted and documents collected during field visits to each of the jurisdictions.

Chapter	Study Objective	Design (and select methods)	Outputs/ Contributions	Links
4.	To explore how policy implementation is structured, the use of intermediaries and the methods they use in large well-developed mental health systems. It examines whether features of the political system impact how implementation is structured and the strategies that are employed ***Descriptive + explanatory goals***	Comparative case study • Three jurisdictions were purposively sampled: New Zealand, Ontario, and Sweden • Data were derived from semi-structured interviews and public documents • Directed content analysis was used to analyze, drawing from existing theory (Kingdon & 3I+E) and theory resulting from Chapter 2 • Study conducted using an IKT approach, in partnership with the International Initiative for Mental Health Leadership	1. In-depth understanding of structures supporting implementation & similarities/ differences across systems 2. Identification of factors that explain structures within individual cases, and factors that explain variation across cases 3. Practical feedback and guidance to systems on how to design/ enhance implementation supports	Chapter 3 & 4 used same sample pool of jurisdictions but different selection criteria Modified ISF and novel determinants framework from Chapter 2 provided theoretical lens for analysis

An examination of current implementation efforts and the 'intermediaries' that support them in New Zealand, Ontario, Canada and Sweden: A comparative case study

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Keywords: intermediaries, implementation, mental health, comparative case study, qualitative

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Abstract

Background: The implementation of evidence-informed policies and practices across systems is complex and multifaceted, often requiring the mobilization of multiple organizations from a range of contexts. In order to facilitate this process, policymakers, innovation developers and service deliverers are increasingly calling upon intermediaries to support implementation, yet relatively little is known about precisely how they contribute to implementation. This study examines the role of intermediaries supporting the implementation of evidence-informed policies and practices in the mental health and addictions systems of New Zealand, Ontario, Canada and Sweden.

Methods: Using a comparative case study methodology and taking an integrated knowledge translation approach, we drew from established explanatory frameworks and implementation theory to address three questions: 1) Why were the intermediaries established? 2) What structures and strategies do intermediaries use to support the implementation of policy directions? and 3) Why are some strategies avoided? Data collection included three site visits, 49 key informant interviews and document analysis.

Results: In each jurisdiction, a unique set of problems (e.g. negative events involving people with mental illness), policies (e.g. feedback on effectiveness of existing policies) and political events (e.g. changes in government) were coupled by a policy entrepreneur to create the intermediary. While intermediaries varied greatly in their structure and characteristics, both the strategies they used (e.g., formal advice/policy input) and the strategies they didn't use (specifically, strategies targeting the public or involving audit and feedback) were surprisingly similar. Our analysis identified five factors that explain why those strategies were avoided: 1) their need to build/maintain healthy relationships with policy actors; 2) their need to build/maintain healthy relationships with service delivery system actors; 3) role differentiation with other system actors; 4) perceived lack of 'fit' with the role of policy intermediaries; and 5) resource limitations that preclude intensive distributed (program-level) work.

Conclusion: Policymakers and implementers must consider capacity to support implementation, and our study identifies how intermediaries can be developed and harnessed to support the implementation process.

"So, we spent a lot of time trying to be a valuable resource to both the sector, which included community-based and specialized service providers. But also to the government so that we would become a resource for them in terms of some of their knowledge needs, which means you maintain a relationship with the bureaucrats and the politicians. And you become a go-to place that can solve problems that they can't solve on their own so that's the advantage I think of an intermediary organization. By design, you are the space in-between so that you shouldn't be hampered as much by some of the government bureaucracy, although that's always a problem. And have the credibility of not being Big Brother so that you can support the needs of service providers, and not feel that you're being as scrutinized in an accountability way in the way government would. So, I think that we worked really, really hard to firmly be in that space in-between, and to be in service of all those different players. And to do it with credibility so that there was a sense of the quality that was being provided and that consistency, so we would always talk about evidence first and not just opinion, and responsiveness in terms of we would try to do things in a way that that could be quicker than if government did it by itself."
KI-47

Background

The implementation of evidence-informed policies and practices (EIPPs) at scale across whole systems is a complex, multifaceted endeavor. Yet an effective implementation process is critical in bridging the gap between the promise of EIPPs and positive outcomes for citizens and society. This is particularly true when the EIPP is psycho-social in nature requiring the mobilization of multiple organizations and roles within them, a need to respond to the diversity of individuals receiving the EIPP, and to take into account a range of contexts. This complexity may account for the continued lack of access to psycho-social EIPPs for both adults and children. For example, in the US, researchers found that the overall penetration rates for six behavioural evidence-based treatments was only 1-3% and adoption rates were static or declining across the states who had invested in them.[1] This is despite an increased understanding of the burden of mental illness and addictions[2] and increased momentum by policymakers around the globe to address the issue.[3]

In response to these challenges, policymakers, innovation developers and service providers are increasingly looking toward organizations or programs that can facilitate the

implementation process. These organizations are often referred to as intermediaries, which act as 'translators' for EIPPs and provide technical assistance to organizations and service providers, while informing policy and systems.[4-7] In general, intermediaries fall under the broader implementation construct of facilitation[8,9] or change agency[10] with the recognition that complex change processes do not on their own reach a high enough rate of penetration and fidelity in systems to produce their intended benefits. Instead, external supports are typically required and intermediaries are one approach to facilitation.

Limited research exists on this type of intermediary and there is not yet a consensus on what precisely defines them and how they contribute to implementation. One reason for this is that the scholarship that exists comes from different fields (e.g. public management, social sciences or implementation science), which naturally draw from different theories, methods and ways of reporting. There is also a great deal of heterogeneity in terms of topics (e.g., child, youth and family services,[5,11] education,[12,13] environment,[14] mental health and addictions,[15,16] occupational health and safety[17] and technology[18]). Furthermore, the contexts surrounding the intermediaries vary, thus limiting comparability. Finally, there is a diversity of terms in use, such as: intermediary (organization), purveyor, technical assistance center, knowledge brokering organization, centre of excellence, implementation team and backbone organization. This means that different terms may be used to describe similar constructs, or that the same term may be used to describe two quite different constructs, leading to further conceptual fuzziness.

The strategies employed by intermediaries vary, but the existing literature does point to some common strategies and approaches. A survey of 68 intermediaries found support for seven core functions of intermediaries, including: consultation activities; best-practice model

development; purveyor of evidence-based practices; quality assurance and continuous quality improvement; outcome evaluation; training, public awareness and education; and policy and systems development.[19] More recently, a web scan and survey of child behavioral health intermediaries found that they used an average of 32 distinct strategies to implement evidence-based interventions, with common strategies including educational, planning and quality improvement strategies.[15] There was little consensus, however, on which strategies intermediaries perceived as the most effective.

Some authors frame the strategies of intermediaries in different terms. For example, they describe the approaches of intermediaries and other "support system infrastructure" as including both general capacity-building approaches as well as those that are innovation-specific,[20] while others identify strategies targeting different levels in the system (e.g. federal, province/state, local).[7] Still others have described intermediaries in economic terms, suggesting intermediaries can address research supply-side issues (supporting the production, translation and consumption of research) as well as the demand-side issues (such as improving service delivery readiness for a particular EIPP, support for implementation, etc.).[13]

We identified three sub-types of intermediaries in the literature that specifically address the knowledge production-to-implementation continuum: 1) those whose focus is mainly on translation and dissemination of research evidence to inform policy and practice (knowledge translation-focused, or "KT intermediaries");[11,12,14,21,22] 2) those whose focus is mainly on the implementation of pre-packaged research evidence to service providers in the form of evidence-based practices (practice-focused, or "practice intermediaries");[15,16,23] and 3) those whose focus is mainly on assisting policymakers or other system leaders embedding EIPPs at

scale in systems (policy-focused, or "policy intermediaries").[13,24-26] Of course, many intermediaries engage in activities across all three types, but this characterization may help to clarify their starting point, goals and theories of change.

Given the focus here on policy and supporting implementation at scale in mental health and addictions systems, our study targets the policy intermediary sub-type. We define intermediaries as: organizations or programs that have an explicit and recognized role to support the implementation of government mental health and addictions policy goals and employ specific methods of implementation support (Bullock & Lavis, under review/Chapter 3). In order to achieve these goals, other system actors must understand and accept this role, including those in government, service providers and other stakeholders.

Purpose & study questions

This study examines the role of policy intermediaries supporting the implementation of EIPPs in the mental health and addictions systems of high-income countries. Guided by implementation theory and drawing from established explanatory frameworks, we address three questions: 1) Why were the intermediaries established? 2) How are intermediaries structured and what strategies do they use in systems to support the implementation of policy directions? and 3) Why are some strategies avoided?

Methods

Integrated KT approach

This study was designed and conducted in collaboration with the International Initiative for Mental Health Leadership (IIMHL) - an international collaborative focusing on improving mental health and addictions services in eight countries: Australia, Canada, England, Ireland,

New Zealand, Scotland, Sweden, and USA (a ninth country, Netherlands, joined after data collection began). Prior to initiating the study, one of the authors (HB) had been collaborating with individuals from IIMHL countries who were either working in intermediaries or interested in harnessing the capacity of intermediaries to support systems change.[27] With those relationships in mind, we asked the IIMHL to partner on this research in an integrated knowledge translation (IKT) capacity. Integrated knowledge translation is an approach where those who produce research and potential knowledge users partner with the goal on enhancing relevance and facilitating use.[28] Our IIMHL partners have thus far participated in three study phases: 1) providing input into the conceptualization and planning of the study, 2) assisting with recruitment and data collection by hosting the research team during site visits and identifying potential key informants, and 3) assisting with the interpretation of findings and identifying next steps.

Study design

We used the holistic multiple case study approach outlined by Yin.[29] A multiple case study approach is often considered more robust than single case designs because of the replicative nature and the ability to make predictions from theory that can be tested across cases leading to higher explanatory power. It is a suitable methodology for our questions as it allows for an examination of intermediaries in their context. We brought a realist-postpositivist philosophical approach to this research, considering it a form of empirical inquiry and focusing on maintaining objectivity through the use of techniques like triangulation to minimize errors and get as close as possible to the ‘truth’.[30]

Ethics approval for this study was granted by McMaster University through the Hamilton Integrated Research Ethics Board (HiREB-15-328) and informed consent was

sought and provided by all participants. The study was conducted in two phases: 1) case selection, and 2) comparative case study. For brevity, we refer to mental health and addictions as "mental health".

Phase 1 - Case selection

Qualitative description was the analytic approach selected for case selection, which has, as its goal, a comprehensive summary of events in everyday terms.[31] The "case" or unit of analysis is defined as: a political jurisdiction that has the ability to develop, implement and evaluate mental health policy and the organizations or programs within it that support policy implementation. This definition means cases may be at different policy levels in systems (e.g., national, provincial/state or municipal). The 'population' of potential jurisdictions included IIMHL countries, which all have well-established health systems and a commitment to mental health systems improvement. They provide variation in terms of health service structures, including how mental health services are designed, managed and delivered and other factors that may impact successful implementation but have enough similarity to ensure the case study is sensitive to the variables of interest.

The research team worked with IIMHL partners to generate a purposive sample of potential interviewees from each jurisdiction. The list included a mix of leaders in government, agencies of government, non-governmental organizations and service providers who played a leadership role in implementation and could speak to the macro-context of their mental health system. From this list, the research team (HB) contacted one or two leaders from each jurisdiction requesting a brief semi-structured telephone/Skype interview. The questions were targeted toward understanding the policy priorities currently being

implemented and the structures in place supporting their implementation. A number of potential interviewees were known to HB through their mutual involvement in the IIMHL.

Interviews were recorded and reviewed by the study team. Using qualitative content analysis and following the qualitative description approach, analysis remained 'close' to the data with minimal interpretation. Structured summary sheets of each interview outlining important characteristics and infrastructure were generated and a table was created to facilitate case selection.

Phase 2 – Comparative case study

Cases for the comparative case study were purposively sampled based on findings from Phase 1 using an approach that approximates the Most Different Systems design or Mill's Method of Similarity.[32] Using this method, cases are selected based on a similar outcome or dependent variable but are diverse in other ways. In this study, cases were selected based on the presence of at least one organization or program that has an explicit role supporting mental health policy implementation (policy intermediary) with differences in the policy level (state/province vs national); mental health system factors (e.g., a range of governance, financial and service delivery arrangements); and, political system characteristics (e.g. diversity in the institutional arrangements, interests and ideas at play) (Table 1). The cases selected include: New Zealand, the province of Ontario in Canada, and Sweden. At the time of case selection, New Zealand and Sweden each had one intermediary operating in mental health while Ontario had three. Thus, Ontario includes three embedded cases. The cases are bounded in two ways. First, by the political areas specified above that have policy authority over mental health. Second, they are bounded temporally, by considering only active implementation efforts and current supporting structures rather than past policy efforts.

Data sources for this phase included key documents, site visits (interviews and field notes) and follow-up interviews.

Review of Key Documents – We analyzed key documents collected as part of case selection and additional documents retrieved through web searches of government and stakeholder websites and a search of PubMed, Google Scholar and LexisNexis in October 2016 and again in June 2018 for relevant research articles and media accounts related to the intermediaries or implementation efforts. Documents were reviewed and data were extracted based on the following domains: health system and political system characteristics; intermediaries and other structures supporting implementation of mental health priorities; and implementation strategies being utilized.

We reviewed and analyzed a total of 73 sources: 24 policy documents, 13 reports or other documents generated by or on behalf of the intermediary, 22 websites and 14 scholarly publications. We also reviewed grey literature on implementation infrastructure that referenced at least one of the cases (n =3) and used news media articles as a source of triangulation to verify events that were mentioned by stakeholders during interviews (additional file 1). We used each intermediary's website to review reports and publications, so many of those are not counted in the tally above.

Site Visits – Our team created a list of the types of stakeholders we wanted to interview and shared it with the IIMHL IKT partners in each jurisdiction. Partners were instructed to identify at least two individuals for each category and provide contact details. Types of stakeholders included: 1) intermediary, 2) policymakers/government, 3) funder(s) of implementation/intermediary, 4) oversight of implementation/intermediary, 5) researchers familiar with the intermediary, 6) knowledge synthesizers & translators, 7) recipients of

implementation supports, 8) partners of intermediary, and 9) others. One to two people from each category were then invited to participate. The consent form was translated into Swedish for the Swedish case, and while the interviews were conducted in English, an informal English/Swedish interpreter who was familiar with the subject was offered to participants.

Interview questions were tailored to each stakeholder type, and focused on constructing a full picture of how policy implementation is structured and delivered in the system, including: 1) what policy priorities are currently being implemented; 2) who (organizations and individuals) are supporting their implementation; 3) what implementation strategies they use (e.g., training, audit and feedback, etc.); 4) the value placed on implementation supports; and 5) important factors in the creation of the intermediary (Appendix 1). Interview guides were revised iteratively as theoretically or substantively important insights were identified. With consent, interviews were recorded for later transcription and lasted approximately 90 minutes each. Interviews were conducted until saturation was reached and no key perspectives were deemed missing. Throughout site visits, descriptive (e.g., who, what, where, etc.) and interpretive (e.g., personal reflections and questions arising from activities) field notes were taken. Additional documents, such as presentations or reports, were requested from participants and reviewed. All site visits took place in 2017: New Zealand (February), Sweden (May) and Ontario (July – September). Ethics waivers were sought and acquired prior to the site visit according to the rules of each jurisdiction.

A total of 49 initial interviews were conducted during the site visits or shortly thereafter (13 NZ, 23 ON, 13 SE). More interviews were conducted in Ontario because the three embedded cases meant that a larger sample of stakeholders was required to reach

saturation. Three of the interviews in Sweden were supported by an interpreter. Stakeholders from all of the categories identified in the stakeholder matrix were interviewed for each case, providing a well-rounded perspective.

Follow-Up Interviews – A final stage of data collection included interviews held between 2017 and 2019 with key informants who were unable to participate during the site visits, or who agreed to a follow-up interview as analysis proceeded. This ensured each case was as complete and comparable as possible across jurisdictions. Five follow-up interviews were conducted.

Analysis

NVivo12 Qualitative Software was used to manage data, thereby establishing a comprehensive and easily accessible case study database. Transcripts and/or audio recordings were reviewed at least twice. Supporting documents were also reviewed and coded. Directed content analysis[33] was employed, which begins the coding process by drawing from existing research and theory as a guide. Within each case, sources were compared with one another to identify common emergent themes.

Analytic goals and frameworks

Goal 1 – To explain why the intermediaries were originally established and brought to the point of being up for active decision by governments, we used Kingdon's multiple streams agenda-setting framework.[34] Kingdon's theory identifies activities in independent 'streams' that have to come together during a brief 'window of opportunity'. These include: heightened attention to a problem (problem stream), an available and feasible solution (policy stream), and the motive to select it (politics stream). The three streams must come

together in order for a change to be made, and this usually happens through the work of a policy entrepreneur.

Using this framework, we identified the timelines of the relevant events and activities leading up to the establishment of the intermediary(ies) based on stakeholder accounts of what was relevant and document review. Next, we developed a comparative table that highlighted: 1) aspects of the problems in each system that each intermediary was created to address, 2) policy proposals and ideas that were supportive of the need for implementation infrastructure in the form of an intermediary, 3) the political environment that made the intermediary(ies) a feasible policy solution, and 4) the relevant actors, including policy entrepreneurs.

Goal 2 – To describe and compare the structures of the intermediaries, their organizational characteristics and the implementation strategies they use, we drew on a modified version of the Interactive Systems Framework for Dissemination and Implementation (ISF) as a descriptive framework. The ISF was originally developed by Wanderman and colleagues[20,35] and is a heuristic that captures how new knowledge moves from research development to widespread use and the systems and processes supporting this movement. The ISF specifies the three systems needed to carry out dissemination and implementation functions: i) Synthesis and Translation System; ii) Delivery System; and iii) Support System. In an effort to capture the important role of policy in implementation, we modified the ISF by adding a Policy System (links with the other Systems and provides a variety of policy-related supports for dissemination and implementation) (Chapter 2).

We used the modified ISF and other research on intermediaries to generate a list of potential strategies related to implementation that were used as prompts during the

interviews. During the analysis phase, we sorted and classified the strategies used by intermediaries according to the "target" ISF System. We then added some categories that emerged during the interviews and that were consistent with the existing literature: strategies targeting the public; strategies targeting individuals with lived experience & family members; and strategies focused on performance assessment and/or system-monitoring. Finally, we cross-referenced our strategies with the implementation strategies identified by Powell and colleagues [36] who used the sub-categories of "Plan", "Educate", "Finance", "Re-structure" "Quality Management" and "Attend to Policy Context". Next, we extracted examples of the strategies for each case from the interview data, and cross-referenced/supplemented these with other data sources.

Goal 3 – To explain the choice of implementation strategies we first drew on the 3I+E framework, which includes a set of political factors that explain policy choice.[37,38] Specifically, the 3I+E framework explains how institutions (i.e., government decision-making structures and processes), interests (i.e., groups with a vested interest), ideas (i.e., values and research-based knowledge) and external factors (i.e., events outside of the policy area of interest) affect the actions of those making decisions or implementing them.

Results

Intermediary case descriptions

Figure 1 depicts the intermediary infrastructure in each case as well as the case boundaries.

New Zealand – The Ministry of Health, through Workforce New Zealand, funds a national infrastructure to support development of the mental health and addictions workforce, including five centres with different foci. Over time, Te Pou o te Whakaaro Nui (Te Pou,

adult mental health and disability focus) and Matua Raki (addictions focus, housed at Te Pou), have developed into an intermediary that aligns with our definition and is the focus of the NZ case. Two other organizations, Werry Workforce Whāraurau (child and youth focus) and the Health Quality & Safety Commission New Zealand were also becoming part of the implementation infrastructure.

Ontario, Canada – We identified three intermediaries that fit our definition in Ontario: 1) Ontario Centre of Excellence for Child and Youth Mental Health (OCoECYMH) located at the Children's Hospital of Eastern Ontario and funded by the Ministry of Children and Youth Services (MCYS, note: post-data collection, funding authority was transferred to the Ministry of Health and Long-Term Care, MOHLTC) ; 2) Provincial System Support Program (PSSP) located at the Centre for Addiction and Mental Health and funded by MOHLTC; and 3) School Mental Health ASSIST (SMH ASSIST) located at the Hamilton-Wentworth District School Board and funded by the Ministry of Education (MED). These three intermediaries collectively comprise the Ontario case, however, other organizations, such as Health Quality Ontario, were also highlighted as increasingly playing an intermediary function. It should be noted that the lead researcher (HB) previously worked with PSSP and has pre-existing relationships with all three intermediaries.

Sweden – Uppdrag Psykisk Hälsa (Mission Mental Health) is the intermediary in Sweden that met our definition and is the focus of this case. Mission Mental Health is located at the Swedish Association of Local Authorities and Regions (SALAR), which is a peak body that acts as both an employers' organization as well as one that represents the interest of the municipalities and regions to the national government. Mission Mental Health is funded

through an agreement between SALAR and the Ministry of Health and Social Affairs. The Public Health Agency of Sweden was also highlighted as an organization beginning to take on more of an intermediary function.

Why were the intermediaries established?

Table 2 identifies the timelines of relevant events and activities leading to the establishment of the intermediary(ies). The results of the analysis of factors influencing the decision to establish the intermediaries is presented in Table 3. The summary that follows is based on the information provided by key informants and documentary sources. Sources are cited in the tables when they are drawn from documents and illustrative quotes from key informants are available upon request.

