Engagement in Mental Health Services:
Stakeholder Attitudes Towards a Local Governance Initiative

by

Peter Ilves

A research project submitted in partial
fulfillment of the requirements for the
degree of Master of Business Administration

Saint Mary's University

Written for MKTG6699
Under the direction of Dr. Ramesh Venkat

November 21, 2011

Approved: Ramesh Venkat PhD

              Faculty Advisor

Approved: Mark Raymond PhD

              MBA Director

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Abstract

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Stakeholder participation is an emerging governance approach within health care. Despite a literature on the theoretical potential of participatory, stakeholder-based governance in health care, less is known about the process variables associated with effective implementation and sustainability. The viability of participation is associated with: clarity of mandate; scope of stakeholder decision making; roles and responsibilities of participants; participant skill and attribute mix; and accountability requirements. This exploratory, qualitative study utilized 20 semi-structured interviews with mental health services stakeholders regarding their expectations of a proposed mental health Community Advisory Committee (CAC's) within the Fredericton-area of the Province of New Brunswick. Findings reveal convergence around four process variables; meaningfulness; trust; legitimacy; and effectiveness. Participants diverged on outcome expectations; some preferring instrumental outcomes (i.e. housing); and others viewing establishment of a well-functioning engagement process as a key outcome in itself. Managerial implications and future research directions are discussed.

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Chapter 1 – Introduction

1.1. Background

Direct involvement in service development and delivery by stakeholders has been noted as an important trend within the marketing and public administration literature. Several authors argue that stakeholder participation in decision making is positively associated with satisfaction and cost effectiveness (Boviard, 2007; Sheedy 2008; Head, 2008). As health delivery systems have become more regionalized in Canada over the past two decades stakeholder 'engagement' in service planning and delivery are increasingly reflected in the health care policy discourse. Consequently mechanisms for public engagement in policy, planning and operations have garnered the attention of government, administrators, health professionals, and local communities and services users. These mechanisms include consultative approaches through to mandated stakeholder representation on executive boards. Within mental health service systems stakeholder participation has been noted as critical factor in mental health services governance; due in part to the complexity of mental disorders and their management.

Several authors have proposed that *engagement* be viewed as a continuous, as opposed to dichotomous, process (Boviard, 2007. Sheedy 2008) describes this trend as continuous shift from *communication* to *co-production*. In its stronger form, engagement involves an ongoing and active relationship. Information is exchanged

between stakeholders and the sponsors. Some degree of dialogue occurs usually in a group setting. The act of dialogue and negotiation serves to transform opinions into more meaningful form (Rowe & Frewer, 2005; Head 2007). At the highest end of engagement, stakeholders collectively co-produce new products and services. Ostrom (1996) defines co-production as "the process through which inputs used to provide a good or service are contributed by individuals who are not in the same organization". In its weaker, more episodic, form engagement represents sponsor communications; a largely one-way approach to informing key publics. Information is conveyed from the sponsors of the initiative to the public. Information flow is one-way: there is no involvement of stakeholders; feedback is not required nor specifically sought. There are no mechanisms for recording or utilizing any response communications by stakeholders. Alternatively, some organizations may undertake engagement processes which lie somewhere in the middle of the continuum; where information is conveyed from stakeholders to sponsors following a process designed by the sponsor. While some degree of formal process is agreed to, the sponsor makes not commitment to act on the information provided by participants (Rowe & Frewer, 2005).

Within publicly administered health care systems, public participation offers a mechanism for managing resource scarcities within complex environments; focusing economic decision making upon primary stakeholders. The Government of New Brunswick, has promoted community advisory committees (CAC's) as a key interface between Regional Health Authorities (RHA's) and the public. The CAC process

raises several issues related to stakeholder perceptions of engagement in service governance. Do stakeholders view CAC's as an effective participatory mechanism; how should the CAC process be structured and what should be its mandate; and to what extent does it meet stakeholder expectations in light of rising public expectations in participatory decision making?

1.2. Need for Study

Like most Canadian Provinces New Brunswick is experiencing contradictory pressures for both localization and Provincial centralization in health care resource allocation decision-making. Consequently the objectives and mechanisms for public participation in health care administration are in flux. Within this context the Government of New Brunswick, has promoted Community Advisory Committees (CAC's) as a key interface between Regional Health Authorities (RHA's), stakeholder groups and the broader public. The mandate, roles and structure of CAC's are subject to local interpretation.