In all three cases, the intermediary infrastructure came on the heels of a monumental shift in how mental health care was delivered – moving from a system of institutional-based care to one based largely in community. While the timelines and trajectories for deinstitutionalization varied across cases[39-44] the process was complete around the turn of the century – and it is in the decade that followed that these intermediaries were established.

The deinstitutionalization process left policy legacies that differed in each case due to the unique political terrain and health policy features of each jurisdiction. However, key informants cited this shift in the model of care as an influential factor that drove the need for different system capacities because of increasing complexity across a new array of community and hospital environments. The type of new capacity required was framed differently across cases and is outlined as part of the analysis below.

New Zealand – During the years following deinstitutionalization, mental health became a much more visible policy issue due to what key informants stated were several 'dreadful

events' involving people with mental illness and feedback about the scale and scope of the issue from the first national epidemiological study on mental health issues (problem stream). This increased visibility of the problem led to a flurry of policy activity, including a government inquiry, at least seven policy documents and a major change in the law (policy stream). Also during this time there was a government that, according to stakeholders, was willing to invest heavily in mental health and a Mental Health Commission was formed (politics stream). Some system challenges also began to be framed as a need for workforce expansion to include roles that were not previously required, and to simultaneously equip the existing workforce to function differently than an institution-based care model.

The policy entrepreneur was recognized by almost all key informants as playing a pivotal role in getting the workforce infrastructure established. However, workforce centres in and of themselves, did not meet our definition of an intermediary. Since their establishment, TePou, Matua Raki and more recently, the Werry Centre, have evolved into the role of an intermediary by expanding their repertoire of activities and implementation strategies well beyond those related to training the workforce. This broader role may have been bolstered by the government's decision in 2012 to eliminate the New Zealand Mental Health Commission and transfer only limited functions to the Office of the Health and Disability Commissioner, leaving additional gaps in the system now filled by these intermediaries.

Ontario, Canada – In Ontario, the first intermediary to be established was the OCoECYMH – almost seven years before PSSP and SMH ASSIST. Prior to OCoECYMH's creation, children and youth mental health was becoming an increasingly visible issue to be addressed at the national and provincial levels. For example, a Federal Senator, Michael Kirby, called

children's mental health the "orphan of the orphan of health care"[45]. In addition, research identifying the true scope of the problem in Canada was developed (problem stream). The sitting provincial government was not doing well in the polls and key informants stated that they were seeking to gain positive political momentum in an election year by announcing investments after several years of cuts (politics stream). Around the same time the provincial auditor general identified children and youth mental health as an area in need of transformation and after a recent round of hospital amalgamations, mental health interest groups were seeking investment to bolster the community sector. Certain government insiders had been advancing the concept of 'centres of excellence' to address a wide variety of policy areas and a new ministry, MCYS, had just been created in 2003 (policy stream). The government then invited the Children's Hospital of Eastern Ontario to develop a proposal for a centre of excellence for children and youth mental health. Those leading the proposal development were identified as policy entrepreneurs.

Conversely, people from outside government first proposed PSSP and SMH ASSIST as policy solutions to support the implementation of a new government strategy for mental health. Policy-makers in MOHLTC and MED adopted these policy ideas as part of their ministerial commitment and actions related to the new strategy. Most of the activity leading to the decisions to create these intermediaries was therefore in the policies stream (the government was developing a new policy and needed resources that could be mobilized quickly and with a good likelihood of success).

Sweden – Prior to the establishment of Mission Mental Health, the mental health system in Sweden was in some turmoil due to a highly visible death of a politician as well as some other violent events by people with a mental illness that were profiled in the media (problem

stream). With the increased visibility of mental health as a policy issue, the government at the time was receptive to further investments in the sector (politics stream). The action they took was to strike a national inquiry that was led by a prominent psychiatrist. The inquiry recommendations included a focus on children and youth and identified several actions to improve their mental health (policy stream). The streams were later coupled by the same psychiatrist who also acted as the policy entrepreneur and enabled the establishment of Mission Mental Health, subsequently becoming its leader.

How are intermediaries structured and what strategies do they use to support the implementation of policy directions?

The structure and organizational characteristics of the intermediaries are summarized in Table 4. There is considerable variation in the structures and organizational characteristics of the intermediaries in our cases in terms of settings (e.g., NGO, service delivery organization or peak organization), age-related focus (e.g., children & youth, adult, full age continuum), scope of mandate (e.g., inclusion of addictions, problem gambling, disability, etc.), primary target audience (e.g., hospital, community, schools or cross-sectoral) and service model (e.g., centralized or distributed). Intermediaries also have different stated areas of investment and quite different EIPPs. They also varied in use of implementation or knowledge exchange models, theories or frameworks to guide their work.

In terms of similarities, three of the five intermediaries were around the same size (40 – 50 people), although PSSP was much larger (150 people) and SMH ASSIST was much smaller (13 people, if only the core team is included). All of the intermediaries also identified their respective government ministry as their primary funding source.

There was a high level of consistency in the mix of strategies employed by the intermediaries (Table 5), despite a qualitative difference in emphasis. For example, Te Pou placed a relatively high emphasis on training. The OCoECYMH had a strong emphasis on lived experience and family-targeted activities. The PSSP had the most well-developed synthesis and translation function. School Mental Health ASSIST had a strong emphasis on leadership development and capacity-building for mental health within school boards. Finally, Mission Mental Health placed a great deal of emphasis on consultation and technical assistance to respond to needs identified by the local authorities and regions, rather than supporting the use of particular EIPPs. Te Pou also had the most well-developed information management strategy, by having national responsibility for managing two data collection systems on behalf of the Ministry of Health.

Despite these differences in emphasis, there is remarkable similarity in implementation strategies employed by the intermediaries, particularly given the variation in their mandates, structures and organizational features. It is also notable that, of the 19 strategies identified from the literature, two were not used by any of the intermediaries. Specifically, none of the intermediaries used strategies that directly targeted the public (i.e., public awareness and education) or used audit and feedback as a delivery system strategy. This led us to question why this was the case and what explained the lack of use of particular implementation strategies.

Why do intermediaries avoid particular implementation strategies?

Our analysis using the 3I+E framework identifies five factors that explain why implementation strategies targeting the public and audit and feedback are not employed by the policy intermediaries. Interest-related factors include: 1) their need to build and maintain

healthy relationships with policy actors (public strategies); 2) their need to build and maintain healthy relationships with service delivery system actors (audit & feedback strategy); 3) role differentiation with other system actors (public strategies). Ideas-related factors include: 4) lack of 'fit' with the role of policy intermediaries (public and audit & feedback strategies); and Institution-related factors include: 5) resource limitations that preclude intensive distributed (program-level) work (audit & feedback strategy). See Table 6 for a summary of factors and illustrative quotes.

The first three of these factors fall under the Interest domain of the 3I+E framework. In particular, the role of these intermediaries necessarily means they must develop and manage effective relationships with other system actors and as such, they must be highly sensitized to actions that may have a compromising effect on these relationships. The power held by other system actors, and in particular policy actors in government and service delivery system actors, is exerted indirectly on the intermediaries (what Lukes calls the second dimension of power[46]), causing them to anticipate what strategies would or would not be considered acceptable to those in power and to avoid strategies that could be damaging to these relationships.

For government and policy actors, publicly targeted strategies can sometimes be viewed as supporting advocacy, and advocacy in turn can be perceived as directly pressuring the government to make changes. Because these policy intermediaries often depend on government in multiple ways (e.g., as a funding source, as an implementation partner, as a target of their activities, etc.), they identified a preference to remain as neutral as possible, being perceived as an 'honest broker' or a vehicle that enables implementation, rather than specifying what should be implemented. Thus, while the policy actors have not specifically

limited the implementation strategies of these intermediaries, these intermediaries have seemingly shaped their activities to avoid those public-facing strategies that could compromise their relationships with policy actors.

The 'honest broker' framing extends to the relationships that intermediaries cultivate with service delivery actors. In order to facilitate implementation, intermediaries must become what they termed a 'trusted source' of implementation support for organizations and individual professionals who deliver mental health services to citizens. To build this trust, they prefer implementation strategies that they perceived as facilitative rather than those that may be perceived as a performance monitoring or a 'watchdog' function. Audit and feedback was perceived by them as falling into the performance-monitoring category and thus, not a preferred strategy of these intermediaries. Interestingly, some of them still play a role in other performance monitoring strategies, by collecting data on behalf of the service delivery system. However, even when they are responsible for this strategy, their approach is focused on enabling the service delivery sector to use their own data for improvement, or to providing policy-makers with context for appropriate interpretation of the data and to avoid direct public reporting.

The lack of 'fit' of both public strategies and audit and feedback, falls under the Ideas element of the 3I+E framework. This relates to the normative assumptions held by intermediaries and their stakeholders about what policy-focused intermediaries 'should' be doing and where they are seen as adding value (and conversely, where they aren't). Finally, under the Institutional domain, past policies (including deinstitutionalization and decisions to offer mental health services across a continuously expanding range of service environments) makes the institutional landscape of mental health services in all three cases large in number

and complex for implementation efforts at scale. All of the intermediaries studied face capacity constraints related to time and money. The strategy of audit and feedback was identified as cost and time intensive when applied at the individual program level and the intermediaries in our study did not feel they could accomplish this strategy effectively with their existing resources and scope of activity.

Discussion

Our study sheds further light on policy intermediaries supporting the implementation of EIPPs across mental health systems. These findings help to advance the understanding of the factors that lead to the development of intermediaries in terms of the problems (e.g. negative events involving people with mental illness), policies (e.g. feedback on effectiveness of existing policies) and political events (e.g. changes in government) that are salient in each case. It also presents an in-depth description of the similarities and differences in intermediary structure, organization and use of implementation strategies (e.g. the wide range of structures and organizational mandates contrasting with the striking similarities in terms of implementation strategies employed). Finally, our study identified five factors that explain why these intermediaries do not use audit and feedback or strategies targeting the public in their work.

Strengths and limitations

This study contributes to the literature in two ways. First, our study answers the call made by Nilsen[47] and others to integrate the field of policy implementation with the field of implementation science. We did this by drawing on established theories from political science and through our focus on policy intermediaries. While we found that using these

theories was not always a perfect 'fit' with questions that relate to the implementation phase of the policy cycle, they were useful in generating unique insights that would not be available from implementation science. Specifically, the consideration of the infrastructure needed to support the implementation of a policy decision is one that often rests within the policy stream, only occasionally garnering the attention of politicians or becoming visible to the general public. In our study we used the Kingdon framework, which was originally designed to explain agenda-setting and how and why issues make their way to the governmental or decision agenda, to help clarify the factors that led to the development of such implementation infrastructure. We found however, that the most plentiful and persuasive evidence, related to the policies stream, and the two Ontario sub-cases that were established after the first, lacked the visibility usually created by the problems and politics streams. It is possible that once one intermediary is created in a system for a particular policy area, the concept of additional intermediary capacity is easier for policymakers to buy into based on the policy legacy established by the first. This may mean that the decisions to create the two more recent intermediaries were less 'visible' and political in nature and became more 'technical' and bureaucratic.

A second contribution is that our study focuses on policy intermediaries in three countries that each have their own unique health and social system arrangements, thereby expanding the literature beyond the USA, where the vast majority of the literature on policy intermediaries (particularly in mental health) is focused. Since our findings demonstrate the dynamic and responsive nature of intermediaries to the systems around them, the study of cases from different contexts contributes to a richer understanding of the phenomenon of intermediaries and their role in implementation.

The pre-existing relationship that one member of our research team (HB) had with the intermediaries and other system leaders was both a source of strength in this study and a potential limitation. First, these relationships enabled the IKT approach and likely contributed to the strong response and participation in all three cases. However, her familiarity with the individuals, and her previous role in Ontario and internationally may have influenced how stakeholders responded in the interviews. For example, there were several instances when participants referenced previous conversations or knowledge that HB had and she was sometimes referenced as an influential actor in the development of the intermediaries. Conversely, this familiarity and being established as credible and knowledgeable, may have also meant that participants were more forthcoming or were likely to delve into issues with greater detail than with an unknown interviewer.

We faced two key challenges with our research. The first was that there were no fluent Swedish speakers on the research team. This may have affected the choice of words and phrases participants used in the interviews, and also limited our ability to triangulate sources because many documents were not available in English. The second relates to conducting research in three constantly evolving systems. Since the data collection period, the research team has already noted some shifts in the intermediaries and their contexts, making it difficult to be both precise and "current" in our analysis. The ability to adapt and change is likely an important trait for intermediaries and can offset the inherent instability that has been identified as problematic in existing literature[21]; however it presents a moving target for researchers.

Implications for policy-makers and implementers

Policymakers and other actors seeking to implement EIPPs must consider the capacity needed to do it effectively. Our study identifies how intermediaries can be developed and harnessed to support implementation and offers a number of transferrable lessons to those in other jurisdictions. When looking to build implementation infrastructure, policymakers and implementers should make explicit choices in terms of design, with appropriate consideration of the political system context in addition to the health and social system context. They must also pay careful attention to the role of other actors in the system to ensure the intermediary(ies) add value and are optimized to work with those actors effectively. Furthermore, they should make active decisions about the implementation strategies they intend to employ and monitor their use and effectiveness. To date, much of the focus in implementation science has been at the intervention level, or on the implementation strategies and organizational contexts in which implementation occurs. We posit that it is equally important to consider the vehicles through which these strategies are delivered at scale in systems. Finally, there is no need to develop such infrastructure "from scratch". Beyond the relatively small number of studies such as this, there is an opportunity for jurisdictions to learn directly from each other through structured knowledge sharing opportunities (like the IIMHL or the Society for Implementation Research Collaboration's Intermediary Network of Excellence) or by developing informal connections with those in other jurisdictions. This should improve the efficiency and effectiveness of intermediaries by ensuring new organizations benefit from the knowledge and wisdom of those who have come before.

Areas for future research

Our study focused on a small number of intermediaries that best fit our definition, yet it was abundantly clear that the infrastructure needed for system-level implementation efforts is much more comprehensive. Many more organizations were engaged in mental health policy implementation efforts in these jurisdictions such as the health quality bodies in New Zealand and Canada and the public health agency in Sweden. Future studies could examine the full complement of infrastructure and how different systems differentiate the implementation strategies among actors. Furthermore, qualitative studies such as this can be a foundation from which to build quantitative research examining a larger number of intermediaries divided among the three sub-types (KT, practice and policy intermediaries). Such studies could explore whether and how the use of implementation strategies varies according to sub-type, and which strategies are most closely tied to intended outcomes.

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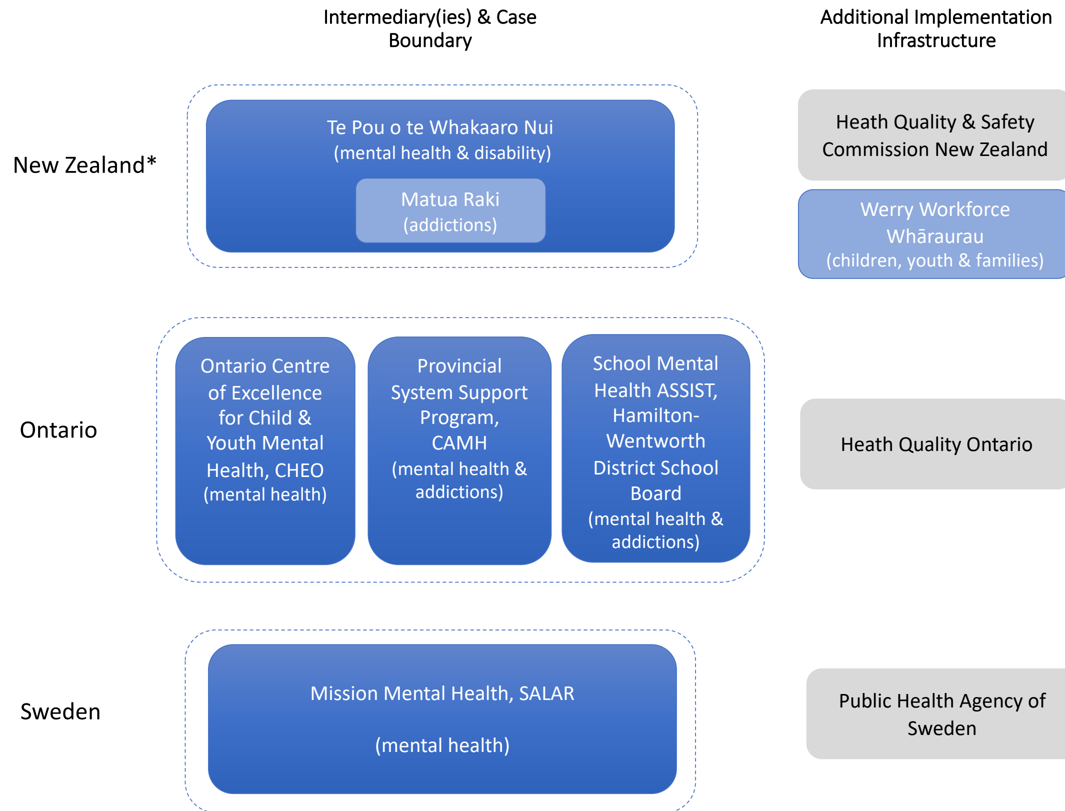
Figure 1 – Graphic depiction of implementation support infrastructure by case



*There are two other workforce development centres: Te Rau Matatini (Māori health) and Le Va (Pacifika) that are part of the mental health and addictions workforce infrastructure in New Zealand, but do not meet our definition of intermediary

Table 1 – Case selection criteria by jurisdiction

Jurisdiction	Level within jurisdiction	Jurisdiction type and population (2015)	Welfare state regime type[1]	Identified structure(s) for policy implementation	Used explicit implementation methods	Receptivity of local stakeholders[2] (1-3)	Similarity of system structure to Ontario	Notes
Australia	national	23.13 million	Liberal	✓*	✗	2	High	Most activity not at national level
	province/state (New South Wales)	7.54 million	Liberal	✓*	✗	2	High	Did not participate in interviews
Canada	province/state (Ontario)	13.6 million	Conservative	✓	✓	3	High	Have connections to stakeholders
	province/state (Saskatchewan)	1.13 million	Conservative	✓	✓	3	High	Mandate not renewed for I-Team
England	national	53.01 million	Liberal Subgroup	✗	✗	2	Med	No current structures with this focus
Ireland	national	4.60 million	Liberal Subgroup		✗	2	Med	Informal structures contracted for some work
New Zealand	national	4.47 million	Liberal Subgroup	✓	✓	3	Med	Clearly defined structure
Scotland	national	5.30 million	Liberal Subgroup	✓	✓	1	Med	No contact with system leaders
Sweden	national	9.59 million	Social Democratic	✓	✓	3	Med/Low	Clearly defined entity but re-structuring
USA	national	318.9 million	Liberal	✓	✓	2	Low	Mix of structures across system
	city (New York City)	8.55 million	Liberal	✓	✓	3	Low	New structures in place

* *structures to support system oversight in form of mental health commissions, but not identified in interview*
[1]Bambra[48] compares countries based on health care services and decommodification
[2] Receptivity Scale: 1 = no contact or low receptivity**;** 2 = some contact and some either some receptivity OR have not asked directly OR consent form indicates interest in being approached**;** 3 = frequent contact or have asked directly and received positive response

Table 2 – Timelines of events leading up to the establishment of the intermediaries for each case

Events and activities by case				
New Zealand Te Pou (est. 2006)	**Ontario, Canada**			**Sweden Mission Mental Health (est. 2008)**
	OCoECYMH (est. 2004)	**PSSP (est. 2011)**	**SMH Assist (est. 2011)**	
1990s. A number of 'dreadful events' involving people with mental illness	**1999.** Mental Health Implementation Task Forces initiated			**1994.** Government Bill 1993/94:218 – *Mentally Ill People's Conditions* identifies separation of care for mental health between counties & municipalities
1993. Dr Janice Wilson becomes Director of Mental Health in Ministry of Health	**1999.** *Making It Happen: Implementation plan for mental health reform* published by government			**Early 2000s**. Shift in technology and thinking fostered demand for new ways of thinking and doing things
1995. Judge Kenneth Mason leads national inquiry and publishes findings	**1999.** 2 provincial standard outcome measures announced for children & youth mental health services			**2003.** Murder of Anna Lindh, Swedish Foreign Minister and several other acts of violence involving people with mental illness
1996. Government passes Mental Health Act (1992) replacing Lunatics Act (1882)	**2000.** Ontario Health Services Restructuring Commission recommends reforms to mental health services (*Looking Back, Looking Forward, 2000*)			**2003.** National review of mental health led by Dr Ing-Marie Wieselgren and Anders Milton (2003 – 2006)
1997. Establishment of Mental Health Commission	**2002.** New premier looking to retain office			**2006.** Commission presents its final inquiry report to government, becoming an important knowledge base for future government activities
1998. Mental Health Commission publishes Blueprint 1	**2002.** *The Time is Now: Themes and recommendations for mental health reform in Ontario* Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs			**2006.** New government with focus on performance-based reimbursements Lyons/Alliance government, including appointment of Goran Hägglund as Minister of Health and Social Affairs