As the Government of New Brunswick seeks to establish CAC's throughout the Province, stakeholder expectations of this engagement mechanism are necessary for both successful implementation and long-term viability. Despite a literature on the theoretical potential of participatory, stakeholder-based governance in health care, limited knowledge exists of the process variables associated with effective implementation and sustainability (Frankish et al, 2007). Key issues include: Mandate; The scope of stakeholder decision making; Roles and responsibilities of

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participants; Appropriate composition and stakeholder mix – including representativeness and legitimacy; Skills and attributes required for effective participation; and Responsibilities of health authorities in facilitating engagement; and Accountability of the engagement process to all stakeholders.

1.3. Scope of Study

In light of the Government of New Brunswick's policy for all Regional Health Authorities (RHA's) to implement CAC's as their primary mechanism for stakeholder engagement, this study examines stakeholder perceptions of participation in the planning and delivery of mental health services within the Horizon Health Network (HHN); one of two RHA's within the Province of New Brunswick. The study includes respondents from the following stakeholder groups: service users; family members; mental health professionals; primary health care professionals; community agencies, and RHA administration. The study seeks to establish attitudes towards local participation in mental health services governance and apply these findings to better understanding expectations regarding the CAC process.

1.4. Research Objectives

The purpose of this pilot study is to better understand the factors which promote and hinder stakeholder participation in local mental health services planning and delivery within a regional health authority governance model. This study seeks to:

i. Summarize, compare and contrast beliefs and attitudes on factors contributing to stakeholder participation; and

ii. Review participant responses in terms of the current promotion of CAC's as a stakeholder engagement mechanism.

Findings outlined in the literature review on engagement in public sector, and more specifically in health care governance, lead to the following research questions:

a) What should be the mandate of the CAC as a stakeholder engagement process?

b) What are the scope and processes of participation?

c) What are the roles of participants?

d) What are the roles of the regional health authority in facilitating engagement?

e) Who should participate?

f) What skills and attributes enhance participation?

g) To whom is the CAC engagement process accountable?

1.5. Organization of this Report

This report examines the expectations of 20 mental health services stakeholders regarding a potential Regional Health Authority (RHA) sponsored community engagement process. The report is organized into five chapters. Chapter 1 introduces the study; describing background, need, scope, and research objectives. Chapter 2 provides an overview of stakeholder engagement and public services governance. The review focuses, primarily on the health care sector. Chapter 3 describes the methodology utilized in the study; a series of 20 qualitative interviews with mental health services stakeholders. Chapter 4 discusses findings in terms of themes related to stakeholder expectations of a future engagement process. Finally, Chapter 5 outlines key conclusions and recommendations regarding the development of an engagement process within New Brunswick. Suggestions for further research are also discussed.

Chapter 2 – Literature Review

Public engagement is a broad term that refers to stakeholder participation in the design and delivery of goods and services. It also refers to the methods employed to facilitate participation (Sheedy, 2008). A trend towards public engagement has been noted within both private and public sectors (Bovaird, 2007; Boxelaar et al, 2006; Ramirez, 1999). This trend can be understood as a confluence of contemporary social, political, economic and technological factors.

The contemporary trend towards public participation can be contrasted to the hierarchical management legacy of the industrial era. The hierarchical paradigm is closely associated with the positivist, bureaucratic tradition of applying professional knowledge and technology to solve economic problems (Nelson, 1978). The term 'managerialism' describes the current form of positivist management; both within the private and public sectors (Quinn, 2003; Brandsen & Pestoff, 2008). Managerialism reflects the "...belief that all aspects of organizational life can and should be managed according to rational structures, procedures, and modes of accountability in the pursuit of goals defined by policymakers and senior managers" (Wallace and Pocklington 2002, p. 68 cited in O'Reilly & Reed, 2010). Within the public sector, the managerialist trend is represented by the New Public Management (NPM) paradigm; the application of private sector methods and approaches to managing government administered services. Gaining prominence in the 1980s, NPM theorists have advocated a strong market orientation to the design and delivery of public

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services. Re-conceptualizing service users as 'customers' NPM practitioners have sought to: a) Utilize private sector-derived Customer Relationship Management (CRM) methods focused on information technology-based customer profiling and quantitative quality assurance (Boviard, 2006); b) Outsource previously government delivered services to the private sector (Tenbensel, 2005; Brandsen & Pestoff, 2008); and c) Reorganize key aspects of public administration structures to match private sector models (O'Reilly & Reed, 2010).