1999 – early 2000s. Government (through Treasury) willing to invest heavily in mental health	**2002.** 1st comprehensive epidemiological reports published on child & youth mental health in Canada *(Waddell, 2002; Health Canada 2002)*	**2007.** Swedish Association of Local Authorities & Regions (Sveriges Kommuner och Landsting) was created as a coordination body between national and regional/municipal levels of government
2001. Ministry of Health announces funding for 2 workforce development initiatives	**2003.** ON Auditor General's report identifies major concerns in children & youth mental health	**2007.** National government institutes new way of supporting mental health by contracting directly with local authorities and regions
2002. Ministry of Health publishes *Mental Health (Alcohol and Other Drugs) Workforce Development Framework*, acknowledging a more systemic approach to workforce development is required	**2003.** Government announces intention to create a centre of excellence for children's mental health at Children's Hospital of Eastern Ontario	**2008.** Government communication document 2008/09:185 – *A policy for people with mental illness or mental disability*
2002. Health Research Council begins to run adult mental health workforce programs	**2003.** Election & change in government	**2008. Mission Mental Health (Uppdrag Psykisk Hälsa) at SALAR is established**
2003. *Werry Centre for Child and Adolescent Mental Health launched by Minister of Health (Annette King) at University of Auckland*	**2004. The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO established**	
2003 - 2004. First national epidemiological survey/report on mental health and addictions *Te Rau Hinengaro – The New Zealand Mental Health Survey*	**2006.** Ministry of Children and Youth Services publishes *A shared responsibility: Ontario 's policy framework for child and youth mental health.*	
2005. Ministry of Health publishes the second mental health and addiction plan: *Te Tāhuhu: Looking forward, moving forward Improving mental health 2005 – 2010*	**2006.** Canadian senate committee publishes *Out of the Shadows at Last: Transforming mental health, mental illness and addiction services in Canada,* Kirby & Keon	
2005. Health Workforce Advisory Committee publishes *Strategic Principles for Workforce Development in New Zealand*	**2007.** Mental Health Commission of Canada is established	
2005. *Tauawhitia te Wero Embracing the Challenge* National mental health and addiction workforce development plan	**2009.** Minister's Advisory Group publishes *Every Door is the Right Door* discussion paper and 5 theme group papers	

2006–2009 is published by Ministry of Health		
2006. Ministry of Health publishes implementation plan for Te Tāhuhu: *Te Kōkiri - The mental health and addiction action plan 2006 - 2015*	**2009.** OCoECYMH contracts a policy-oriented paper on school-based mental health: *Taking Mental Health to School: A policy oriented paper on school-based mental health for Ontario* (authors include Kathy Short)	
2006. Te Pou o te Whakarro Nui is established	**2009.** Mental Health Commission of Canada releases *Toward Recovery and Well-Being: A framework for a mental health strategy for Canada* and prioritized child and youth mental health	
	2010. Minister's Advisory Group publishes *Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy* final report	
	2010. All-party committee submits final report *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians*	
	2010. Ministry of Education requests proposal from Kathy Short (for what later becomes SMH ASSIST)	
	2011. Government publishes *Open Minds, Healthy Minds, Ontario's 10-year mental health and addictions strategy*	
	2011. Provincial System Support Program at CAMH is established	
	2011. School Mental Health ASSIST at Hamilton-Wentworth District School Board is established	

Table 3 – Factors that influenced the decision to create intermediaries, drawing from Kingdon (1995)

Factors	**Description of factors that influenced decisions to create intermediaries by case and embedded case**				
	New Zealand **Te Pou (est. 2006)**	**Ontario, Canada**			**Sweden** **Mission Mental Health (est. 2008)**
		OCoECYMH (est. 2004)	**PSSP (est. 2011)**	**SMH Assist (est. 2011)**	
Problems stream	**Focusing Events** A number of 'dreadful' events involving people with mental illness happened with a lot of public attention in 1990s (KI-13) **Feedback About a Problem/Change in Indicator** First national epidemiological study conducted, that shed light on the full scale of the problem (mental health issues)	**Feedback About a Problem/Change in Indicator** Visibility about mental health increasing in general (internationally, nationally and provincially) and children and youth mental health in particular Federal Senator Michael Kirby labels children's mental health as the most neglected area of health care and dubs it '*the orphan of the orphan*' Government elites needed to be perceived as investing on the heels of hospital amalgamations, including changes to mental health services	**Feedback About a Problem/Change in Indicator** ***Government*** Receiving feedback through Select Committee on Mental Health and Addictions and other government activities that people were 'falling through the cracks' of systems when transitioning between them (e.g. from child and youth to adult services etc) ***CAMH*** New CEO looking to restructure the organization and was getting feedback to consider the provincial capacity that was available through policy	**Feedback About a Problem/Change in Indicator** Provincial government was receiving feedback from multiple directions that more needed to be done to support mental health of children and youth in schools e.g. Mental Health Commission of Canada issued RFP for work on school-based MH in 2008; efforts by OCoECYMH to increase visibility of issue	**Focusing Events** Murder of Anna Lindh, former Swedish Foreign Minister by individual thought to be mentally ill (2003) and several other incidents of harm by persons with mental illness profiled in media around the same time **Feedback About a Problem/Change in Indicator** Government Bill 1993/94:218 – *Mentally Ill People's Conditions* identified separation of care for mental health between counties & municipalities. This resulted in problems of coordination across

		ON Auditor General's Report 2003 identified many problems in child & youth mental health Key study (Waddell et al 2002) and key report (Health Canada 2002) identified scale and scope of child and youth mental health problems in Canada	legacies through the merger of 4 mental health and addictions facilities in Toronto and ensuring it was put to good use		organizations that left gaps in the system. Mental health viewed broadly (not just mental illness) – this view increased visibility of coordination problems across levels of government and sectors
Policy stream	A great deal of policy activity in decade before establishment, identifying the need for major system reforms, including an increasing focus on workforce development. Examples: -Mason Inquiry (1996) -*Blueprint 1* (Mental Health Commission, 1998) -*Mental Health (Alcohol and Other Drugs) Workforce Development Framework*, Ministry of Health, 1992)	Activity at the national level (e.g. consultations to develop *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (2006) Final Report of The Standing Senate Committee on Social Affairs, Science and Technology led by Senators Michael Kirby & Wilbert Joseph Leon and *Toward Recovery and Well-being* released by Mental Health Commission of Canada (2009)with a national consultation process that followed) and	Respect, Recovery, Resilience: *Recommendations for Ontario's Mental Health and Addictions Strategy* (2010) developed by the Minister's Advisory Group identified need to work across services & sectors. Direct proposal from CAMH to government repositioning some of its capacity as policy implementation support (2010/2011)	A process that brought policymakers together to support the development of the document: *Taking mental health to school: A policy-oriented paper on school-based mental health for Ontario* (Santor, Short, & Ferguson 2009) increased salience & acceptability of idea Policy documents began to identify schools as a key	Government strikes a *National Coordination of Mental Health Services* Commission led by Ing-Marie Wieselgren and Anders Milton Policy documents identified a need for better coordination across actors and levels of government Policy decision by national government made to contract differently with local authorities and regions for mental health services through direct agreements

	-*Te Tāhuhu: Looking forward, moving forward Improving mental health 2005* – 2010 (Ministry of Health, 2005) *Strategic Principles for Workforce Development in New Zealand* (Health Workforce Advisory Committee, 2005)	provincially (e.g. *Ontario Auditor General's report* (1993) increased visibility of the need for changes to the child and youth mental health sector. 'Centres of Excellence' as a policy concept was attractive across different policy areas (KI-47)	Ministry of Health & Long-Term Care was looking for implementation partners to support their initiatives in the upcoming 10-year mental health strategy, *Open Minds, Healthy Minds* (2011)	location to support early identification/ intervention and school graduation rates as key outcome K. Short already running technical assistance centre in HWDSB (government saw idea had credibility and could be scaled) MED sought proposal from Short	
Politics stream	**Swing in national mood** Increasing visibility of the issue and decrease in stigma created widespread support for investments in mental health **Changes in the balance of organized forces** Formation of Mental Health Commission	**Changes in the balance of organized forces** Hospital amalgamations in early 2000s caused an even greater need for strong community services The striking of mental health implementation task forces engaged stakeholders in solution-finding	**Events within government** Striking of All-Party Committee Needed to find partner(s) to support implementation of key policy initiative on transitions between services and sectors Fit – CAMH already had capacity and	**Events within government** Striking of All-Party Committee & MAG who were taking a broader perspective on mental health including more focus on prevention/ promotion and early intervention	**Swing in national mood** Increased visibility of the issue due to publicity related to Anna Lindh and aided by advances in information technology **Changes in the balance of organized forces** Creation of Swedish Association of Local Authorities & Regions

	Events within government Treasury willing to make investments in mental health "And, in part, because the money was flowing. The money was really flowing at that point, so we could afford to build infrastructure." Hired Dr Janice Wilson as Director of Mental Health	**Events within government** Government was not polling well and looking to hold power prior to next election through investments after years of cutbacks. This was unsuccessful and the government changed in 2003 but the idea of a Centre of Excellence remained relevant. Lack of opposition to investments in children's mental health (clear 'win' and concept of "centre of excellence" was politically palatable)	could get up and running quickly	Congruent with provincial mood Needed to be seen as doing something regarding mental health in schools	SALAR (Sveriges Kommuner och Landsting) as a coordination body between local/regional levels and national government provided natural 'home' for an intermediary **Events within government** Health and Social Care minister who was willing to invest and believed that while you can't win an election based on mental health as a policy issue, you can lose one (KI-16)
Participant s	**Policy entrepreneur** Dr Janice Wilson, psychiatrist and first Director of Mental Health for NZ government **Other visible participants** Judge Kenneth Mason (led 2 inquiries)	**Policy entrepreneurs** Dr Simon Davidson, prominent child psychiatrist who was an expert advisor to government on hospital amalgamations related to children's services and considered an innovator in the field Peggy Taillon, key figure in mental health implementation task	**Visible participants** Dr Bob Bell, Deputy Minister of Health Dr Catherine Zahn, President and CEO of CAMH **Hidden participants** Susan Paetkau, MOHLTC Director - key decision maker in appointing PSSP lead for service	**Visible participants** Dr Kathy Short, school psychologist, and now lead of SMH ASSIST Dr Bruce Ferguson, psychologist, member of the MAG and expert advisor to government	**Policy entrepreneur** Dr Ing-Marie Wieselgren, psychiatrist and co-lead of national inquiry. Then became first chief executive for Mission Mental Health **Other visible participants** Dr Anders Milton - prominent physician and co-lead of national inquiry

	Barbara Disley (first Mental Health Commissioner)	force work and advisor to government on this and other health reforms, suggested a "centre of excellence" to government officials (KI-47) **Hidden participants** Dr Ian Manion, CPsyc who became co-executive director of the OCoECYMH Peter Finkle, Regional Director, MOHLTC	collaboratives initiative Susan Pigott, VP at CAMH - reporting line for PSSP and liaison with MOHLTC Dr Nick Kates, physician & member of MAG, originally developed service collaboratives concept	**Hidden participants** Barry Finlay, MED Director – key decision maker John Malloy – Director of Education, Hamilton-Wentworth District School Board	Goran Hägglund - Minister for Health and Social Affairs who understood the political value of the mental health agenda **Hidden participants** Karin Johansson, state secretary, Ministry of Health and Social affairs

Table 4 – Structure and organizational characteristics of intermediaries

	Intermediary				
	Te Pou o te Whakarro Nui (including Matua Raki)	**Ontario Centre of Excellence for Child and Youth Mental Health**	**Provincial System Support Program**	**School Mental Health Assist**	**Mission Mental Health**
Country	New Zealand	Ontario, Canada			Sweden
Setting	Non-governmental organization (Wise Group)	Service delivery organization (Children's Hospital of Eastern Ontario, CHEO)	Service delivery organization (Centre for Addiction and Mental Health, CAMH)	Service delivery organization (Hamilton-Wentworth District School Board)	Peak organization (Swedish Association of Local Authorities and Regions, SALAR)
High-level description	National centre of evidence-based workforce development for the mental health, addiction and disability sectors in New Zealand	Drive high-quality child and youth mental health services by setting the bar for excellence and collaborating with others to pursue continuous quality improvement	Works with communities, service providers and other partners across Ontario to move evidence to action to create sustainable, system-level change	Provincial implementation support team designed to help Ontario school boards to promote student mental health and well-being using evidence-based approaches	Team developed to encourage the improvement and enhancement of mental health services operations and contribute to increased accessibility and equality of the system
• **Focus**	Adults and older adults	Children & youth	Youth, adults & older adults	School-aged children & youth	Full age continuum
• **Boundaries of mandate**	Mental health, addictions and disability	Mental health	Mental health and addictions (including problem gambling)	Mental health and addictions	Mental health
• **Primary target audience**	Mental health and addictions workforce (focus on District Health Boards)	Child & youth serving community mental health agencies funded by MCYS	Organizations serving people with mental health and/or addictions problems across sectors	School boards	Cross-sectoral regional and local authorities working with mental health in

					social care, education and health care
Governance structure	Board of Directors	CHEO's Board of Trustees	CAMH's Board of Trustees	Hamilton Wentworth District School Board of Trustees. Reports directly to Director of Education	SALAR's Board (who report to a congress of politically elected officials) & different political committees
Advisory structure(s)	Clinical Sector Reference Group (27 members, including people with lived experience, family/ whanau, service sector leaders, and researchers)	Strategic Advisory Council (12 members, including youth, parents/family members and organizational leaders)	Project-specific advisory structures (e.g., EENet persons with lived experience & family panel, provincial collaborative advisory group)	No formal ongoing advisory structure. With co-creation model, regularly receive input from a range of stakeholders	SALAR steering group comprised of internal and external stakeholders
Main funding source	National government: NZ Ministry of Health (Health Workforce NZ)	Provincial government: Ontario Ministry of Children & Youth Services* (mi)	Provincial government: Ontario Ministry of Health and Long-Term Care	Provincial government: Ontario Ministry of Education	National government: Swedish Ministry of Health and Social Affairs
Annual budget (approx.)**	$17.5 million NZD	$5.9 million CAD	$19 million CAD	$2.2 million CAD (does not include funding for mental health leaders)	60 million SEK/5.7 million EUR
Service model	Distributed (travel as needed, particularly to South Island)	Centralized (travel as needed to other locations)	Highly distributed (less travel required based on number of regional offices)	Highly distributed (coaches located across province; mental health leaders in each school board)	Centralized (travel as needed to other locations)
# Offices & locations	3 offices (Auckland, Hamilton & Wellington)	1 office (Ottawa)	10 offices (Barrie, Hamilton, Kenora, Kingston, London,	1 office (Hamilton)	1 office (Stockholm)

			Ottawa, Sudbury, Thunder Bay, Toronto Central & Toronto Regional)		
Size (approx.)	43 people	50 people	150 people	13 people supporting 72 mental health leaders in schools	40 people
Stated goal(s)	To improve the workforce performance of mental health, addiction and disability services	Working to strengthen Ontario's mental health programs and services for all children, youth, families and caregivers	Transforming mental health and addictions systems to improve the lives of Ontarians	Enhance quality and coherence in mental health promotion and prevention programming in schools	Create conditions for a sustainable mental health system by encouraging the improvement and enhancement of services and supports, and increasing accessibility and equality
Investment areas	1. Practice & leadership 2. Information & outcomes 3. Training & development 4. Workforce planning	1. Support evidence-based practice & knowledge in use 2. Maximize capacity in training, research & evaluation 3. Collaborate with stakeholders	1. Knowledge exchange 2. Implementation 3. Information management 4. Health equity & engagement 5. Evaluation	1. Leadership & guidance 2. Implementation coaching 3. Tailored resources 4. Community of practice	1. Coordinate local improvement work 2. Analysis & implementation of local and regional conditions 3. Support development of data collection template for reporting of data and action plans

Recent EIPP foci	• Reducing the use of seclusion & restraints • Increasing the use of talking therapies • Service user, consumer and peer workforce capacity building • Addressing co-existing mental health and addiction problems • Improving the physical health of people experiencing mental health or addiction problems	• Enhancing family engagement in services • Enhancing youth engagement in services • Improving service quality and performance • Promoting community-based suicide prevention and life promotion through coaching • Coordinating a Lead Agency Community of Practice	• Developing service collaboratives to supports transitions of people across services and sectors • Implementing Ontario Perception of Care Mental Health and Addictions tool • Implementing Staged Screening and Assessment protocol • Supporting knowledge exchange for Early Psychosis Intervention Ontario Network • Developing an Opioid Resource Hub	• Enhancing the organizational conditions for mental health in schools • Improving mental health literacy for educators • Addressing tragic events in schools • Decision support for school boards for mental health programming selection • Life promotion and suicide prevention	• Mental health for asylum seekers and new arrivals • Supporting the implementation of social investment • Workplace mental health • Creation of a multi-region infrastructure for knowledge sharing and improvement • Mental health in schools
Use of knowledge exchange and/or implementation theory to underpin work	No • Does not draw for any theory in particular but will integrate concepts as deemed appropriate (e.g., PDSA cycles)	Somewhat • Concept of co-production used in youth and family engagement work • Created toolkits for sector on knowledge mobilization and	Yes • Network theory (EENet) • NIRN's Active Implementation Frameworks	Yes • Co-production • NIRN's Active Implementation Frameworks	No • Does not draw for any theory in particular but will integrate concepts as deemed appropriate (e.g., IHI's model for improvement)

		implementation based on theory			

[*]In 2018 the Ontario government dissolved the Ministry of Children & Youth Services. Responsibility for this portfolio now rests with the Ministry of Health and Long-Term Care

[**] In many cases, the intermediary acts as a flow through for funds to others in the system. The full annual budget is not necessarily retained and used directly by the intermediary

Table 5 – Implementation strategies used by intermediaries by target and by case

Target	Implementation Strategy	Powell et al (2012) Typology	Use of Strategy by Case				
			New Zealand	Ontario			Sweden
			Te Pou & Matua Raki	Ontario Centre of Excellence for Child and Youth Mental Health	Provincial System Support Program	School Mental Health Assist	Mission Mental Health
Synthesis and Translation System	Developing and disseminating products and tools to support the use evidence in policy/practice	Educate strategy – develop materials (develop effective educational materials) – educate (distribute materials)	✓	✓	✓	✓	✓
	Conducting research and/or contracting with researchers/ research organizations	Plan strategy – develop relationships (develop academic partnerships) Quality management strategy – use data experts – capture and share local knowledge	✓	✓	✓	✓	✓
	Bringing exemplars of best practice/ evidence from other provinces or countries	Educate strategy – develop materials – educate – educate through peers	✓	✓	✓	✓	✓

	Supporting capacity development for knowledge exchange/ implementation	Plan strategy – build buy-in (identify and prepare champions; involve patients/consumers and family members) Educate strategy – develop materials (related to knowledge exchange/ implementation)	✓	✓	✓	✓	✓
Delivery System	Training	Educate strategy – educate (develop educational meetings; conduct ongoing training; make training dynamic)	✓	✓	✓	✓	✓
	Consultation and technical assistance	Educate strategy – educate (provide ongoing consultation) Quality management strategy – centralize technical assistance	✓* limited	✓	✓	✓	✓
	Quality assurance/quality improvement	Quality management strategy – develop and organize quality monitoring systems – develop tools for quality monitoring	✓	✓	✓	x	✓
	Leadership development/ capacity-building	Plan strategy – initiate leadership (recruit, designate or train for leadership)	✓	✓* limited	x	✓	✓* Goal, but no direct program
	Audit and provide feedback	Quality management strategy	x	x	x	x	x

		– audit and provide feedback					
Other Support System	Developing partnerships (with other intermediaries or support system infrastructure)	Plan strategy – develop relationships (build coalitions)	✓	✓	✓	✓	✓
	Undertaking collective action amongst support system infrastructure related to implementation	N/A	✓	✓	✓	✓	✓
Policy System	Formal advice/policy input	N/A	✓	✓	✓	✓	✓
	Informal linkage & exchange with policymakers	N/A	✓	✓	✓	✓	✓
	Bringing forward new policy ideas/system improvements	N/A	✓	✓	✓	✓	✓
	Providing feedback to government on implementation activities/barriers/ challenges	N/A	✓	✓	✓	✓	✓
Public	Public awareness/ education	Educate strategy – inform and influence stakeholders (use mass media)	x	x	x	x	x
Lived experience & family	Engaging PWLE and families in activities of intermediary	Plan strategy – build buy-in	✓	✓	✓	x	✓* via partner

	Developing tools/resources/ training for PWLE and families	Educate strategy – develop materials (develop effective educational materials) – inform and influence stakeholders (prepare patients/ consumers to be active participants)	✓	✓	✓	✓	x
Performance assessment/ System-monitoring	Hosts data collection system(s)	Quality management strategy – develop and organize quality monitoring systems – use data warehousing techniques – use data experts – capture and share local knowledge	✓	x	✓	✓	x

Table 6 – Interest-, ideational- and institutional-related factors that explain the avoidance of particular implementation strategies

Factor	Sub-factor	Strategy avoided	Illustrative quotes
Interests	Need to build and maintain healthy relationships with policy actors	Public	*"We don't rush into that space because a lot of the open dialogue in the media is misconstrued and very risky. We prefer to influence those people who might be interviewed by reporters, and on occasions, even advise the media on how to provide a story that is more balanced."* KI-1
	Need to build and maintain healthy relationships with service delivery system actors	Audit & feedback	*"Reluctantly, because that's the bad cop zone. Once we start acting as an enforcement body, it will damage relationships."* KI-1 *"No, but it's right because that will usually be seen as something that the inspectorate would do in different kinds of ways… But we would never go in and say, well, you're underperforming, there's no, absolutely no credibility, and if we do that, we'll be gone like this."* KI-15
	Role differentiation with other system actors	Public	*"Public awareness and education sits with an organization called Health Promotion Agency which used to be a part of the Ministry of Health and got sent out on its own little island a little while ago. They are the people that would do the Like Minds campaign, the John Kirwan campaign around depression, some of the national roll-outs and public awareness campaigns. And that's very fragmented, again, about public awareness."* KI-12
Ideas	Lack of 'fit' with the role of policy intermediaries	Public + audit & feedback	*"Yeah. I would say we try to be the Geneva, so keeping peace and keeping neutral is really important, and you can't get trust without that. So, we say that we work with everybody, and part of our bottom line is, where strong relationships exist, anything is possible."* KI-2 *"It's [strategies targeting the public] not our mandate. It happens. That's part of the challenge with our program is that we have a mandate and then we have some things that are on the periphery of our mandate, but a) we're filling a gap, we're being asked to do it by a funder or an important leader, like [name of leader], and to just say, well, that's outside of our mandate, feels a little bit artificial. Also, sometimes we're being asked because we're [host organization]. So, for [name of leader], that's an example of being able to stamp something … [host organization] gives it credibility from a content perspective."* KI-26
Institutions	Resource limitations that preclude intensive	Audit & feedback	*"And then we get lots of requests to do things, but really, we don't have the funding to do that. We try to accommodate them within the projects that we've got or descriptions or aims that we've got, but we can't do sort of the spoke training. And we get asked to do reviews a lot, and we don't engage in*

	distributed (program-level) work		*reviews because … there was a request that came centrally this week. But because we play a support role, being involved in service reviews ruins our relationship with the sector.*" KI-3

Appendix 1 – Interview guide for stakeholder interviews

The role of implementation in mental health systems improvement: Study 2 - an examination of current implementation efforts

Ethical considerations:
A description of the study will have been presented during the recruitment phase. A signed confirmation of commitment to participate will be obtained prior to engaging in the questions. Any ethical issues arising will be addressed prior to the first question and will be documented by the Interviewer.