Head (2007) argues that there has been substantial critical commentary on the inadequacies of a narrowly managerial approach both within the private sector and in public governance. Despite the promise of technology, private sector efficiencies, and rigorous methodologies, the managerialist approach has been criticized for failing to effectively address the wants of product/service consumers and 'solve' national problems such as crime, drug addiction, mental illness, and obesity (Ramirez, 1999; Conklin, 2009). Within the public sector, outsourcing, combined with CRM and administrative efficiencies was intended to create more participatory and responsive services. However a review of the literature suggests that neither service users, employees, nor the public report substantial improvements from NPM oriented administrative approaches (Boviard, 2006; Tenbensel, 2005; Brandsen & Pestoff, 2008). Consequently the managerialist paradigm has declined in both the public and private sectors (Tenbensel, 2005).

Several interrelated factors likely account for with the decline of managerialism, including: *Perceived Social Complexity* - Human endeavors are multifaceted,

complex, unpredictable and therefore non-reducible (Conklin, 2009). Addressing

socially complex problems requires deliberative discussion, consensus through

debate, and the exposing of competing interests and careful consideration of

alternative options (OECD, 2004). *Value of Authentic Relationships* – The methods

and approaches of Customer Relations Management (CRM) have largely failed in

implementation; with a focus on data collection and information management as

opposed to authentic participatory decision making (Mitussis et al, 2006). While

advances in information-technology have greatly expanded organizations' capacity to

capture and manage customer profiles across touch points, most organizations have

chosen to remain in the center of the relationship (Wagner and Majchrzak, 2006).

Resource allocation decisions continue to be made by managers and professionals

(Boviard, 2007). *Political Enfranchisement* - Citizen participation is a long-standing

tenet of liberal–democracy. Deliberation and stakeholder inclusion have emerged as

normative components of public engagement (Bloomfield et al, 2001; Boviard, 2006;

Sheedy, 2008). Consequently historically disenfranchised groups have made

participatory gains in political dialogue. The notion of 'active citizens' who

substantively participate in policy development and/or institutional governance has

long been championed by democratic reformists (Head, 2007; Boviard, 2006);

Information Communications Technology - Critical information has become evenly

distributed, allowing multiple stakeholders to claim legitimacy in proposing how

resources should be allocated (Head, 2007; Barnett, 2009; Ozanne, 2009; Bovaird,

2007; Boxelaar, 2006). Benklar (2006) argues that information technology

Information technology has flattened knowledge hierarchies leading to loosening of boundaries between private and public spheres. Benklar states that networked information economy improves the practical capacities of individuals to do more: 1) for and by themselves; (2) in loose commonality with others; and (3) in formal organizations that operate outside of the constraints of the market and established organizations.; and *Participant Diversification* - The legitimacy of multiple forms and sources of knowledge has become normative. This shift rests on two assumptions: a) Expertise dispersed and distributed as there is no single repository of critical knowledge; and b) Experiential knowledge is as legitimate as any other form (Bovaird, 2007; Boxelaar, 2006).

2.1. Redefining Participants

The language used to describe product/service users has changed over time. In the industrial era, 'consumers' were passive, terminal point of the value chain. Goods and services were designed and provided to a market of end users. It was assumed that value was finite, rested strictly in the physical qualities of the product, and was fully consumed (Ramierz, 1999). This paradigm became institutionalized through management models such as Porter's Value Chain Analysis (Porter, 1996). As discussed in the previous section, Customer Relationship Management (CRM) redefined consumers as 'customers'. The New Public Management movement adopted these concepts for use in the public sector.

With a trend away from managerialism, and emergence of collectivist governance models, terms such as 'customer' or 'consumer' are less relevant. Frequently no single and comprehensively accepted body of knowledge can be referred to in formulating an unequivocal decision (Conklin, 2009). Many issues are beyond the capacity of any single agent, or group, to grasp and control (Bovaird, 2007; Boxelaar et al, 2006). Additionally diverse constituencies coalesce around specific issues in which they have a direct stake; and subsequently create value through cooperative effort (Ramirez, 1999). Consequently a breakdown in the barriers between market, state and third sector has been observed; leading to the emergence hybrid organizations and networks of stakeholders (Evers, 2004; Brandsen, Van de Donk and Putters, 2005).

The term *stakeholder* is more precise descriptor of the range of participants engaged in a collectivist or network-based value creation process. Within the context of public engagement Alford (2001) states that "...knowledge and capacity to generate insights into these problems is distributed across those who have some stake in it". With a trend toward hybrid organizations and issue-specific networks, government structures are increasingly relegated to the status of but one of several stakeholders engaged in resource allocation decisions (Head, 2007; Barnett, 2009; Ozanne, 2009; Bovaird, 2007; Boxelaar, 2006).

Sheedy (2008) argues that 'stakeholders' can be defined in two ways: a) as representatives of organized constituencies entering discussions with defined positions that they are mandated to defend; and/or b) as individuals representative of

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defined constituencies. In the latter case, individual may not have a formal mandate from constituencies they ostensibly represent. Using Sheedy's nomenclature it is important distinguish between 'citizen engagement' and 'stakeholder engagement'. The former being a wider term which aims to include all citizens as individuals who represent themselves; and the latter focused on more specific constituencies. This paper focuses on participation in mental health services policy and operations within a defined service region of New Brunswick, consequently practical inclusion involves specific, primary stakeholders and not the general Canadian public. As will be noted later, stakeholders include service users, their families, clinicians, managers, and agency administrators, primary health–care professionals, and mental health advocacy organizations.

2.2. Deliberation and Inclusion

The importance of *deliberation* and *inclusion* as critical concepts underlying any specific activity are reviewed. Deliberation and inclusion are fundamental components of engagement.

   Deliberation is defined as 'careful consideration' or 'the discussion of reasons for and against' (Bloomfield et al, 2001). Deliberative decision making has been strongly influenced by the writings of Jürgen Habermas; notably his *Theory of Communicative Action*. Sheedy (argues that deliberation involves collective problem-solving and prioritization resulting in more legitimate decision-making processes. Centered on dialogue more than conversation – it requires one to be open to the other

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and a willingness to be persuaded (2008). Bloomfield et al (2001) argue that deliberation consists of: First, social interaction normally incorporating face-to-face meetings; while information technology can be used adjunctively, face-to-face meetings are critical for building participant trust. A sense of conversation between individuals must develop. Second, a *constitutive* language which language is neither neutral nor passive; it reflexively constructed in relation to the contributions made by other participants, emphasizing interpretation, feedback, and revision. Third, participants value and respect the positions of others within without necessarily conceding their positions for the sake of consensus; not simply having good intentions but also embodying respect, exercising critical judgment, paying attention; drawing upon shared knowledge and experiences.

Inclusion is the act of including others in the processes of consideration, decision, and implementation (Laws, 1996). Inclusion is focused on identifying stakeholders, who should be responsible for identifying participants; and how stakeholders can best be best represented (Laws, 1996). Inclusion however goes beyond debate over who should be involved; it is also concerned with the means by which participants can take part, the agendas they are permitted to discuss, and the arrangements they make for those who cannot be present. Bloomfield et al (2001) argue that an inclusionary should seek to capture the widest range of stakeholders or 'publics' on the principle that this will increase the sense of ownership, outcome legitimacy, and extend the parameters of 'valid' knowledge with regard to an issue (Bloomfield et al, 2001):

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"Inclusion raises legitimacy even if the outcome of the deliberation is unacceptable to some of the participants. They have at least engaged in the process. They will have a sense of how best to reformulate their opposing views, and to whom these should be addressed at the next stage. This is why such processes should not be seen as linear and closed" p. 506.

It is important to note that while both overlap, inclusion and deliberation remain conceptually separate processes. The challenge of legitimacy is underscored by the reality that deliberation is not necessarily inclusive. Some authors argue that `effective' deliberation outweighs the benefits of wide inclusion. There may be practical limits to including stakeholders. Deliberation is less likely to be effective in large groups because individuals would have less time to express themselves and learn from others. Not all interested parties can, or want, to attend all of the time. Webler (1995) emphasizes the importance of participants' roles in determining rules and procedures as well as agendas, to decide who are appropriate participants at what stages, and crucially to establish who or what constitutes a representative forum. It is important for participants to establish reasonable access to discourses, while recognizing that absolute inclusion is not feasible. Thus how participants (and the excluded) perceive the about the process is critical for defending against charges of co-option and clientelism (Bloomfield et al, 2001).