Process:
Interviews will be recorded on a digital audio device or computer, transcribed, and uploaded into a qualitative software program. Hand written notes will also be made by the interviewer into her field notebook.

Date:
Time:
Place:
Interviewer:
Interviewee:
Position of Interviewee:

Questions

Do you have any questions for me before proceeding to the interview?

Before we start, I wanted to mention that we will be using the term "mental health" to refer to fields of "mental illness", "addictions", "behavioural health" and "health promotion and prevention of mental illnesses and/or addictions" inclusively. It also refers to the health of individuals across the lifespan, not just at particular life stages. Feel free to point out particular or unique features of any of these depending on how your system is arranged, if you feel they are relevant.

A – Current Mental Health Policy Priorities

- Can you tell me a little bit about the current policy priorities in [your jurisdiction] that are being implemented? (top 2-4)

B - Structures Supporting Implementation of Mental Health Priorities (Support System & Synthesis & Translation System)

- I understand from the previous phase of my study that [organization or program] has a role in supporting the implementation of some of the mental health strategic directions/policies/ targets. Can you tell me a little more about them?

- Who do they provide these activities to? (recipients)
- Do organizations/programs/people from communities voluntarily come to [organization/program] to access implementation supports or does [organization/program] proactively approach the organizations/programs/people in the community? (push vs pull)
- How are they perceived by other organizations/programs/people in your system?
- Are there other organizations or programs that also play a role supporting the implementation of mental health priorities?

C – Delivery methods and approaches to change being utilized

- What types of activities does [organization/program] engage in?
- Are the activities targeted at the organizational level, the provider level or the consumer/patient level?
- What is the frequency with which they provide these activities?
- Are the people who deliver these activities from [organization/program] located in the communities in which they are delivered? If not, where are they from? (central vs regional)
- Are there any particular over-arching methods or approaches the [organization or program] utilizes?

D – Value, Challenges & Outcomes

- Do you have a sense of what the strengths of this structure and methods might be?
- In your opinion, is [organization or program] valued by the system?
    - Who in the system values them?
    - Why?
- What are some of the barriers or challenges that are faced in this work?
- Is [organization/program] able to help achieve the identified policy goals?
- Are there evaluation or outcome data available?

E – Factors Shaping Implementation Structure(s)

- What health and mental health system characteristics helped shape your implementation structure(s) and methods?
- What political and policy features may have played a role in shaping your implementation structure(s) and methods?
- Were there any particular actors who played a key role in shaping the implementation structure(s) and methods? If so, who? And how?

Request documents, presentations or other items that might address any of the topics discussed

Chapter 5. Preface

In order to achieve the goal of mental health for all citizens, governments are increasingly realizing that policies must go beyond the health sector and include areas such as child welfare, education, justice, workplaces, among others. This chapter explores how the government of Ontario, Canada took such an approach in the development and implementation of *Open Minds, Healthy Minds, Ontario's 10-year Mental Health and Addictions Strategy* (the *Strategy*). It identifies three features that set this policy process apart from previous efforts, suggesting there is reason for optimism that the approach of the *Strategy* has increased the prospects for the transformation of Ontario's mental health and addictions system. The use of policy analysis to follow a policy cycle through two phases (policy development and implementation) is a unique scholarly contribution. Our findings are useful to governments looking for ways to work cross-sectorally to achieve goals in areas where the problems are complex and multi-faceted and require the mobilization of different sectors to achieve outcomes for citizens.

The manuscript presented in this chapter has been published in the journal *Healthcare Policy*. What is presented here is the pre-publication version and is printed with permission from the journal. The full citation is:

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I was responsible for conceiving of the focus and design of the study and for completing all data collection, analysis and interpretation. I also drafted the manuscript. Dr Julia Abelson

contributed to the analysis and refinement of the manuscript. We are both authors on the paper.

Using Table 2 from the Introduction as a guide (see excerpt below), this study is the fourth of the five included as part of my dissertation. This study provides a detailed analysis of the *Strategy* and hence acts as the foundation for Chapter 6. The goals of this research are: 1) to describe the activities and approaches taken by the government, citizens and other stakeholders in the development and implementation of the *Strategy*, and 2) to use analytic frameworks to explain how these actions could lead to transformational change.

Chapter	Study Objective	Design (and select methods)	Outputs/ Contributions	Links
5.	To analyze the formulation and implementation of the policy: *Open Minds, Healthy Minds, Ontario's Comprehensive Mental Health and Addictions Strategy* guided by the question of whether there is something in particular about this policy process that increases the prospects of it leading to transformative change. ***Descriptive + explanatory goals***	Qualitative policy analysis using interpretive description • Analysis of key documents of the policy process, drawing on policy network and horizontal governance theory • Focus on a) describing the policy process, and b) identifying key features distinguishing it from past policy efforts	1. Further insights into the policy that has been the backdrop for much of the activity in the mental health and addictions system in Ontario for the past decade 2. Identification of features that set the policy process apart from previous reform efforts	Background underpinning Chapter 6

A fresh approach to reform? A policy analysis of the development and implementation of Ontario's mental health and addictions strategy

Authors: Bullock HL, Abelson, J

Keywords: mental health, addictions, policy development, implementation, network, governance, policy analysis

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ABSTRACT

Open Minds, Healthy Minds, Ontario's Comprehensive Mental Health and Addictions Strategy (2011) commits to the transformation of mental health and addictions services for all Ontarians. We analyzed the formulation and implementation of this *Strategy* to address the question: What are the prospects for transformative change in Ontario's current approach to mental health and addictions? **Methods**: Qualitative policy analysis using interpretive description of key documents of the policy process, drawing on policy network and horizontal governance theory. **Results:** Three features set this policy process apart from previous reform efforts: 1) expansion of the actors and policy network to those outside of health, 2) extension of the policy network approach into the *Strategy*'s implementation stage, and 3) the combined presence of political and policy leadership. **Conclusions:** There is reason for optimism that the approach of the *Strategy* has increased the prospects for the transformation of Ontario's mental health and addictions system.

BACKGROUND

Ontario has had a long and challenging history of addressing its populations' mental health and addictions problems. The move towards deinstitutionalization beginning in the 1960s and continuing for over 40 years (Hartford et al. 2003) has increased governments' and communities' awareness of the need to address these problems. However, the provincial government has been slow to respond to this shift, leaving communities poorly resourced and with a community-based mental health system that is fragmented and difficult to navigate (Hartford et al. 2003; Mulvale et al. 2007).

Several authors have examined this lack of progress by analyzing reform efforts and various commissioned reports, task force documents and provincial government policies. Notably, Wiktorowicz (2005) sought to understand why the shift to a community-based system in Ontario has not kept pace with institutional downsizing, with particular focus on the years 2000–2004. Their analysis found that a lack of political will to reallocate funds to the community and to delegate control for them was the largest barrier to reform. Additional challenges identified were arm's-length and internal government policy processes with varying degrees of authority, a lack of consistent engagement with the policy community and the complexity of intersectoral coordination. Mulvale and colleagues (2007) also identified challenges to reform in their analysis of the role of legacies produced by psychiatric hospital policies stemming from the introduction of psychiatric hospitals in the 1850s and public health insurance in the 1960s.

While some incremental gains have been achieved in terms of investments in community mental health and addictions services since that time, programs still lack capacity to serve all those in need and clients still lack access to a broad range of supports and

services (SEEI Coordinating Centre 2009). This may be partly attributable to insufficient funding levels. In 2013–2014, there was an estimated $3.5-billion direct investment from the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Child and Youth Services (MCYS) as well as investments from other sectors such as education, justice and housing (Brien et al. 2015). This investment equates to approximately 6.5% of Ontario's health budget, markedly lower than many other countries and lower than the 9% target in *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (MHCC 2012).

In 2008, the Ontario government once again embarked on a reform process targeting mental health and addictions, this time with the goal of developing a 10-year mental health and addictions strategy. *Open Minds, Healthy Minds, Ontario's Comprehensive Mental Health and Addictions Strategy* (the Strategy) was released in June 2011 (Government of Ontario 2011). The Strategy commits to the "transformation" of mental health and addiction services for all Ontarians. It includes four goals: (1) improve mental health and well-being for all Ontarians; (2) create healthy, resilient, inclusive communities; (3) identify mental health and addictions problems early and intervene; and (4) provide timely, high-quality, integrated, person-directed health and other human services. It has been seven years since the release of the Strategy, so it seems reasonable to take stock of whether Ontario is any further along in realizing the transformation it promised and to assess whether this attempt at reform has been any different from the "frustrated" attempts of the past.

This paper traces the formulation and implementation of the Strategy guided by the question of whether there is something specific about this policy process that increases its prospects for leading to transformative change. We approach this research with two specific

objectives in mind: (1) to describe the policy process; and (2) to identify key features that distinguish it from past policy efforts in this area. We draw on relevant policy theory to advance our core argument in the paper that the current Strategy has reasonable prospects for achieving its goals because of the approaches taken for its development and implementation.

METHODS

We undertook a qualitative policy analysis using interpretive description (Thorne et al. 2004), which allows the researcher, through reflexive and critical examination, to extend the descriptive account to one that is also explanatory (Thorne 2016). In this case, interpretive description was particularly useful because it allowed us to critically examine a wide range of documents to create a descriptive account of the policy process, which we then interpreted through the lens of our research question and the theory we drew upon for our analysis.

Conceptual frameworks

We used two recognized theories from the political science field to guide our analysis: (1) policy networks; and (2) horizontal governance. These theories were selected based on a preliminary review of the Strategy and selected policy documents that suggested differences in the size and scale of engagement in both the development and implementation phases of the Strategy. When compared to previous reform efforts, the Strategy gave greater emphasis to the broad and inclusive engagement of stakeholders within and across sectors, as well as

across government ministries. It also extended this engagement beyond the policy formulation stage and into the implementation stage. Recognizing these differences, we hypothesized that two key structural features in the Strategy – the mobilization of policy networks and the horizontal coordination of public policies – might increase the prospects for the Strategy to lead to more transformative change of Ontario's mental health system.

Policy networks

Policy networks can be simply described as the links that join state and societal actors together in a policy process (Katzenstein 1977). According to Kenis and Schneider (1991), policy networks can "be understood as those webs of relatively stable and ongoing relationships which mobilize dispersed resources so that collective (or parallel) action can be orchestrated towards the solution of a common policy problem" (p. 36). These networks vary according to the number of members and whether the state or the societal actors are perceived as dominant (Howlett and Ramesh 1998). Interest in policy networks continues to grow in part because it reflects important shifts in our forms of governance based on societal changes, including increases in the complexity of society and government, the emerging importance of information and technologies and a better understanding that policy objectives often require implementation support from non-government actors (Pal 2014). For most healthcare issues, a policy network of actors in government and society already exists, but network activation to realize policy goals is more haphazard. The draw of a network approach, Pal suggests, is the thinking that the wider the networks and the more competition among actors, the better the policy outcomes.

Horizontal governance

Horizontal coordination of public policies (or horizontal governance) refers to efforts made

within government to coordinate across existing bureaucratic boundaries to solve problems that span bureaucratic jurisdictions. As Pal (2014) notes, horizontal governance is not new in the sense that it has traditionally occurred at high levels of government such as cabinet. However, he points to a growing interest in horizontality extending to all levels of the government bureaucracy and an increased expectation that departments work together. Hopkins and colleagues (2001) identify the key dimensions of horizontal management as: mobilizing teams and networks, developing shared frameworks, building supportive structures and maintaining momentum. There is some conceptual overlap between the horizontal governance and policy network literatures; however, for the purposes of this study, the former will refer to actors and interactions within government structures and the latter will refer to actors and interactions across government and societal boundaries. Both of these approaches have been described elsewhere in varying forms as either "joined-up government" or "whole-of-government" approaches (Christensen and Laegreid 2007; Davies 2009; Hunt 2005).

Data sources

We searched for publicly available documents using the search engine Google and academic documents using PubMed, EBSCOhost and Google Scholar using the key words: mental health, addictions, "Open Minds Healthy Minds," "mental health addictions strategy Ontario," "minister's advisory group," "select committee" and "every door is the right door," in various combinations to identify publicly available documents related to the Strategy. We also reviewed the websites of the Ontario government and key organized interests across sectors, including mental health and addictions (such as Children's Mental

Health Ontario), health (such as the Ontario Medical Association), education (such as the Ontario Public School Boards' Association), justice (such as the Ontario Association of Chiefs of Police) and child welfare (such as the Ontario Association of Children's Aid Societies), and we searched the Canadian Newswire for press releases from organized interests. All searches covered the period from 2009 (two years prior to the release of the Strategy) to 2016 (five years after the release of the Strategy). These sources were supplemented with additional documents from the authors' personal files.

The search resulted in 43 documents that included: (1) publicly available government documents and presentations by government officials on the Strategy and related policy formulation and implementation activities; (2) hearing transcripts from the Select Committee on Mental Health and Addictions; (3) academic articles focused on the policy process or outcomes; (4) Canadian Newswire press releases from organized interests; and (5) reports from the Mental Health and Addictions Leadership Advisory Council.

Analysis

To describe the policy process, documents were read in their entirety, sorted and classified as either being related to policy formulation or implementation. A timeline was created to identify key activities and documents according to policy stage (Figure 1). The documents were then analyzed with the goal of identifying key features drawing from relevant theory and using the analytic procedures of interpretive description (Thorne 2016).

RESULTS

Description of the policy process

Policy formulation

We identified three key government actions taken to inform the Strategy development that illustrate a policy network and horizontal governance approach to policy formulation: (1) the appointment of an all-political-party Select Committee; (2) the convening of a group of stakeholders to advise the Minister of Health on strategy development; and (3) the striking of an interministerial working group at the assistant deputy minister (ADM) level across multiple government ministries.

In February 2009, the legislative appointment of an all-party Select Committee on Mental Health and Addictions (Select Committee) to develop a comprehensive mental health and addictions strategy, in structure alone, improved the likelihood that the resulting strategy would be acceptable to and supported by each of the parties in the event of a change in political leadership at the provincial level. The Select Committee began its work in 2009 with three main goals: (1) to determine the mental health and addiction needs of children and young adults, First Nations, Inuit and Metis peoples and seniors; (2) to explore innovative approaches to delivering services in the community; and (3) to identify ways to leverage existing opportunities and initiatives within the current mental health and addictions system (Ontario Legislative Assembly 2010a). The committee held a series of 30 public hearings, toured sites and accepted written submissions from a wide array of organized interests and members of the public. In total, over 230 witnesses presented to the committee providing diverse perspectives from the health and mental health sectors, as well as education, human rights, justice, housing and social care. In addition, 300 written

submissions were received. The Select Committee submitted an interim report to the Legislative Assembly of Ontario in 2010 (Ontario Legislative Assembly 2010b) followed by a final report outlining recommendations to the Government in advance of the Strategy six months later (Ontario Legislative Assembly 2010a). While a committee of elected officials alone could be considered an authoritative policy instrument, the committee's engagement with such a broad range of actors demonstrates the additional efforts taken to engage the policy or "issue" network (Mulvale et al. 2014) in the formulation of a policy direction.

The *second action* involved the identification and convening of a Minister's Advisory Group (MAG) in 2008, to provide overall direction and priorities for the Strategy. The MAG comprised stakeholders outside of government, representing a range of individual and organized interests including researchers, service providers, professional associations, consumer groups, the Mental Health Commission of Canada, social development organizations and immigrant services (Government of Ontario 2009). The MAG consulted over 100 Ontarians, held workshops, commissioned five background or "theme group" papers on different topics and then created a discussion paper *Every Door is the Right Door*, which presented a framework for the proposed strategy (Government of Ontario 2009). Shortly after the discussion paper's release, the Minister of Health and the MAG held a summit, inviting over 1,000 consumers and experts from across Ontario to contribute to the discussion paper. Additional feedback was solicited following the summit through round-table consultations and written submissions. The MAG's final task was to develop recommendations for Ontario's mental health and addictions strategy, which were presented in a 2010 report (Minister's Advisory Group on Mental Health and Addictions 2010). This action put actors with varying interests in a position of power and responsibility in the

formulation of policy. It allowed the government access to a wide array of ideas, including research evidence, tacit knowledge of practitioners and stakeholder values.

The *third action* was the creation of an interministerial assistant deputy ministers (ADMs) group, which reflects a horizontal governance approach to policy making. Comprising 14 different ministry ADMs, this group was tasked with identifying and streamlining services, policies and initiatives that address mental health to foster coordination (Government of Ontario 2009). They were also tasked with including mental health as a standing item on existing interministerial meeting agendas.

All told, the policy formulation process took place over almost three years, culminating with the release of the Strategy in June 2011 (Government of Ontario 2011). The scale and scope of this process reflect a deliberate and concerted effort at engaging and mobilizing a very broad policy network for the purposes of policy formulation.

Policy implementation

We identified five features of the implementation plan and its subsequent roll-out that illustrate the government's persistence in extending the policy network and horizontal governance approach into the policy implementation process: (1) the dispersion of leadership and accountability for Strategy initiatives across government ministries beyond health; (2) the development of a range of interministerial approaches for ongoing collaboration and coordination across the government ministries; (3) the engagement of actors outside the government structure to lead Strategy initiatives; (4) the appointment of the Mental Health and Addictions Leadership Advisory Council; and (5) the delegation of leadership to the policy network to determine what should be done to meet some of the Strategy goals.

The distribution of the leadership – a key feature of a horizontal governance approach

could be identified in the first wave of implementation of the 22 initiatives across government ministries. While one ministry (MCYS) had overall accountability for the first three years, each particular initiative had an identified program lead in government. In total, four government ministries (MCYS, Ministry of Education, MOHLTC and Ministry of Training, Colleges and Universities) with multiple divisions and programs within those ministries had direct accountability for the initiatives.

Another horizontal governance feature used to support their efforts was the government's articulation of a range of interministerial approaches (Government of Ontario 2013). These included both decision-making and coordination approaches, such as a Deputy Ministers Social Policy Committee that would meet quarterly to discuss priorities including the Strategy, bi-weekly and monthly meetings of interministerial working groups at staff/ manager, director and ADM levels and a clear process vetting communications/memos, advisory committee activity, education/training and advisory committee activities through the working groups (Government of Ontario 2013).

The government's implementation approach also included actors outside of the government structure. This is most apparent through the delegation of accountability for many of the Strategy initiatives from ministry programs to policy network actors. For example, the initiative "Provide Nurses in Schools to Support Mental Health Services" was delegated for implementation to the Registered Nurses Association of Ontario. Similarly, in education, the Hamilton Wentworth District School Board was designated lead for "Implement School Mental Health ASSIST Program and Mental Health Literacy Provincially." Within the health area, "Create 18 Service Collaboratives" was delegated to the Centre for Addiction and Mental Health. It should be noted that, in all cases, leads

represented well-established institutions. This delegation continued in the second wave of implementation that began in the fourth year of implementation when lead accountability for the Strategy shifted from the MCYS to the MOHLTC. During this period, the government appointed a Mental Health and Addictions Leadership Advisory Council comprising 20 system stakeholders with a mandate to provide implementation advice for three years, from 2014 to 2017. The Council, in turn, identified a number of working groups, led by council members but comprising additional experts from the province on specific topics. This widened the engagement of the policy network even further during the second wave of implementation.

The government also took a networked approach to determine what should be done to meet some of the Strategy goals by creating a $27-million "Mental Health Innovation Fund" aimed at supporting innovative approaches to on-campus mental health service delivery for post-secondary students (Ontario Undergraduate Student Alliance 2014). In 2012, the Ministry of Training, Colleges and Universities solicited proposals from stakeholders based on the objectives of the fund. Thirty-two initiatives were supported as of 2015, led by a variety of actors (Ministry of Advanced Education and Skills Development 2015). Thus, leadership and engagement in the implementation of this particular policy objective was shared with actors who were selected during the process, thus diffusing the responsibility and accountability for improving campus mental health across the system.