2.3. Engagement as a Continuum

Several authors have proposed that *engagement* be viewed as a continuous, not dichotomous, process (Rowe, 2005; Bovaird, 2007; Boxelaar, 2006). Focused on public governance sphere, Head (2007) suggests that in its stronger form, engagement has come to represent an ongoing and active relationship. In its weaker, more episodic, form engagement has been described as 'public consultation'. Rowe & Frewer (2005) present a conceptualization of engagement as a continuous phenomenon based on the nature and direction of information exchange: *Stakeholder Communication* - Information is conveyed from the sponsors of the initiative to the public. Information flow is one-way: there is no involvement of stakeholders; feedback is not required nor specifically sought. There are no mechanisms for recording or utilizing any response communications by stakeholders; *Stakeholder Consultation* - Information is conveyed from stakeholders to sponsors following a process designed by the sponsor. No formal dialogue exists between individual stakeholders and the sponsors. The sponsor makes not commitment to act on the information provided by participants; *Stakeholder Participation* - Information is exchanged between stakeholders and the sponsors. Some degree of dialogue occurs usually in a group setting. The act of dialogue and negotiation serves to transform opinions into more meaningful form.

Co-Production repositions design control to stakeholders, allowing *co-creation* of new products and services. Ostrom (1996) defines co-production as "the process

through which inputs used to provide a good or service are contributed by individuals who are not in the same organization". Ramirez (1999): "value co-produced by two or more actors, with and for each other, with and for yet other actors." With focus on the public sector Joshi and Moore (2003) propose a narrower definition, or 'institutionalized co-production' as the "provision of public services through regular, long-term relationships between state agencies and organized groups of citizens, where both make substantial resource contributions." Bovaird (2006) argues that coproduction is not restricted to dichotomous state-citizen relations and includes "...long-term relationships between professionalized service providers (in any sector) and service users or other members of the community" (p. 847). Co-production is centered on the offering, on jointly creating value, on stakeholders, not the organization: "In co-production it is co-produced offerings, not the 'business unit' actor, which become the central unit of (competitive) analysis" (Ramirez, 1999). Benklar (2006) suggests that coproduction traces a lineage to libertarianism and collectivist anarchy. Benklar argues that because contemporary information technology is ubiquitous, neither the state nor market forces constrain individual expression. Access to communication allows individuals to affiliate, establish hybrid non-hierarchical relationship structures, to achieve shared objectives. Boviard's continuum from consultation to co-production enhances Rowe and Frewer's scheme by the inclusion of *co-production* as a fourth, strongest level of engagement within the participation continuum. In addition to the participation models noted, The International Association for Public Participation (IAP2) offers a set of core values

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which guide the structure of participatory process within the public domain (see Table 1).

2.4. Participation in Public Health Systems Governance

Paralleling overall public sector trends, governance approaches within public health systems have become increasingly diverse over the past two decades; with varying degrees of participatory process implemented in many Canadian jurisdictions.

Hierarchical-Managerialist Governance focuses on applying centrally developed policies with a high degree of fidelity at the local level. This can lead to difficulties when local circumstances do not neatly fit within the operational expectations of central planners. Accountability mechanisms tend to be internally focused; with upward reporting through the administrative structure.

Table 1

Core Values International Association for Public Participation

1. Public participation is based on the belief that those who are affected by a decision have a right to be involved in the decision-making process.

2. Public participation includes the promise that the public's contribution will influence the decision.

3. Public participation promotes sustainable decisions by recognizing and communicating the needs and interests of all participants, including decision makers.

4. Public participation seeks out and facilitates the involvement of those potentially affected by or interested in a decision.

5. Public participation seeks input from participants in designing how they participate.

6. Public participation provides participants with the information they need to participate in a meaningful way.

7. Public participation communicates to participants how their input affected the decision.

Source: International Association for Public Participation (2007)

Network-Collectivist Governance have been described by Tuohy (2003) as health

systems management by "...dense and complex populations of organized interests"

p. 196. Tenbensel (2005) argues that healthcare *networks* can be characterized as

structured around service delivery or community engagement. Service delivery

networks involve multiple provider professional organizations sharing resources and

reflect either provider or professional interests. Community engagement networks

involve stakeholder groups; both professional and non-professional. Participation

within a network may be voluntary or government mandated. Consequently

relationship structures may be externally designed or internally negotiated.