Assessing the prospects for transformative change

Our findings identified a number of features of policy network and horizontal governance approaches visible in the Strategy that offer promising prospects for transformative change.

First, in contrast to previous reform efforts that have focused on a narrower set of actors from the mental health and health sectors, the Strategy defined the policy network more broadly and intersectorally, an approach viewed as critical to successfully address wicked problems (Roberts 2000). Involving multiple actors and government ministries through horizontal governance distributes leadership in policy reform, but may also increase collective accountability, making the process less likely to stall at the implementation phase. It may also reduce resistance to implementation among organized interests (as noted by the series of news releases from organizations mainly applauding the release of the Strategy) (Canada Newswire 2011a–g).

A second distinguishing feature is the concerted effort to extend the engagement of the policy network and the horizontal governance approach beyond the policy formulation stage and into implementation. Continuing to mobilize policy network actors into the implementation stage significantly increases the prospects for reform by embedding changes across systems and developing shared ownership at the implementation level. Policy networks are important sinews for implementation and delivery (Pal 2014), so early and continued engagement of relevant actors lays the groundwork for success.

Finally, this process involved both political and policy leadership. The political leadership (the Select Committee) was a unique feature when compared with past policy activity in the mental health and addictions domain. Committee membership from all three main political parties increased the likelihood that the Strategy would be sustained through changes in government.

DISCUSSION

Our findings demonstrate that many of the features of the policy network and horizontal governance approach to policy making were present in the Government of Ontario's Strategy. Notably, our analysis revealed an expansion of the state pluralist network to include both governmental and non-governmental actors beyond those in the health sector. Second, we see examples of the various dimensions of horizontal governance as identified by Hopkins and colleagues (2001). The presence of these features reveals a deep commitment to responding to the challenges of the complex, multi-faceted problem of mental health policy in a comprehensive and collaborative way across multiple sectors and in both the policy formulation and policy implementation stages.

Although our findings offer an optimistic account regarding the potential for transformative change in mental health and addictions in Ontario, there are several limitations to policy network and horizontal governance approaches. One drawback is time. As this case illuminates, using a networked approach can be lengthy because of the coordination of inputs and consensus building required before decisions can be made. This approach may take longer than a centralized authoritative model of policy formulation, which places pressure on governments who want to be seen as "doing something" and making strides towards reform. This challenge is amplified by relatively short electoral cycles, which can increase the impetus for swift action and constrain the perceived options for implementation. A related challenge is the value conflicts that arise during the policy development and implementation process and the need to create effective resolutions to ethical dilemmas that are encountered, particularly when the policy development and implementation process involves the engagement of such a wide array of actors. Scholars

have suggested that network and horizontal approaches can ignore important political value conflicts because of the focus on consensus and partnership, which creates only shallow goal consensus and can result in a replication of silo practices that were meant to be avoided by using these approaches (Davies 2009).

In addition, actors who engage in horizontal and network approaches still must interact with and, to some degree, operate within the authoritative structures that exist in the system. Hierarchical organizations have not been designed for this mode of operation, which can have challenging consequences. For example, joint communications announcing the Strategy implementation initiatives were initially slow to surface. However, once these processes were established, they began to move more swiftly, and a subsequent memo with four ministry signatories was circulated to key actors in a timely way announcing a particular implementation initiative (Srinivasan 2012).

A further potential limitation of the network approach is the boundaries that networks create, resulting in some stakeholders being left out and therefore unable to contribute in a direct way. One example of stakeholders who were excluded from the network in this case was private sector service providers who continue to play a key role in delivering mental health and substance use services that are not covered by publicly funded health insurance plans.

Finally, networks require some form of governance and management. Applying a network approach requires both a different frame of thinking and a different way of acting. Network management has been acknowledged as no easy task (Klijn and Koppenjan 2000). When the government does not use horizontal governance and policy network approaches frequently, additional leadership and individuals with skills in brokering, communication

and systems thinking are required. This is a particular challenge with high turnover in bureaucratic positions and leadership and will continue to be a challenge for the Ontario government as it manages the Strategy moving forward.

Underpinning any approach to reform is a need to resource the system appropriately to undertake the reforms and deliver services that meet the needs of citizens. As identified by Bartram and Lurie (2017), and as alluded to earlier, Canada has a long-standing gap in mental health funding relative to the disease burden of mental illnesses and addictions. Any reforms identified through this approach will require appropriate financial investments to ensure success.

Our study included a thorough document analysis but did not include other empirical strategies such as interviews or surveys with relevant actors, which would enrich the understanding of the intricacies of the policy process related to the Strategy. This analysis is therefore most helpful in identifying the features of the policy process that are salient for future investigation and hypothesis development.

Because the Strategy is only midway through its implementation, there are many avenues for additional exploration as it continues to unfold. Future research should examine and measure the policy outcomes of the Strategy with the aim of specifying the components of the policy network and horizontal governance approach most important in explaining the policy outcomes. Comparative studies that examine Ontario's approach to that of other provinces/states based on either the same subject area (mental health and addictions) or on other similar policy network and horizontal governance approaches would yield additional explanatory power. Furthermore, studies comparing the costs of such approaches with more traditional approaches to health policy development and implementation, and related

trade-offs in efficiency and outcomes, would be of value to begin to understand when such approaches are warranted. Moreover, quantitative social network analysis of the policy network could offer important insights into how the structure of the network and the ties among actors affect the policy outcomes (Brandes et al. 1999; Rhodes 2006). Finally, evaluation activities should focus on the changes implemented as a result of the policy, whether those changes address the original problems and if they result in positive outcomes for citizens.

CONCLUSION

Our analysis suggests that there is reason to be optimistic that the policy formulation and implementation stages of the Strategy as currently constructed have increased the likelihood for transformative change. Further evaluation will be required to determine whether this was enough to improve outcomes for Ontarians.

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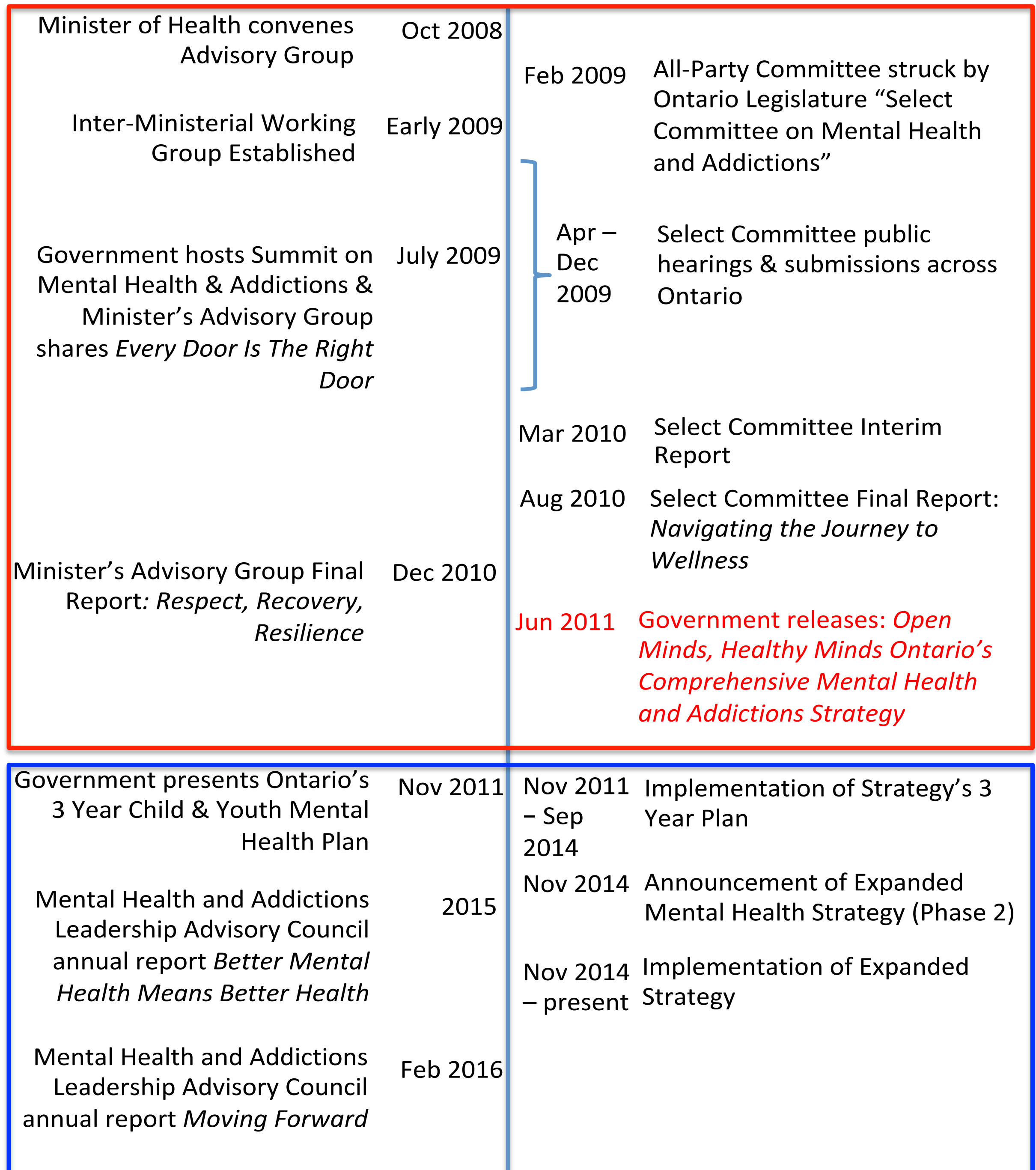
Figure 1 – Timeline of key activities and documents related to policy formulation and policy implementation of Ontario's Mental Health and Addictions Strategy



Chapter 6. Preface

Newer approaches to public governance stress the importance of participation of citizens and other stakeholders throughout the policy process in order to achieve better alignment between policy goals and policy outcomes in health and social systems. This chapter investigates the role of citizens and other stakeholders in the implementation of *Open Minds, Healthy Minds, Ontario's 10-year Mental Health and Addictions Strategy* (the *Strategy*). Using a single case study design and drawing on an integrated knowledge translation approach, it addresses two questions: 1) Who was engaged in the implementation of the *Strategy* and how were they engaged? and 2) How and why did their involvement contribute to the implementation process and early outcomes? The study highlights the range of inter-dependent actors who were involved and uses an analysis of the political landscape to identify important institutional, interest and ideational influences on the process. It also draws on actor-related determinants identified in Chapter 2 as an explanatory frame. Our findings are useful to governments, citizens and other stakeholders who are seeking to develop mechanisms and approaches for engagement during policy implementation.

I was responsible for conceiving of the focus and design of the study, with support from my supervisor Dr John N. Lavis and with my integrated KT partners. I conducted all of the interviews as well as the preliminary analysis and interpretation. Dr John N. Lavis contributed to the analysis and provided feedback on earlier drafts of the manuscript. Committee members, Dr Michael G. Wilson and Dr Gillian Mulvale also provided feedback on earlier drafts of the manuscript. When submitted for publication, we anticipate our ministry partners may also be named as authors on the manuscript.

Using Table 2 from the Introduction as a guide (see excerpt below), this study is the fifth of the five included as part of my dissertation and is the second in the two-part in-depth examination of the *Strategy* in Ontario.

Chapter	**Study Objective**	**Design (and select methods)**	**Outputs/ Contributions**	**Links**
6.	To examine the roles that citizens and other stakeholders are played in implementation of the *Strategy* and how their involvement is contributing to systems change. ***Descriptive + explanatory goals***	Single case study • Case is the implementation of the *Strategy* • Analytic frameworks include 3I+E and policy actor determinants • Methods include qualitative interviews and mapping of citizen and other stakeholder involvement • Study conducted using an integrated KT approach in partnership with Ministry of Health and Long-Term Care's (MOHLTC) mental health and addictions branch	1. Network map of citizen and other stakeholder involvement in implementation of the Strategy 2. Identification of factors that explain how involvement contributes to process and outcomes 3. Practical outputs for MOHLTC	Used the determinants framework from Chapter 2 (actors and attributes) to inform analysis + policy networks and horizontal governance theory from Chapter 5

Why stakeholders matter in policy implementation: An examination of citizen and stakeholder engagement in the implementation of Ontario's mental health and addictions strategy

Authors: Bullock HL, Lavis JN, Mulvale G, Wilson, MG

Keywords: citizen engagement, stakeholder engagement, public policy, implementation, co-production, mental health

Word count: 5290 (main text) – 11,547 (inclusive of abstract, references and exhibits)

Abstract

Background: Shifts toward "new public governance" (NPG), where policy decisions and their implementation are "co-produced" by a policy network, have captured the attention of policy-makers as an approach that may produce better outcomes. It is particularly promising in policy areas such as mental health, where it is increasingly acknowledged that effective change requires actions by multiple actors across a range of policy and system settings. In Ontario, Canada, the government's most recent mental health reform effort, *Open Minds, Healthy Minds, Ontario's Comprehensive Mental Health and Addictions Strategy (*the *Strategy*), is unique from past efforts in terms of the scope of the goals and the NPG-inspired processes used to develop and implement it. This study addresses two questions: 1) Who was engaged in the implementation of the *Strategy* and how were they engaged? and 2) How and why did their involvement contribute to the implementation process and early outcomes? **Methods:** We used a single case study design and engaged Ontario Ministry of Health and Long-Term Care staff in an integrated KT approach. We relied on two complementary analytical methods: 1) stakeholder analysis, and 2) key informant interviews and document analysis. A

total of 14 interviews were conducted and 21 documents analyzed using directed content analysis and drawing from theoretical frameworks regarding political and actor-related determinants of implementation. **Results:** Stakeholder mapping highlighted the range of inter-dependent actors who were involved, the multiple ways that they provided input, and the structures through which they provided input. The analysis of the political landscape identified the role of interests as having a large influence on the implementation process and early outcomes, particularly political actors' decision to tie the process to their election platform. Relational and contextual variables contributed to this influence. For example, the relative instability of the policy actors had a negative impact on the process, although participants were impressed with the level of dedication and commitment of the individuals involved. **Conclusions**: Based on our findings, we offer five considerations for policy and systems leaders when undertaking similar initiatives.

"Well, I think that our goal was to advise the government on how to proceed with improving and enhancing mental health and addiction services in Ontario from the perspective of the people who are either working in the system for many years, the experts, and the people who were receiving, or had received, with their family member, services. Really, it was I think an onerous task, but I think that our job was to try to, with honesty and expert eyes and in a spirit of neutrality, put together some pathway points so that when the government was going ahead with some of their changes to the system that they would be more effective and efficient. So, basically, they recognized that what they had been doing already wasn't helpful enough. Change and transformation was required, and they wanted to maybe look at the past and say there's got to be another way of doing this, and we have to think outside the box." Interviewee 2

Background

The role of citizens and other stakeholders in governance activities, particularly the development of government strategies or action plans has long been a topic of interest to scholars and public policy-makers alike. However, the specific role of citizens and other stakeholders during the process of implementing evidence-informed policies and practices (EIPPs) is less clear. Theory suggests that citizen and stakeholder engagement is particularly important for implementation when the problem the policy is attempting to address is complex in nature (Sabatier & Mazmanian, 1980) and where solutions require the mobilization of multiple sectors and actors at various levels within large systems (Papadopoulos & Warin, 2007).

Mental health and addictions is one such policy area, where policies must have components that address a wide range of sectors, including healthcare, education, justice, workplaces, housing, and the broader community; and policies must also address a wide range of actors within those sectors, such as psychologists, social workers, nurses, physicians, teachers, police, employers, landlords, among others. Additionally, the nature of mental health and addiction problems means treatment approaches are complicated to deliver and require a large investment of time and effort from the people who receive them and their

families or other caregivers. Thus, the involvement of people with lived experience and their families is increasingly acknowledged as foundational to any successful change effort in the field (Rapp et al., 2005).

The area of mental health and addictions, therefore, seems ripe for applications of a 'new public governance' (NPG) approach (Osborne, 2006, 2010; Torfing & Triantafillou, 2013). New public governance thinking has at its core, the concept of "co-production," whereby state and non-state actors collectively produce or inform public service delivery (Howlett, Kekez, & Poocharoen, 2017; Pestoff, 2006), as well as other principles, including: coordination, participation, and a dual focus on process and outcomes (Torfing & Triantafillou, 2013). Unlike past approaches, NPG posits that the development and implementation of public policy is improved by cooperation, negotiation, and the active participation of relevant stakeholders who contribute knowledge, ideas and resources (Osborne, 2006; Torfing & Triantafillou, 2013). Osborne (2006: 384) describes it as both a plural state where a range of inter-dependent actors contribute to the organization and delivery of public services, as well as a pluralist state whereby multiple processes inform the policy-making system.

This type of participatory inclusion is thought to be a driver of democratization (Warren, 2009) and requires trust, relational capital and relational contracts as the mechanisms for involvement (Bovaird, 2007). It also requires a shift in the government's role from one of steering to one of facilitating (Howlett et al., 2017). The NPG approach is seen as critical to the successful implementation of complex problems, which includes efforts to collaborate horizontally across government ministries as well as with a diverse range of stakeholders outside of government who are part of a broader policy network and have a

role in facilitating the implementation and adoption of the policy (Agranoff, 2006; O'Flynn, 2007).

In Ontario Canada, the provincial government's most recent mental health and addictions reform effort is unique from past efforts in terms of the scope of the goals as well as the processes used to develop and implement it, and, on the surface, reflects many of the elements of the NPG approach. A recent policy analysis of the process used to develop and implement *Open Minds, Healthy Minds, Ontario's Comprehensive Mental Health and Addictions Strategy* (the *Strategy*) (Government of Ontario, 2011) identified – compared to past efforts – an expansion of the state pluralist network to include both governmental and non-governmental actors beyond those in the health sector and a more intentional use of a horizontal governance approach through the engagement of multiple government ministries (see Bullock & Abelson, 2019/Chapter 5 for full analysis). However, while the policy analysis traced key structural elements of the process and the mechanisms for engagement, it relied on documentary sources, which limited its ability to draw insights on the process from the perspective of participants. Moreover, the analysis was also bounded in time, beginning three years prior to the *Strategy* launch and stopping in 2016 - mid-way through the implementation process. This leaves an opportunity to delve more deeply into the process, especially during the second phase of implementation (2014-2018), and to comprehensively examine the role that citizens and other stakeholders are playing, as part of an NPG approach.

Context and background

Ontario is Canada's most populated province and is home to over 14 million people. It also has a relatively large geographic footprint at 1.076 million square kilometers, akin to three times the size of Germany or 1.5 times the size of the state of Texas, U.SA. Policy authority

for health, including mental health and addictions, rests mainly at the provincial level. The size of the province, in terms of population and its distribution of the across a large geography, makes the successful implementation of EIPPs at scale a challenge in any policy domain, and mental health and addictions is no exception. Ontario has made repeated efforts at policy reform in mental health, arguably with limited success (Hartford, Schrecker, Wiktorowicz, Hoch, & Sharp, 2003; Mulvale, Abelson, & Goering, 2007; Wiktorowicz, 2005). In 2011, the Ontario government released the *Strategy*. The first three years of the *Strategy* focused on children and youth, with the Ministry of Children and Youth Services as lead. For the second phase, leadership was passed to the Ministry of Health and Long-Term Care (MOHLTC) and the focus expanded to across include all ages. The Minister of Health appointed a Mental Health and Addictions Leadership Advisory Council (the council) in 2014 with a three-year mandate to advise him on implementation of the *Strategy*.

Purpose & research questions

This study aims to deepen the understanding of the role that citizens and other stakeholders played in the implementation of the second phase of the *Strategy* and how the policy network and horizontal governance approach taken, as key components of the NPG, contributed to systems change. This includes how citizen and broader stakeholder engagement influenced "up" to political decisions, and "down" to service agencies and others. We specifically address two related questions about stakeholder engagement in implementation of the *Strategy*: 1) Who was engaged in the implementation of the *Strategy* and how were they engaged? and 2) How and why did their involvement contribute to the implementation process and early outcomes? Because this study took place mid-way through the implementation of the second phase of the *Strategy*, it was too early to examine a full causal

story based on the ultimate outcomes it aimed to achieve. We therefore focus on the processes of engagement and precisely how the citizens and other stakeholders involved in them contributed, thereby building an important piece of the causal story.

Methods

Integrated knowledge translation approach

Our study used an integrated knowledge translation (IKT) approach as an overarching framework. Integrated KT is an approach involving the engagement of potential knowledge users as partners in the research-generation process (Gagliardi, Berta, Kothari, Boyko, & Urquhart, 2016). It can have more impact because the end-user is engaged and interested, ready for results, and often more willing to move those results into policy or practice because they are more relevant (Kothari & Wathen, 2013). We worked in partnership with MOHLTC's Mental Health and Addictions branch as our IKT partner. They specifically helped to: 1) shape the study questions, 2) assist with stakeholder mapping, 3) facilitate access to potential participants, and 4) provide context and interpretation of the findings. Our research team maintained independence during the interview and analysis phases and led the development of academic outputs from the process.

Study design

This study employs a single case study design as outlined in Yin (2013). The 'case' is defined as the implementation of the second phase of the *Strategy* in Ontario. The rationale for this design rests on the observation that the approach the Ontario government is taking to implementing the *Strategy* is quite innovative and unique compared to past implementation efforts in the mental health and addictions area, in terms of both the breadth and scale of

citizen and broader stakeholder involvement, exemplifying the NPG approach. It therefore constitutes an unusual and interesting case to examine. This study does not focus on other stages of the policy cycle, such as the earlier stages of problem definition, agenda setting, and policy development, or the later stage of policy evaluation, instead limiting the analytic focus to the implementation process itself.

Within this design, we relied on two separate but complementary analytical methods that address our questions of interest: 1) stakeholder analysis, and 2) key informant interviews and document analysis. The study was conducted in 2018.

Stakeholder analysis

In order to address the first question (who is being engaged and how), we used a combination of document review and information provided by our IKT partner to conduct a stakeholder analysis. Stakeholder analysis is an important approach to generate knowledge about actors and assess the perspectives and influences they bring bear on policy activity (Varvasovsky & Brugha, 2000), particularly when an NPG approach is employed (Howlett et al., 2017). Our stakeholder analysis included: 1) identification and visualization of the structures through which engagement occurred, and 2) identification and categorization of the specific actors involved and the citizen or other stakeholder groups from which they were drawn. To assist with the categorization of stakeholders, we drew from a framework that categorized the types of policy actors relevant to systems-level implementation activities (Chapter 2).

Key informant interviews & document retrieval

Key informant interviews - Using the list of citizens and stakeholders generated by the stakeholder analysis, we purposively sampled a subset of individuals who had differing types

of involvement (e.g., public servants from different ministries, council and working group members, etc.) and contacted them with a brief description of the study and requested their participation in an interview. In order to protect the identity of individuals who participated in the Persons With Lived Experience and the Family and Caregiver Panels, our IKT partners (who had an existing relationship with panel members) did not share names or contact information with the study team but contacted them directly instead, sharing the study information and asking interested members to identify themselves directly to the PI if they wished to participate. Semi-structured interview questions focused on five areas: 1) general description of their involvement; 2) how their involvement contributed to the process; 3) how their involvement contributed to outcomes; 4) factors that were important to the process; and 5) process quality (Appendix 1). All interviews were conducted by the principal investigator (HB), who had prior knowledge of, and connections to, many of the study participants through past activities and employment. With consent, interviews were recorded for later transcription and lasted approximately one hour each. Interviews were conducted until saturation was reached and no further theoretical or substantive insights emerged. A total of 14 interviews were conducted (29 invitations were sent, 8 did not respond, 4 declined, and 3 more consented but saturation was reached prior to scheduling). Two of the participants declined recording so written notes were taken instead.

Document retrieval – Publicly available documents related to the *Strategy* and the work of the council and other activities were retrieved through a search of the government of Ontario website and the council's website. Additional documents were provided by our IKT partners. A total of 21 documents were retrieved, and additional web content (video interviews, blogs, etc.) were also reviewed through this process.

Data management and analysis

Data from the interviews were transcribed and uploaded into NVivo12 for analysis. Supporting documents were also reviewed and coded. Directed content analysis was employed (Hsieh & Shannon, 2005), which begins the coding process by drawing from existing theory (see theoretical frameworks below). Next, sources (interviews and documents) were compared with one another to identify themes that emerged across them. Comparing across data sources provided an opportunity for triangulation, which can strengthen the validity of findings (Patton, 1999).

Data collection and analysis proceeded iteratively with each interview contributing additional insights that were tested in future interviews with the goal of developing a full explanatory picture of the perceived value of citizen and other stakeholder engagement in policy implementation (Yin, 2013). This process further refined the interview questions.

Analytic frameworks

We first used the 3I+E framework (Lavis, 2013) to assess the political landscape and identify how features of institutions (e.g., government decision-making structures and processes), interests (i.e., groups with a vested interest), ideas (i.e., values and research-based knowledge) as well as factors outside of the policy area (external events) affected the actions of those engaged in the implementation activities as well as the outputs.

Next, we used an integrated theoretical framework that identified policy-related determinants of implementation (Chapter 2), specifically drawing on the elements that focused on the types of policy actors engaged in implementation as well their relationships (e.g., goal alignment, level of engagement, degree of communication, etc.) and context (e.g., power and visibility of stakeholders during implementation, dedicated leadership, stability of

policy actors, and sustained political will, commitment and support) (see Figure 4, Chapter 2). Out of scope for this study but included in the theoretical framework are the individual characteristics of the actors (innermost circle in figure) as well as a host of other non-actor-related determinants. This framework was used descriptively and as an explanatory aid to shed light on how and why stakeholder participation can affect the process of policy implementation.

Ethical considerations

Ethics approval for this research was sought and obtained by McMaster University through the Hamilton Integrated Research Ethics Board (HiREB-3685). Our partners at the MOHLTC sought permission for their participation through their normal approvals process. The study was attentive to the ongoing ethical considerations that emerged throughout the research process, as studies using qualitative research methods are often evolving and may uncover ethical challenges that were not anticipated at the outset, although we did not encounter any major challenges along the way.

Results

General characterization of the process

Implementation proceeds through a series of stages and this one was no exception. Using the EPIS framework developed by Aarons and colleagues (2011), we classified the activities that took place during this implementation process as "Exploration". Exploration is the first of four EPIS stages and is described as the phase where potential implementers consider what problems they intend to solve and what evidence-informed policies and practices might be adopted to achieve the identified goals, while considering the outer contextual factors (e.g.

socio-political environment, available funding, etc.) and inner contextual factors (e.g. organizational climate, absorptive capacity, etc.) that may present opportunities or challenges to the implementation process. Due to the types of activities in this phase, and because the *Strategy* was considered by those involved as "a very broad document" (Interviewee 12) and "vague and hard to work with" (Interviewee 11), many participants did not believe they were implementing the *Strategy* at all and instead concluded, "We made our own assessment of what we thought needed to be done and moved forward from that." (Interviewee 6)

Who was engaged in the implementation of the Strategy and how were they engaged?

The structures that supported the *Strategy* implementation process, including the policy network and horizontal governance approach are depicted in Figure 1. The 20-person council and its substructures (4 working groups, 2 task groups, a separate Francophone engagement process and 2 reference panels: Persons with Lived Experience and Family/Caregiver) were the main structures supporting the policy network approach. A parallel but separate engagement process was launched to develop an Indigenous mental health and well-being strategy that was Indigenous-led but had links to the council through two of its Indigenous members who participated in both processes. There were also five organizations that supported the activities of the council by providing in-kind resources and/or developing products and resources as inputs to the deliberations. The council was appointed by the Minister of Health, who received recommendations from them on an annual basis.

On the government-side, the structures supporting the horizontal governance approach included the secretariat for the council that was located in the Mental Health and

Addictions Branch in the MOHLTC. The secretariat provided coordination and administrative support to the council and its sub-structures and served as an informal "liaison hub" with other branches at MOHLTC and with other government ministries. There were also two inter-ministerial working groups formed for senior public servants from 13+ ministries who participated with varying levels of commitment.

The stakeholder mapping process identified at least 138 individuals who were directly involved in the process in an on-going way. Table 1 presents a summary of the types and sub-types of policy actors involved in the implementation of the second phase of the *Strategy* and their roles. This summary demonstrates the expansiveness of involvement including the participation of political, public servants, special interest and expert actors. While many of the political actors did not participate as members of the various implementation structures, they did attend council meetings, participate in meetings with the council chair, and deliberate together regarding the advice and potential investments at cabinet meetings.

How and why did their involvement contribute to the process and early outcomes?

A full analysis of the institutional, interest, ideational and external factors that influenced the implementation of the Strategy along with illustrative quotes is presented in Table 2. The factors and findings are ordered according to their relative influence on the implementation process and outcomes from highest to lowest based on our analysis.

The factor that had the most influence is interests, followed by institutions and finally, ideas. It is important to note, however, that there were salient influences on the process identified from each factor. There was one major external event that was influential (the provincial election in 2018), however, we have captured its effects under the interests

domain. The interests factor-related finding that had the largest influence on the process and outcomes was the role of elected officials deciding to tie the council's recommendations to their election platform. This politicized the work (despite the council being non-partisan) and stalled commitments and investments that may have benefited the public if they had been acted upon earlier. Ultimately, this political gamble did not pay-off and there was a change in government, leaving participants to question whether outcomes (in the form of activities and investments based on their recommendations) would be realized and many expressed a concern that their efforts might have been wasted. This concern was felt less, however, by public servants who are more familiar with how policy ideas can be re-shaped or re-positioned after changes in government. Based on our findings, they were much more optimistic about the potential for outcomes to be realized from the process.

Since interests were highlighted as such an important factor in the 3I+E analysis, we chose to delve more deeply into the role of actors by exploring how actor relationships and actor context influenced the process and outcomes (Chapter 2). Findings from this analysis are presented in full along with illustrative quotes in Table 3. Variables within the relational and contextual categories are ordered according to their relative influence on the process and outcomes, from highest influence to lowest based on our analysis.

Notably, many of these relational and contextual determinants had a positive influence on the process and were seen by participants as strengths, with some opportunities for improvement in future implementation exercises. Overall, the contextual variables had a greater influence on the process and outcomes than relational variables. Most significantly, the relative instability of the policy actors, due to repeated staff turnover and organizational changes at MOHLTC, had a negative impact on the process because it meant new actors

needed to be brought up to speed and all participants needed to adjust to new ways of operating. Despite the instability this caused, participants were impressed with the level of dedication and commitment of the individuals that were involved. Participants also spoke highly of the leadership provided during the process by the chair and secretariat, which they felt was a strong enabler of an effective process, however, distributing leadership responsibility further (to senior government officials) may have facilitated implementation further.

Discussion

By examining the policy implementation process, and the role that citizens and other stakeholders play in it, this research contributes an increased understanding about how systems can better achieve policy objectives and the benefits and challenges when 'coproducing' public services. Our findings document the breadth of engagement in the implementation of the second phase of the *Strategy* and detail how citizens and other stakeholders contributed. The mapping process makes clear the "double plural" nature of the NPG (Osborne, 2010) by highlighting the range of inter-dependent actors involved, the multiple ways that they provided input, and the structures through which they provided input. The analysis of the political landscape was helpful in extricating the various influences on the process and the particularly important role of interests. Finally, the exploration of policy actor-related determinants explained how the relationships between actors and, even more importantly in this case, their context (e.g., instability of policy actors) affects the process and the outcomes it was able to achieve.

Strengths & limitations

A key strength of this research is the IKT partnership approach used to develop and conduct the study. By engaging our ministry partners throughout the research process, we believe we have produced knowledge that is more tailored and usable at this stage than we would have with other approaches, echoing others' experience using IKT approaches (Bullock, Watson & Goering, 2010) and the literature more generally (Bowen & Graham, 2014). A second strength is the timing of the study, given our active data collection period occurred just after the process had come to a close. Interviewing participants just after their formal involvement ended meant the experience was "fresh" in their minds, but because it had concluded, the experience could be examined holistically.

We also identified two potential limitations in our study. The first was the lack of documents related to the process that were in public domain (e.g., terms of reference for committees, meeting minutes, etc.), which resulted in us relying more heavily on participant accounts. Although this limitation could have been overcome with a formal access-to-information request to government, we did not feel it was necessary due to the somewhat surprisingly consistent accounts provided by the participants we interviewed and the informal understanding of the process we gained through our IKT partners. However, we cannot be certain that these sources did not contain additional insights that would have strengthened our analysis. The second possible limitation relates to the large number and diversity of citizens and other stakeholders who were directly engaged in the process, which meant we had to limit our sample to a sub-set of participants. While we are confident saturation was reached in the key thematic areas for which we considered saturation, it is still possible some themes or insights were missed in areas that we did not consider explicitly.

Meaning of the study and implications for policy-makers and system leaders

In general, this study complements the policy analysis by Bullock and Abelson (2019) by adding a more in-depth account of the experience of citizens and other stakeholders who were engaged in the implementation of the *Strategy*, and contributes to the growing literature on the important role of policy and governance in implementing systems change in mental health in Canada (e.g., Bartram & Lurie, 2017; Fleury et al., 2016; Wiktorowicz et al., 2010) and internationally (e.g., Awenva et al., 2010; Bergmark, Bejerholm, & Markström, 2017; Grace et al., 2015; Isett et al., 2007; Lurie, 2005; Shera & Ramon, 2013). It is also a relatively novel empirical contribution to the literature regarding newer models of system governance, such as NPG, and presents a rich account of the experience and the strengths and limitations encountered when attempting to govern in this way.

The study highlights five important considerations for policy-makers and system leaders when designing or engaging in similar policy implementation exercises. First, our findings point to the need to explicitly consider power and its uneven distribution even when such a wide range of actors are being engaged. While one goal of "coproducing" public services is to reduce the power and influence of traditional elites by bringing more voices to the decision-making table, our findings suggest that power imbalances continue to affect the process. Power was exerted, for example, through the ability to dedicate in-kind resources in support of the process, which potentially gives organizations that are well-resourced an advantage over smaller organizations and those who are participating as individuals. Ensuring there are opportunities to overtly acknowledge power imbalances and how they may influence the implementation process could mitigate some of the potential covert effects of such imbalances.

A second consideration to note is the importance of building and maintaining trust and reciprocity among actors when using an NPG approach. The transaction costs of participating in such an involved implementation effort are considerable for both individuals and organizations. It requires a commitment that spans years (approximately 3.5 years in this case). By participating, citizens and other stakeholders enter into a type of social contract where they will dedicate the time and resources needed for participation and in return, they expect their participation will ultimately result in some positive system impacts. In our study, this trust and reciprocity was threatened by the decision to tie next steps to the election platform of the governing party. While there is an inevitable level of uncertainty inherent to any policy process occurring in an ever-changing system, it is important for policy-makers and system leaders to understand this social contract and to make decisions that are congruent with it. It may also mean revisiting expectations over time. For example, in the case presented here, this threat could have been avoided if the process had been timed differently, finishing either much earlier or later than the planned election or if more policy decisions and investments had been made along the way, rather than waiting until the end of the council's mandate.

The third consideration relates to the efficiency (or lack thereof) of collaborative approaches. Governing in this way is resource-intensive for the system. It requires multiple organizational structures and venues for participation that all need to be continually coordinated and aligned as the process unfolds, and this can create redundancies and other inefficiencies. In fact, many participants in our study commented on the 'heavy lifting' required to undertake this work effectively and offered thoughts on its efficiency and how it might be improved. It is important for policy-makers and system leaders to spend time

planning and estimating the resources required to fulfill the facilitation role effectively prior to initiating the work. Making careful selections regarding key roles, such as the council chair in this study, can help ensure the process runs smoothly and efficiently. Even with careful planning, adaptations along the way will likely be required.

The fourth consideration is the critical issue of timing and sequencing. Implementation is a process that unfolds over time and through (typically identifiable) stages. Timing has been identified as a determinant of implementation (see Chapter 2), with various time-related elements having demonstrated impact on the success of such efforts, including the timing/pace of political, policy and funding cycles as one example (Rubin et al., 2016). Planning and attending to the potential impacts of time-related factors (such as the election cycle in our study) and mitigating risks associated with them (e.g., shifting actions or decisions within the processes' control in order to synchronize or purposively asychronize with timing-related factors that are external to the process) will improve the prospects for success.

The final consideration relates to the types of actors and expertise needed to support the implementation process. In our study, many participants mentioned the need to include expertise beyond the policy area (i.e., beyond mental health) and that for systems-level policy implementation initiatives, expertise in governance and systems thinking are crucial. This may mean expanding the policy network even further with actors who can bring these types of expertise. Even more broadly, our study points to a need to consider who brings what type of expertise, and how that expertise can best be utilized in the process. Several participants in our study pointed to times when individuals were put in situations where they were asked to make decisions on topics far beyond their knowledge base. This is consistent

with reflections from the growing literature on "co-production", where some scholars are teasing apart its different forms, whilst considering how to respect the costs, in terms of time and effort, required for citizens and other stakeholders to participate and how they can best add value (Bovaird & Loeffler, 2012). The process under study here did make some attempts to do this, for example by developing the 'persons with lived experience' and 'family and caregiver' panels as separate inputs, but participant experiences suggest more could be done. Thus, policy-makers and system leaders should consider what the implementation process is trying to achieve, what expertise is optimal to "co-produce success", and how to design the process so that input from the different types of experts is optimized. This may mean moving beyond equal participation (having all actors at the same table) to equitable participation (shaping participation to optimize the experience and outcomes for the different types of actors with different expertise).

Questions for future research

There are many areas for research related to the considerations presented above, however, our study also leads to some more specific questions for future investigation. Firstly, our study mapped the citizens and other stakeholders who were engaged in this phase of the *Strategy* implementation. Future studies could take this mapping a step further and use complementary tools such as social network analysis to more clearly understand the ties among network actors and how they may shift over time. Other scholars have also cited social network analysis as an important tool for understanding NPG approaches (Brandes, Kenis, Raab, Schneider, & Wagner, 1999; Rhodes, 2006). Secondly, there are many aspects of the NPG approach that were not addressed here; most notably those related to deliberative processes. Papadopoulos and Warin (2007) identified several constructs that contribute to

democratic and effective decision-making, including: 1) openness and access; 2) quality of deliberative activity; 3) impact; and 4) insertion in the public space. This framing could be used to understand, from stakeholder-participants, whether they felt the process of engagement was credible, and reflective of what theory would suggest is important in terms of being meaningful. Finally, future studies could examine the outcomes of the implementation process as the ten-year strategy comes to a close in 2021. Outcomes could be examined according to Proctor's conceptual model of implementation, which divides outcomes into implementation-level (acceptability, penetration, fidelity, etc.), service-level (safety, equity, patient-centredness, etc.) and client-level (satisfaction, function, symptomatology, etc.).

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Figure 1 - Structures that supported the *Strategy* implementation process, including the policy network and horizontal governance approach

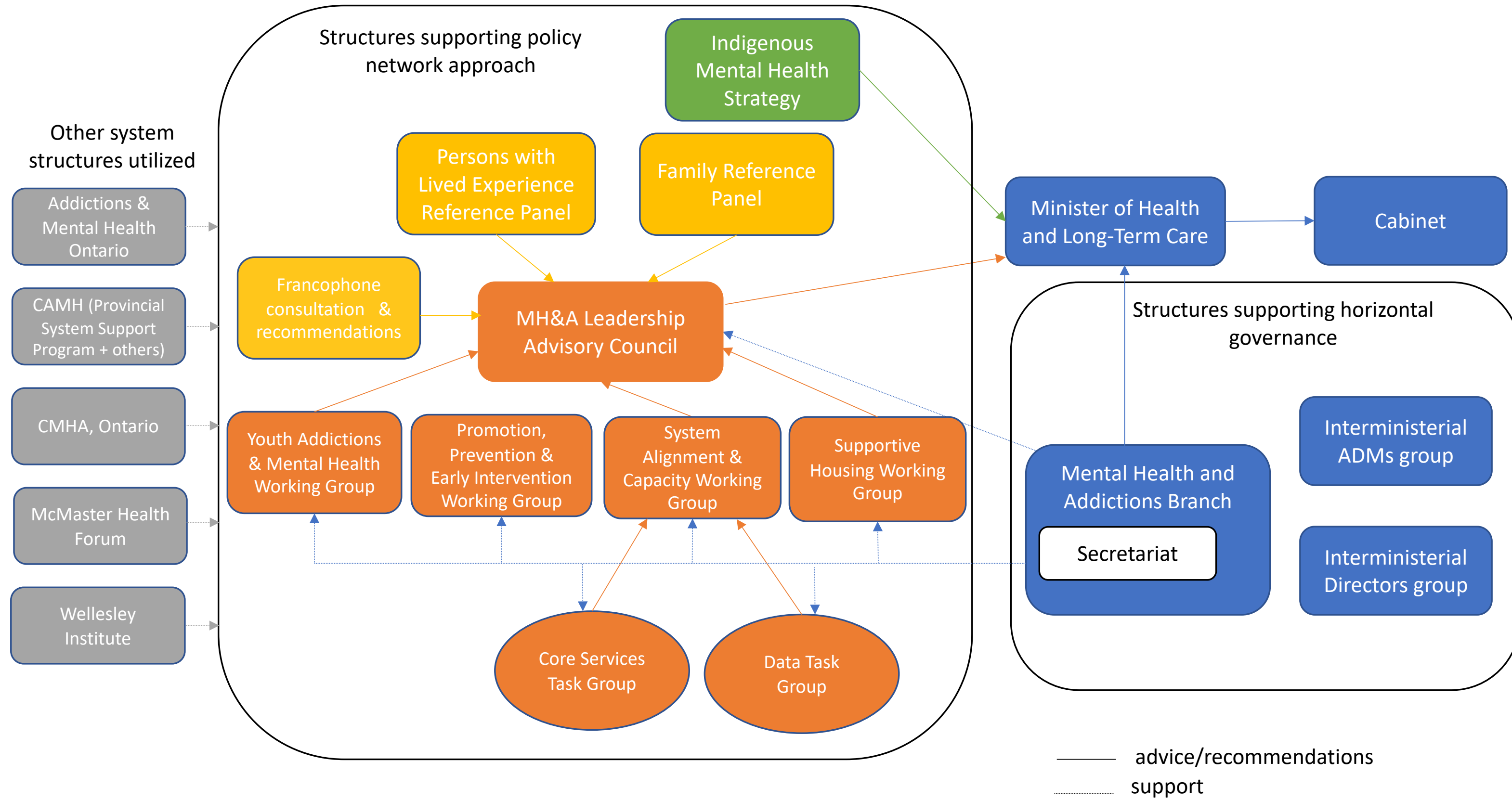

Table 1 - Policy actors involved in the implementation of the second phase of the *Strategy* and their roles

Actor type	**Sub-type**	**Actor(s)**	**Role**										
			Interministerial Committees	Secretariat	MHALAC Council	- Prevention, Promotion & Early Intervention WG	- Supportive Housing WG	- System Alignment & Capacity WG	- Youth Addictions & Mental Health WG	- Data Task Group	- Core Services Task Group	Francophone-specific activity	Indigenous Mental Health Strategy
Political	Politicians	• Minister of Health & Long-Term Care • Other Ministers (e.g. Education, Children & Youth Services, Housing) • Premier of Ontario											
	Political Appointees	• Chair of council • Council members			✓								
Public servants	Ministry of Health and Long-Term Care	• Deputy Minister • Associate Deputy Minister • Assistant Deputy Minister • Staff of: • Mental Health & Addictions Branch • Healthy Living Policies & Programs Branch	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

		• Addiction & Substances Policy & Programs Unit • Housing, Forensic Mental Health & Community Services Unit • Health Equity Branch • LHIN Liaison Branch											
	Ministry of Children & Youth Services	• Staff of: • Children & Youth at Risk Branch • Policy Development & Program Design Division • Mental Health Policy Unit, Children & Youth at Risk Branch	✓			✓		✓		✓	✓		
	Ministry of Education	• Staff of: • Special Education Policy & Programs Branch • Strategic Planning Unit	✓			✓		✓	✓		✓		
	Ministry of Community & Social Services	• Staff of: • Social Assistance Service Modernization Branch • Poverty Reduction Strategy Office	✓				✓		✓				
	Ministry of Housing	• Staff of: • Housing Division • Housing Policy Branch • Policy & Program Development Unit	✓			✓	✓						
	Agencies of Government	• Consent & Capacity Board • Health Quality Ontario			✓			✓	✓	✓	✓		
	Regional Health Bodies	• Mississauga Halton LHIN • North East LHIN			✓			✓	✓	✓			

	Regional/municipal government	• Community & Health Services, Regional Municipality of York • Housing Strategy & Program Delivery, Regional Municipality of York			✓	✓	✓	✓					
	Public Health Units	• Middlesex-London Health Unit • Public Health Sudbury and Districts				✓							
	Police Services	• Toronto Police Service			✓	✓							
	School Boards	• Durham District School Board							✓				
Special interests	Member Organizations	• Addictions & Mental Health Ontario • Children's Mental Health Ontario • CMHA, Ontario			✓		✓	✓	✓	✓	✓		
	Service Providers	• **Hospitals** (CAMH, Hawkesbury & District General Hospital, Hôtel-Dieu Grace Healthcare, Ontario Shores, St. Joseph's Health Care, Waypoint Centre for Mental Health Care) • **Primary Care** (Department of Family & Community Medicine UHN, Anishnawbe Mushkiki Thunder Bay Aboriginal Health Centre) • **Community Mental Health & Addictions** (Across Boundaries, CMHA Durham, CMHA Toronto, LOFT Community Services, Reconnect, Youth Services Bureau) • **Community Services** (Parkdale Activity and Recreation Centre) • **Indigenous** (Kenora Chiefs Advisory)			✓	✓	✓	✓	✓	✓	✓		✓
	Street-level Bureaucrats	• MH&A professionals			✓	✓	✓	✓	✓	✓	✓	✓	✓

		• Ontario College of Family Physicians											
	NGOs	• Jack.org			✓	✓							
	Advocacy Organizations	• Ontario Family Caregivers' Advisory Network			✓	✓							
	Equity & Social Determinants Organizations	• Wellesley Institute • Cochrane District Social Services Administration Board (housing division) • Ottawa Salus			✓	✓	✓						
Experts	Persons with Lived Experience	• Persons with Lived Experience Expert Panel			✓	✓	✓	✓	✓				
	Families & Caregivers	• Family & Caregivers Expert Panel			✓	✓		✓	✓				
	Indigenous	• Thunderbird Partnership Foundation • Indigenous nurse practitioner • Paawidigong First Nations			✓	✓		✓		✓			✓
	Francophone				✓							✓	
	Scientists/ Researchers	• Institute for Clinical Evaluative Sciences • CAMH • Pine River Institute • Royal Ottawa Hospital • Ryerson University • Wellesley Institute			✓	✓	✓	✓	✓	✓	✓		
	Intermediaries	• Provincial System Support Program • School Mental Health ASSIST			✓	✓	✓	✓	✓			✓	

Table 2 – Interests, institutional, ideational and external factors that influenced the implementation of the *Strategy*

Category of factors	Factor	Details about factor	Illustrative quotes
Interests	• Process was linked to the election platform over time • Tying the process to the interests of elected officials politicized the work and introduced risk	• Tying the policy implementation process with a political process (a general election), thus preferencing the interests of elected officials, put the process and recommendations at risk • The political gamble did not pay-off: the party lost and the government changed, leaving citizens and stakeholders wondering whether their work would go anywhere • The end result was a further delay in mental health and addictions system investments and improvements • Post-election, participants have stressed the broad engagement and non-partisan nature of the process, in the hopes that the new government will act on the recommendations	*"I think that the fact that they started a year late was the main problem. I'm not completely sure the Liberals wanted to do this. They said they wanted to do it and they said it was a priority, but in truth, if it really was a priority, they could have got a whole bunch of money out of the door in their last year or in their last two years rather than lumping it all into an announcement and a budget just as they were leaving office. Because they knew that they had a 19% approval rating, they knew that the most likely scenario was that they were going to lose. And if they really wanted services to change as opposed to really wanting to take a political position, then they would have done this two years ago, two years beforehand, and they didn't. And consequently, they must have been able to see what would happen."* Interviewee 6
	• A wide array of interests/interest groups participated • Perspectives were missing from some individuals/groups, whose buy-in is needed to implement recommendations and who face concentrated costs	• Generally, the 'right' people were at the table, however, there may not have been 'enough' of particular perspectives and/or the timing of their engagement was slower than it could have been (e.g., persons with lived experience, family members, people from a breadth of geographies and ethno-racial groups) • Perspectives missing from the process that may face concentrated costs as implementation proceeds (but also concentrated benefits): ○ primary care, ○ professionals & professional associations,	*"So, I thought, this is great, at least we have got a nurse. We had no practicing social workers. I mean, we are trying to develop a system that is going to be implemented by two groups of people: professionals and families. I mean the people who do all of the work. And I think they had one family member and we had some people who run professional organizations, but we didn't actually have anybody. We didn't have the College of Nursing there. We didn't have somebody who was the top of the field in psychiatry. We didn't have any system leaders from the professions and if we had actually tried to transform things, we don't*

		○ unions, ○ justice, and ○ colleges & universities. • Other missing perspectives/needed for the next phase: ○ experts in systems & transformation	*know whether the social workers would have done it. No idea whether the unions would do it."* Interviewee 6
	• Several participants struggled with issues of representation throughout process • Intersectionality & ability to bring multiple perspectives viewed as a strength	• Individuals selected for council understood why they had been selected, even if it wasn't communicated to them directly • Efforts were made to put organizational or sectoral interests aside during the process, but these efforts were not always successful and there were some perceived conflicts of interest • Participants had a strong desire to bring their whole self to the table, including the "many hats" they wore, and did not want to be viewed as only representing one particular interest • Through the process, additional perspectives emerged (e.g., the large number of participants who had lived experience of a mental health problem)	*"For me, there were a lot of issues around representation. Not from an identity politics standpoint, but, you know, if you're sitting at the table, are you representing yourself, are you representing your sector, are you representing your organization? Who are you speaking for? What are you advocating for? It seemed like most of the time most of the people were in some sort of conflict of interest. And, that wasn't actually talked about. It's fascinating. The whole process was fascinating to me."* Interviewee 10 *"Right, right, so you've got the experience, you've got the big picture, you have personal experience, you're a northerner. You wear many hats, and contribute, I think, in a constructive and realistic fashion."* Interviewee 8
	• Individual interests were refined and re-shaped through participation • Relationships among interest groups and their relative stance on issues were	• At an **individual level**, participants pointed to: ○ insights they gained about how government works; ○ greater understanding of how other stakeholders view the system; and ○ realization that the experience influenced their career choices and mentorship of others.	*"I'm grateful that I had this opportunity. It literally fell at my feet and it has changed my career, personally. It's opened a lot of doors for me that otherwise would not have opened. And, the other thing it's done is it's changed how I've mentored people, where I see that they have advocacy potential, in helping them to find tables that they can sit at and having that more in the foreground of my mind. As people are coming and looking for advice around career or making meaning or involvement in the community, then I*

	continually shaped through process	• At the **interest group** level, participants: ○ saw the process as an opportunity to educate others on how to work effectively with particular interest groups to achieve change (e.g., Indigenous communities) thus shaping the perspectives of other interest groups; and ○ Identified how, over time, they and the interest groups they represented became increasingly tied to particular perspectives (e.g., "community" or "youth") or further differentiated from others as the process progressed (e.g., addictions vs mental health).	*can say, like, I think this is a valid way of bringing your strengths and showing up, and then being able to advocate for people to sit at those tables where I see that they have promise and potential and skill."* Interviewee 10
Institutions	• Policy legacy of the *Strategy* created interpretive effects that shaped the second phase of its implementation • The *Strategy* did not exert a strong influence on the council's activities or recommendations	• The *Strategy* created interpretive effects by: ○ Framing mental health as a whole-of-government policy issue and expanding the focus beyond treatment to include prevention, promotion and social determinants. This shaped the composition of the council and who was selected to participate; and ○ shaping how the Mental Health & Addictions branch framed new policy recommendations by interpreting new recommendations through the lens of the *Strategy).* • The policy legacy of the Strategy was otherwise limited: ○ council used it as "context" or "a jumping off point" rather than grounding deliberations or recommendations on it.	*"I looked at your questions this morning and I thought, yeah, well, it's nice to say that this was implementation of the Strategy, but in fact, the Strategy at best provided a jumping off point. The very beginning the Ministry brought in a deck to say here's what you're all being asked to do to help implement this Strategy. So, they did that, but it was like a framework. That Strategy didn't provide much direction. And so, we had buckets of things, those five pillars or four pillars or whatever, and that was about it. So, we really had to give it a lot of shape, I would say. That Strategy was not really a strategy. It was not even a framework. If you look at Making it Happen or any of those, they were far more grounded than that Strategy was."* Interviewee 5

	• The structures used to support the horizontal governance and policy networks approach evolved during the process • This was seen as both a facilitator and a barrier to the process	• Government created structures for regular communication amongst senior public servants across ministries • Teams worked hard at creating and maintaining informal communication channels • Overall architecture evolved - from a unit to a branch that included a secretariat • **Barriers** to structural changes included: o evolution created a large amount of turnover at all levels within the ministry; and o degree of turnover slowed process and adaptations were required with each change. • **Facilitators** to structural changes included: o individuals supporting the work were viewed positively and participants were impressed with their commitment.	*"There were several inter-ministerial committees, so that all the ADMs and the directors could keep each other informed, because there are so many ministries involved in mental health and addictions…Oh yeah, there was a lot of discussion within the branch, across the ministry, with other ministry partners at [each] level."* Interviewee 1 *"At the ministry level, every time you turned around it was somebody different. That is a very, very sad statement. It was clearly not the priority it should have been by the ministry, and I think they dropped the ball significantly. I say that with all due respect to individuals…"* Interviewee 8 *"I must say by and large, and I've told everybody this, I was incredibly impressed with the intelligence and commitment and just the overall quality of the people on the secretariat."* Interviewee 4
	• Concerted attempts made to connect work to existing policy networks • Extent of this reach was limited by formal & informal rules about confidentiality	• Council members provided regular updates and engaged their networks when they saw opportunities for input on a specific issue • This supported a slightly larger 'reach' and engagement of the broader mental health and addictions policy network of citizens and stakeholders • Reach was limited because of the formal restrictions (e.g. the confidentiality agreements that council members had signed) and informal restrictions (e.g. culture of the bureaucracy) on their ability to provide complete transparency on the deliberations taking place	*"…we would go out of our way to reach out to get feedback from the field and from all of the players in the sector. And [we] worked very closely with our respective members to make sure that they were brought along. …At every opportunity through those meetings they were briefed on the latest work with the council."* Interviewee 3 *"But, like I said, I think there were opportunities missed for communicating to the public what we were doing and what we were aiming for. Transparency in government is always a challenge, because you're not allowed to say anything until you've had it approved… Like, I couldn't really*

			tell my friends at cocktail parties what I was working on." Interviewee 11
	• Broader policy & legislative context was important input to the process, but there was a trade-off	• Great deal of activity and time directed toward ensuring the council was familiar with the existing policy and legislative context. This helped to: ○ Inform council's recommendations by providing an opportunity to shape them according to the existing and emerging policy context; ○ Provide an opportunity for input on new policy and legislative decisions by mental health and addictions experts; and ○ Increase policy coordination and contribute to policy decisions (e.g. supportive housing announcement of $200 million in 2017). • Trade-off was keeping focus and scope manageable and on mental health and addictions versus becoming a consultation group for other government work	*"Yeah. We had all of that. We had the anti-poverty strategy. The housing strategy people were front and centre. Those are two big ones that come to mind. But, yes, [the council chair] was good at that. She was good at bringing in where we were linking to other stuff and overlapping…We had a lot to say about it. These poor soldiers would come present the thing and we'd all lay it on. And they would say, okay, thank you, this has been very helpful. And they would go away and we'd never see it again. So, we turned into kind of a consultation group for a number of government strategies."* Interviewee 5
Ideas	• Process explicitly included multiple sources of knowledge • This was viewed as a strength	• One source of knowledge was not privileged over another in the process • Lived experience was viewed by all involved as being a particularly important input and had a grounding effect that kept things focused on 'what really matters'	*"I think it was multi-faceted. I think for sure the evidence and best practice around the initiative that they recommended, in particular, was a key driver. I think their experience in the sector, as sector experts, from both the council and the working group perspective. I think they brought system-wide perspective, but the working groups also brought the on-the-ground knowledge to the table. Then, the people with lived experience. I think the reference panels were key. I know the council said that quite a few times, that they were really grateful for the input from the reference panels. So, I think all of that. Having the right people providing insights and then having evidence from the literature and from*

			research, to drive, were the key drivers of the policy recommendations, the policy work that came forward from our end. And, I think that's also what drove the council's recommendations." Interviewee 1
	• Values generally shared by participants • Values-conflicts arose on highly contested issues	• Values were most clearly expressed as "guiding principles": a system that is equitable, recovery-oriented, high-performing, accessible and person-centred • Values conflicts arose early in council's mandate regarding changes to the Mental Health Act - this divisive issue was highly values-laden because of the impact on personal rights and freedoms • Council was not able to make progress on the issue, reflecting a limit on its ability to make values-laden decisions	*"Oh, yeah, there was a big issue at the very beginning about the Mental Health Act. In the very beginning, somebody raised the issue of should there be a relaxing of the Mental Health Act. They opened the Mental Health Act to make treatment easier….Yeah. So, that came up pretty early on. And that was a hard decision to make. That was an ugly first incident. I was opposed to it because I said, we're just a brand new group. This is the most divisive issue in the whole field. Why are we are starting with this? I know the timing is bad and we can't leave it to the end because it's going to be too close to an election. So, for the same reasons. But, of course, the whole thing just got shut down…"* Interviewee 5
External	Election	• *see Interests above*	

Table 3 – Factors related to actor relationships and actor context and their influence on the implementation of the *Strategy*

Categories of factor	Factor	Details about factor	Illustrative quotes
Relational			
Goal alignment	Alignment of broadly defined goals, but challenges in communicating them and agreeing on their relative priority	Challenges: • not "speak(ing) with one voice" and communicating goals slightly differently; • uncertainty about alignment between council and ministry and what would have been helpful to support bureaucratic processes; • relative prioritization between prevention ("going broad") and treatment, which was a source of on-going tension.	*"There was certainly a tension in the whole council between people who wanted to go really, really broad. And that would be people like [council members], who basically wanted to make the whole project of improving the mental health system one of the whole of government, that the mental well-being of Ontarians is a job for the Premier and all the Ministers. And others who said, okay, that's great, that's the broader context, but right now let's just get some recommendations out that will improve the quality of healthcare for people who do have mental illness. So, that tension between prevention and treatment was there throughout. We never got that wrestled to the ground."* Interviewee 12
Active engagement of key actors and feedback loops	Feedback loops were evident	How feedback drove process: • communication among political, bureaucratic, citizen and stakeholder actors about what was likely to feasible/acceptable; • process attentive to windows of opportunity for investment; • feedback loops shaped recommendations (e.g., governance of the mental health system).	*"At various points, and I can't remember precisely, but we'd hear back from the senior parts of the secretariat that it just can't happen that way. That's not a door that's open. And you kind of go, why not, right? But there are probably good reasons why that's wouldn't be something, that's not how it's done type of thing….Timing for when there's a window to get a recommendation in because there's some room in this budget or that budget, all those sorts of things, were a little bit behind the scenes. And sometimes, being frankly open here, you kind of wonder how much is being done by either the secretariat or above to almost use the council as a tool."* Interviewee 4

Degree of communication among actors	High degree of communication enabled process but some challenges and gaps were identified	Mechanisms for communication: • formal (e.g., interministerial groups); • informal (e.g., individual meetings with secretariat or chair). Challenges: • volume of information; • number of sources; • concisely communicating about mental health as a policy issue to those not involved. Gaps: • government processes (e.g., not being aware a cabinet submission was being developed); • time between meetings and drafting of annual report; • interactions between council and panels.	*"It was learning, yeah, because some of the things, some of the different topics that were presented, some of the information that was sent out to people, were mind-boggling. We had reams and reams….I also learned that the communication, there wasn't anybody steering the ship when it came to sending information to the government. It was like spaghetti. I looked at this chart, and I saw all the ways that government receives reports, evaluations, surveys, and stuff from all the different sectors, and who would ever be able to make any sense out of that?"* Interviewee 2
Level of shared values and beliefs	Values and beliefs not explicitly discussed but emerged through process	Role of values and beliefs: • general sense that values were shared but they did not expressly drive process; • process was less about "what" and more about "how," which might lend itself less to overt values discussions; • values and value conflicts emerged with contentious issues (e.g., reviewing the Mental Health Act).	*"I think that knowing the people, as I do now, everything was really grounded in values and I would say that as values go it was a very cohesive group…So no and that's a beautiful thing about the work is that people weren't coming to the table questioning why we would want to do this. It was always about what is the best way forward."* Interviewee 3 "*Oh, yeah, there was a big issue at the very beginning about the Mental Health Act…They opened the Mental Health Act to make treatment easier….Yeah. So, that came up pretty early on. And that was a hard decision to make. That was an ugly first incident. I was opposed to it because I said, we're just a brand new group. This is the most divisive issue in the whole field. Why are we are starting with this?..."* Interviewee 5
Coordination and alignment	Strong efforts to coordinate and	Enablers of coordination/alignment: • chair & secretariat;	*"Our chairperson was amazing…she was absolutely amazing, and when [the director of the Mental Health*

of actors and activities across levels	align bureaucratic and policy network actors who were directly & indirectly involved	• structures within government and council; • additional efforts by council members to coordinate/align with policy network (e.g., LHIN-led coordination table for "implementers").	*and Addictions branch] was involved, I'm sorry she didn't stay for the very end, she was great too. She was wonderful, very approachable, and I had some meetings and conversations with her on the side, which were very helpful for me. So, I think that having those two always available kinds of people really helped this process to move forward."* Interviewee 2
Visibility of policy actors and the role they play in the process	Policy actors at multiple levels were present and visible throughout the process, signalling ongoing commitment	Indicators of visibility: • presence of senior politicians at council meetings (e.g., premier and minister of health); • presence of senior public servants at council meetings (e.g., deputy minister of health and assistant deputy ministers from other ministries); • number of in-person meetings secured with senior government officials.	*"There were a few senior members that came to the meetings. We had [the deputy minister] there all the time. That guy is amazing. The premier came to our meetings, she dropped in one time. So, we can't say we didn't have commitment from high levels of government. I think we did, and they showed that commitment by dropping in and being there, and saying yes to the things that we were asking for, like they didn't tell us we were being ridiculous."* Interviewee 9
Contextual			
Stability of policy actors supporting or leading implementation	Relative instability of policy actors had a negative impact	Stability affected by: • significant levels of staff turnover and organizational restructuring at ministry; Effects: • turnover caused continual need to bring new actors up to speed and adjust to new processes; Mitigation: • despite turnover, actors were impressed with secretariat staff and its support.	*"I think having consistent support from the beginning for the council probably would have been helpful. The ongoing turnover, which is, you know, sort of par for the course, but I think that would have been probably a little bit … It was a little bit of a bump, in that there were learning curves and the council had to be patient while staff was getting up to speed every time there was turnover."* Interviewee 1

Dedicated leadership for implementation	Dedicated leadership was present and instrumental in the process but was not distributed enough for optimal impact	Effects of leadership: • leadership important for actors within and outside of government; • chair provided key leadership & seen as instrumental to the work; • chair's leadership viewed as necessary but not sufficient to achieve implementation; • distributing leadership responsibilities to senior government officials could have further driven decision making and implementation.	*"And I felt like the chair was very good. [the council chair] is an amazing lady, she was our chair. So, she's basically like we haven't heard from the, say, Francophone population. How do we engage them? She was so good at ensuring that we had a province-wide approach and view…I realized why they were doing it, because we were a council and we had to show some unity. So, we didn't want people going off in a little corner, feeling bad or feeling unheard or whatever. So, I thought she was really good…."* Interviewee 9
Sustained political will, commitment and support	Questionable level of commitment and political will at senior government levels	Why political will and commitment questioned: • gaps in knowledge about what was taking place within government caused participants to question level of commitment and support at higher levels of government; • some equated presence at meetings with commitment, while others referenced what went on outside of meetings and expressed disappointment/frustration that they were not able to achieve more, faster; • new investments made during the process (e.g., supportive housing or structured psychotherapy) were pointed to as evidence of commitment and political will.	*"I never felt as if we had somebody at the senior Assistant Deputy Minister level who was really, really, really driving this thing and encouraging the Deputy Minister and the Minister to make it a high priority. It just felt as if they were scrambling all the time."* Interviewee 12 *"I would say if anything, it's the political folks who could have been driving that agenda much more vigorously, moved us into much more of an implementation mode before the election. And for reasons that I understand now but at the time was I very frustrated with, they were not picking up the ball and running with it and really driving that work to be completed and moving us into the much more important next step of where do we go."* Interviewee 3
Power and visibility of stakeholders during implementation	Distribution of power was uneven across stakeholders and process was not highly visible to non-participants	Power: • concept of power connected to ability of actors to contribute organizational resources (not positional or professional); • power imbalance may have led to uneven influence on recommendations.	*"I mean, it was also interesting to see … So, at the time, I was working for a really small organization…I had nothing to offer in terms of resources. Then, you have someone like [names of council members], who just have all of these resources, so they can appoint two FTEs to do this piece of work or the [program] or whatever…Like, there's power and influence there.*

		Visibility: • not a lot of press or public visibility during process; • limited evidence of government attempts to generate attention; • council members reached out to constituents/ networks to consult and provide progress updates.	*These sort of decision-makers that hold the purse strings. But, that also meant that there was a lot of influence in terms of recommendations that were made. One doesn't go without the other."* Interviewee 10 *"…we would go out of our way to reach out to get feedback from the field and from all of the players in the sector. And [we] worked very closely with our respective members to make sure that they were brought along."* Interviewee 3

Appendix 1 – Interview guide for semi-structured interviews

Why stakeholders matter in policy implementation: An examination of citizen and stakeholder engagement in the implementation of Ontario's mental health and addictions strategy

Ethical considerations:
A description of the study will have been presented during the recruitment phase. A signed confirmation of commitment to participate will be obtained prior to engaging in the questions. Any ethical issues arising will be addressed prior to the first question and will be documented by the Interviewer.

Process:
Interviews will be recorded on a digital audio device, transcribed, and uploaded into a qualitative software program. Hand written notes will also be made by the interviewer into her field notebook.

- ✓ Denotes probes

Date:
Time:
Place:
Interviewer:
Interviewee:
Position of Interviewee:

Questions

Do you have any questions for me before proceeding to the interview?

Before we start, I want to mention that I will be referring the Open Minds, Healthy Minds, Ontario's Comprehensive Mental Health and Addictions Strategy as the *Strategy*

A – Participation in the process of implementing the Strategy?

- Could you describe, in general, your involvement in the Strategy?
  - ✓ How have you been involved?
    - o Leadership Council
    - o Working groups
    - o Persons With Lived Experience or family member panel
    - o MOHLTC MH&A branch

  - o Other MOHLTC branches
  - o Other ministry partner (MCYS, MEd, etc)
- ✓ How long have you been involved?
- ✓ How would you describe your role to someone else who was not directly involved?

B - How do you believe your involvement contributed to the PROCESS of the implementation of the *Strategy*? (Thinking about your personal contribution, your contribution as a member of a citizen or stakeholder group/organization, and overall as a whole system)

- ✓ Personal
- ✓ Citizen/stakeholder group/organization
- ✓ Overall

- What were some of the challenges with respect to the process in your view?

C - How do you believe your involvement contributed to the OUTCOMES of the implementation of the *Strategy*? (Thinking about any personal outcomes, outcomes as a member of a citizen or stakeholder group/organization, and overall whole system outcomes)

- ✓ Personal
- ✓ Citizen/stakeholder group/organization
- ✓ Overall

- What were some of the challenges with respect to the process in your view?

D - What factors do you think were important to the process of implementing the *Strategy*?

Ideas (research evidence + values)

- What types of information were used to inform decisions?
  - ✓ Research evidence
  - ✓ Lived experience of people experiencing mental health problems
  - ✓ Professional experience/tacit knowledge
  - ✓ Evaluation data
  - ✓ Past policy experience

Interests

- Do you believe the “right” people (e.g. citizens and stakeholder) were involved? Why?
- Which (if any) perspectives were missing?
- Were all perspectives considered equal in the process? (were some valued or ‘heard’ more than others?)
  - ✓ If yes, which ones?
  - ✓ If yes, what do you think the reasons for this are?
- If another person wanted to participate, were there opportunities to do so?

Institutions

- Did the existing structures and capacities of government impact the process or the decisions you made? If so, how?
- Were other policies or legislation consulted, used or discussed? If so, which ones?
- Did you draw on other networks during the process?

E – Can you tell me a little about the quality of the process?

- Quality of discussion and deliberation (transparency)
- How decisions were made & conflict resolved (consensus, voting, etc)
- Efficiency and effectiveness of the process and your involvement

Those are all the questions I have for you. Thank you so much for your time and participation in this study. Do you have anything else you want to add?

Ask participants for any documents that might be helpful and to specify anything that is confidential

Chapter 7. Conclusions

Collectively, the research presented in this dissertation helps to unpack the "black box" of implementation[1] further by shedding light on the role that policy plays within it. It examined implementation processes in mental health systems in jurisdictions that have received relatively less scholarly attention than jurisdictions such as the US, where the unique health and social system arrangements can sometimes limit the comparability and transferability of insights. While each study presents a unique individual contribution, taken together the package reflects substantial advances in knowledge that have important implications for the research community, but also for policy-makers and systems leaders seeking to implement evidence-informed policies and practices (EIPPs) in their own context. In this concluding chapter, I present a short summary of the key findings, and reflect on the main theoretical, methodological and substantive contributions of the thesis as a whole. I then consider the overall strengths and limitations of the research and conclude with implications for research and policy.

Principal findings

The studies in this thesis explore the process of the implementation of EIPPs with a focus on policy, which is sometimes referred to as the "outer context" the implementation science literature.[2] The first study (Chapter 2) takes a broad view of implementation, drawing from different fields and from studies addressing a range of topics to generate theoretical insights using the critical interpretive synthesis method. It represents one of the first comprehensive attempts to answer the call of scholars to integrate the fields of political science/public

management, knowledge translation and implementation science in an effort to build a more comprehensive and accurate understanding of implementation. It first identifies six ways that policy is described in the implementation literature, including as: 1) the context; 2) a focusing lens; 3) the innovation itself; 4) a lever of influence; 5) an enabler/facilitator or barrier; or 6) an outcome. The study also identifies policy actors as important participants or leaders of implementation. Most substantively, the analysis led to the development of a two-part conceptual framework, including process and determinant components. Finally, the findings are used to improve existing theory using Wandersman and colleagues' Interactive Systems Framework for Dissemination and Implementation as an exemplar,[3,4] which resulted in the addition of a "Policy System".

The next two studies hone in on one specific feature of the implementation process – the infrastructure developed to support such processes. These studies focus specifically on the policy area of mental health. They stem from a basic question: What types of supports are necessary for the implementation of EIPPs in mental health to be successful in systems at scale? Both studies draw on data collected from a comparative case study and using a sample pool of countries that are part of the International Initiative for Mental Health Leadership (IIMHL). The IIMHL also acted as my integrated knowledge translation (IKT) partner for these studies. The first in this two-part series (Chapter 3) explores the placement of intermediaries in three jurisdictions: New Zealand, Ontario, Canada and Scotland. It demonstrates that the placement of these intermediaries is explained by their institutional landscapes and in particular, the mix of public/private mental health service delivery created by policy legacies and the differing administrative capacities of their systems. A system such as Scotland, with public delivery and administrative capacity within the government, is more

likely to have the intermediary function within that setting. When delivery is a public/private mix (like New Zealand) or primarily private (like Ontario), then the location of the intermediary is explained by where the administrative capacity exists in the system (NGO sector in New Zealand and service delivery system in Ontario).

The second of this two-part series examines the role of intermediaries supporting the implementation of EIPPs in the mental health systems of New Zealand, Ontario, Canada and Sweden (Chapter 4). The cases sampled in this chapter differ from the previous because different case selection criteria were used. The theory underpinning the study and used in the analysis includes the modified Interactive Systems Framework for Dissemination and Implementation (m-ISF) developed in Chapter 2. The analysis first explores how implementation infrastructure in the form of policy-related intermediaries gets created. The findings show that in each jurisdiction, a unique set of problems (e.g. negative events involving people with mental illness), policies (e.g. feedback on effectiveness of existing policies) and political events (e.g. changes in government) were 'coupled' by a policy entrepreneur to create the intermediary. The study also presents rich descriptions of the intermediaries themselves in terms of their structure and characteristics and the strategies they employ. While intermediaries varied greatly in their structure and characteristics, both the strategies they used (e.g., formal advice/policy input) and the strategies they didn't use (specifically, strategies targeting the public or involving audit and feedback) were surprisingly similar. The analysis then identified five factors that explain why these two particular strategies were avoided: 1) their need to build/maintain healthy relationships with policy actors; 2) their need to build/maintain healthy relationships with service delivery system actors; 3) role differentiation with other system actors; 4) perceived lack of 'fit' with the role

of policy intermediaries; and 5) resource limitations that preclude intensive distributed (program-level) work.

The next two studies shift away from implementation infrastructure, instead focusing on the processes used to implement mental health policy. They draw insights from the development and implementation of Ontario's most recent policy, *Open Minds, Healthy Minds, Ontario's Comprehensive Mental Health and Addictions Strategy* (the *Strategy*) [5]. The first study (Chapter 5) is a policy analysis investigating whether there is anything setting this process apart from previous policy efforts. The analysis identifies three distinguishing features from previous reform efforts: 1) an expansion of the actors and policy network to those outside of health, 2) an extension of the policy network approach into the *Strategy*'s implementation stage, and 3) the combined presence of political and policy leadership. These findings suggest there is reason for optimism that the approach of the *Strategy* has increased the prospects for a more successful implementation process thereby improving the likelihood of achieving its goals.

The final study, and the second in this two-part series, is an examination of citizen and stakeholder engagement in the implementation of the *Strategy* (Chapter 6). It was based on the observation that the policy network, which is comprised of citizens and other stakeholders from multiple sectors, continued to be engaged in strategic activities related to the *Strategy* well into implementation. The choice of topic for this chapter was also shaped by my IKT partner – the Mental Health and Addictions branch of the Ontario Ministry of Health and Long-Term Care. By examining the policy implementation process, and the role that citizens and other stakeholders play in it, this study contributes an increased understanding about how systems can better achieve policy objectives and the benefits and

challenges when 'coproducing' public services. The findings detail the breadth of engagement in the implementation of the *Strategy* and specifically how citizens and other stakeholders contributed. The mapping process highlights the range of inter-dependent actors involved, the multiple ways that they provided input, and the structures through which they provided input. The analysis of the political landscape explicates the various influences on the process and the particularly important role of interests. Finally, the exploration of policy actor-related determinants (drawing on the framework developed in Chapter 2) explains how the relationships between actors and, even more importantly in this case, their context (e.g., instability of policy actors) affects the process and the outcomes it was able to achieve.

Novel contributions

Reflecting on these studies as whole, there are eight contributions that this thesis makes to the fields of implementation and mental health. These can be divided into theoretical, methodological and substantive contributions and are outlined and discussed below.

Theoretical

While implementation models, theories and frameworks have become plentiful, giving scholars and implementation practitioners the ability to select a theory that best fits their implementation endeavour e.g., see[6,7], one area that has received relatively less theoretical attention is the role of policy in implementation. The major theoretical contribution of this thesis fills that gap with a new theory that better incorporates policy considerations, which is grounded in the existing literature using the rigorous critical interpretive synthesis method. The first part of the two-part framework is a process model that specifies the stages of implementation while being attentive to policy-related activities and inputs. The second part

is a determinants framework that identifies eight categories of determinants, the policy instruments and strategies that can be employed to support implementation by target, and the policy actors, their characteristics, relationships and context. This framework provides scholars with a more precise understanding of the role of policy in implementation and identifies measurable variables that can be tested empirically.

A second theoretical contribution is the refinement of existing theory based on the findings from the critical interpretive synthesis. By modifying the ISF[3,4] to include a 'policy system', I demonstrate how the findings generated from the critical interpretive synthesis can be used to improve current theories by better incorporating policy considerations.

Methodological

This thesis makes three key methodological contributions. The first is the unique interdisciplinary approach taken with the intentional integration of the political science/public management, knowledge translation and implementation science literature. The combining of theory, explanatory frameworks and empirical works from these three fields results in unique findings and insights that would not be available from one discipline alone and demonstrates the potential utility of integration that has been called for by other scholars.[8] The second contribution to methodology is the novel application of theory from political science to questions focusing on implementation rather than other stages in the policy cycle. By using these frameworks analytically, I found they were not always a perfect 'fit' with the questions being explored (which supports the assertion that there is a need for more explanatory theories to explain the implementation of EIPPs), however, they were useful to explain phenomena related to implementation, such as the emergence of intermediaries or how stakeholders contributed to implementation. The third methodological

contribution was the IKT approach taken in three of the studies (Chapters 3, 4 and 6). While IKT is not new, it is not regularly undertaken at the graduate level (unless it is already part of a broader program of research) nor used in three separate studies with two unique IKT partners (the IIMHL and the Mental Health and Addictions branch at the Ministry of Health and Long Term Care), as is the case here.

Substantive

There are also three key substantive contributions made by this thesis. First, it provides policy-related insights into the implementation process and identifies policy-related determinants of implementation – both of which have been lacking relative to other areas in the implementation literature (such as characteristics of the innovation, inner context, etc.). Secondly, it clarifies the role of policy intermediaries in several well-developed mental health systems, including how they came about, where they are placed in systems and why, what strategies they use, and what explains why some strategies are avoided. Thirdly, it identifies key features of Ontario's most recent approach to developing and implementing its mental health and addictions policy that distinguish it from past efforts and explains how and why citizens and other stakeholders contribute to the implementation process therein.

Strengths & limitations

There are two features of this thesis that strengthen it but also introduce limitations: the IKT approach, and the author's pre-existing relationships with the field. First, the purpose of conducting research with an IKT approach is to generate research that is more relevant and more suitable for uptake because potential knowledge users are engaged from the start and have an opportunity to provide input and feedback throughout the knowledge generation

process.[9] One strength of using this approach here is that in each case, the IKT partners helped to shape the research questions, therefore giving confidence that the study findings would indeed be more relevant than had they been investigator-driven alone. It also meant my partners created opportunities for me to share progress and get regular feedback throughout the research process, thus creating a sense of shared ownership. Additionally, the IIMHL organizations acted as gracious hosts during the site visits for the comparative case study (Chapter 4). In both cases, the IKT partners facilitated access to key informants by providing names and contact details of individuals or reaching out directly with the study information if confidentiality was a concern. Furthermore, both sets of partners remained accessible throughout the process when I had questions or needed to 'fact check' information gathered to ensure accuracy. On the other hand, the IKT approach did pose some challenges. To begin with, I now have a better understanding of why graduate students tend not to work with two separate sets of IKT partners concurrently. This is likely because of the additional time and resources (such as other team members) required to execute the IKT approach effectively, and graduate students are often limited in both. Working in this way added a burden and responsibility that needed to be carefully managed because failure carried reputational risks as well as risks to effective project execution. Furthermore, there was a change in leadership at the Mental Health and Addictions branch, which delayed the process and required some additional relationship building.

A second factor that acted as both a strength and a potential limitation is my pre-existing relationships with the field. I came to this dissertation with work experiences and relationships with people and organizations in Canada and internationally that had been developed over the prior 15 years. Some of these organizations became the subject of my

scholarly inquiry or an IKT partner and many people became potential participants in at least one of the studies. On the one hand, this was a definite advantage because I did not have to build relationships from scratch that were necessary to conduct the research, but rather could 'activate' existing ones. I also suspect that it may have facilitated a relatively strong response to the initial interview requests for Chapters 3, 4 and 6 since I was a familiar name to many. On the other hand, given the qualitative methods employed, it likely influenced how people responded to questions (e.g., based on a certain level of assumed knowledge) and what they chose to highlight in their responses. Some also mentioned me specifically in their responses (e.g., as an influential person in the system). I attempted to mitigate risks this posed to my research by practicing reflexive processes such as taking field notes, adjusting interviews to ensure participants were explicit and did not rely on an unspoken shared understanding, triangulating interview data with other sources (e.g., documents), and using other members of the research team who were less familiar with the subject to review findings and interpretations.[10] On the whole, I believe these pre-existing relationships were an advantage because it facilitated access to elites, which can be challenging for doctoral students who often have had limited time and ability to develop relationships through previous work.

Research & policy implications

Future research

This research begins to unpack some policy features of implementation processes that have largely been clustered together in one or two categories of variables in the "outer context", making them difficult to accurately define and measure. It adds more precision and clarity regarding policy-related elements and the connections between them. It also

demonstrates how frameworks from political science can be used to better understand implementation, especially at-scale in systems. It therefore leaves researchers with an abundance of opportunities to study specific policy-related determinants of implementation or to clarify the policy-related influences on the process. Specific future research opportunities include empirical tests of the newly developed theory to refine it and to understand its potential utility for different topics (e.g., mental health, child welfare, justice, etc.) and different types of implementation endeavors (e.g., implementation of a specific evidence-informed intervention versus implementation of a broad evidence-informed policy). The observations and explanations derived from the studies examining intermediaries beg for large-N quantitative projects that examine intermediaries in a larger range of system contexts and that can yield some helpful generalizations. Future studies related to citizen and stakeholder engagement in the process of implementation could continue to examine the process over a longer period of time in order to trace the inputs and influences with implementation outcomes. Predictions about citizen and stakeholder influences in other processes could also be made and tested empirically based on these findings. Finally, there are an abundance of opportunities to draw from other explanatory frameworks and theory from political science to enhance implementation science research and vice versa, thereby enriching both fields of scholarship.

Implications for policy-makers, implementers and system leaders

Collectively this body of work offers five considerations for those seeking to undertake large-scale EIPP implementation activities in the hopes that they might help to improve the structure and execution of implementation processes thereby leading to a higher likelihood of achieving successful outcomes. These considerations include:

1. *Seek guidance from a range of scholarly sources prior to, and during, the implementation process.* As this thesis demonstrates, the fields of political science/public management, knowledge translation and implementation science each have something to offer regarding implementation. Implementation is not a new phenomenon and people have been 'doing' it and studying it for a long time. While there may be a tendency for one to draw on the scholarship from the field they are most familiar with, doing so may mean missing particular insights from other fields that could be highly relevant to the challenges at hand. My advice is to go broad and be interdisciplinary in practice (not just in research).
2. *Use theory to guide your implementation work.* Implementation models, theories and frameworks abound and there are many from which to choose. This thesis presents another novel theoretical option. While it may seem counter-intuitive, using theories can be a short-cut because the theory-user is succinctly benefitting from the knowledge of scholars who have studied implementation deeply and often over many years. They offer a high-level overview of what to expect during the process (process models) or what should be attended to in terms of factors that may affect the process and outcomes of implementation (determinants frameworks). Furthermore, as demonstrated in Chapter 2, modifications can be made to existing theory if what is found isn't suitable. My advice is to be cognizant of what is being added and why, and reflect later if your modifications were helpful.
3. *Political and policy context matters in implementation* (as much as in agenda-setting or policy development). The findings in this thesis demonstrate that political and policy context matters and offers explanations on *how* it matters for certain features of the implementation process. Given this, context scanning is an important activity for those

engaged in implementation efforts to anticipate challenges or identify windows of opportunity during the implementation process.

4. *Assess the infrastructure required and available to support implementation and if it doesn't exist, consider building it.* The investigation of implementation infrastructure in the form of intermediaries in the thesis provides helpful insights about how intermediaries emerge in systems, where they are placed, and what they do to support implementation. It is becoming increasingly clear that effective implementation requires supports beyond the service delivery system to make it successful. Intermediaries can undertake many of the implementation strategies linked to positive implementation outcomes and support service providers, policy-makers and people with lived experience, for whom implementation activities can often be 'off the side of the desk'.
5. *Intentionally engage those who will be affected by the implementation efforts (i.e., the policy network, broadly defined) in implementation activities and oversight of the process.* Citizen and stakeholder engagement (both those inside and external to government) can enhance the process and possibly lead to better implementation outcomes through the "co-production" of public services, as the studies in this thesis suggest. Engaging citizens and stakeholders early and consistently throughout the implementation process can result in decisions that reflect the perspectives of those who may be expected to adjust their behaviour or relationships in order to achieve implementation goals and provide an opportunity to surface and address unanticipated challenges so that the process does not stall later. It also supports buy-in and improves readiness for change. However, as these findings suggest, engagement must be done thoughtfully and with the understanding that the expectations

for change are heightened because of the time, effort and goodwill citizens and other stakeholders dedicate to the process.

In sum, this thesis yields many novel insights about implementation generally, and implementation in mental health systems specifically, by unpacking the role of policy in large-scale implementation efforts. It is my hope that the findings will be taken-up and built upon by the research, policy and implementation communities to further improve implementation processes thus leading to better health and social outcomes for citizens in Ontario, Canada, and around the world.

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