While the managerialist approach continues to dominate health care delivery there

has been significant debate and experimentation with regionalized, community-based

governance networks (Barnett, et al 2009; Elson, 2007)). In practice, administrative

regionalization, with its promise of enhanced local participation has oscillated in

implementation within Canada. Ostry (2006) concludes that this oscillation has been

driven by jurisdictional uncertainties regarding health care between the Canadian

Federal government and the Provinces. On the whole, local and national control has

eroded with Provincial Governments assuming more authority in planning and

delivering health care services due in part to the prevailing constitutional opinion that

primary accountability for health system performance rests at the provincial level.

Consequently Provincial Governments have become increasingly attentive to

accountability expectations for local and regional boards, including performance

agreements of various types. Consolidating the number of regions and concurrently limiting the scope of action of regional health authorities have served to increase provincial control over the health care system. For example, in some jurisdictions elected health boards have been eliminated in favor of boards appointed by the provincial health ministers in all provinces with regional systems; and most provinces have developed legislation affecting the hiring of CEOs resulting in increasing accountability of CEOs to provincial governments. In spite of the trend towards consolidation, Provincial governments have also sought to create participatory mechanisms for stakeholder engagement in survive governance. Provincial health administrations in Prince Edward Island, New Brunswick and Alberta have made commitments to establish advisory structures to ensure community participation (Philippon & Braithwaite, 2008). Specifically, the Government of New Brunswick has stated in its most recent mental health policy document that the "…Department of Health will support the regional health authorities in establishing mental-health community advisory committees in all zones" (New Brunswick Department of Health, 2011).

2.5. Participatory Governance in Health Care

While key tenets of managerialism have declined in influence, administrators and health professionals continue to exercise substantial authority within health services design and delivery. Stakeholder engagement in health and health-system decision making has gained prominence during the last three decades. Organizational

networks and/or stakeholder-community derived networks represent alternative governance strategies. Frankish et al (2007) argue that it this participatory trend is driven by the following:

- The doctrine of informed consent that individuals' preferences must be reflected in treatment choices and decisions

- A public demanding greater responsiveness of health professionals and policy makers to communities

- Calls for greater accountability for allocations of economically-pressed health resources by governments, health-care providers and organizations

- Increased interest in "social capital" and the role of community-level factors in generating "healthy communities"

- The idea that programs may be more effective if they emerge from local consensus and priorities

- An erosion of public confidence in professional knowledge in health-care decision making

Frankish et al (2007) outline the theoretical, practical, and political arguments for citizen involvement in health care resources allocation. Theoretical reasons include: 1) that health needs and health services should be more closely matched; 2) that people have the right to participate in planning, implementing, and evaluating their health system; 3) Community members will have a sense of contribution within the system; 4) the potential for a broader range of inputs to decisions allowing for more

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comprehensive solutions to health problems; 5) User participation may lead to more cost-effective decisions; and the belief that public participation increases systems delivery efficiencies; and 6) citizen participation in planning and delivering health programs can yield greater awareness of health problems, more appropriate use of health services, and prevention of diseases

2.6. Challenges to Public Participation in Health Care

Arguments against public participation in health care policy and operational decision making have been advanced. One view holds that professional elitism is necessary in advanced societies due to technological and process complexity; therefore a *democratic deficit* is a structural feature of such societies (Head, 2007). Adherents to this managerialist perspective hold that administrators and health professionals are the most effective and legitimate makers of resource allocation decisions; as other stakeholders have limited skills and knowledge (Brownlea, 1987). The signficance of experiential knowledge is typically discounted by proponents of health services managerialism (Dunston et al., 2009). Community participants are less accountable for outcomes than administrators and health professionals; the process of participation may be inefficient and financially costly; and quality of care may be diminished (Tenbensel, 2005; Brownlea, 1987). In addition Labonte (1990) argues that many health care resource allocation problems have national and transnational dimensions making some aspects local decision-making infeasible.

The creation of regional health authorities has led to a significant change from the traditional professional-dominated care system (Davidson, 1999). The roles of government, administrators and health professionals have become less clear with a shift to greater citizen participation in health reform. Some researchers suggest that collectivist governance approaches inherently create tensions when implemented in systems historically managed centrally by administrative and health care professionals (Foley & Martin, 2000). Some professionals may view moves toward participatory governance as leading to a loss of influence and role clarity (Lomas, 1997).

2.7. Mental Health Care Governance

Governance trends affecting general health care likely impact mental health services in similar ways. However some differences also exist. Fleury, Mercier & Denis (2002) note that governance within mental health services systems is challenged by 'complexity', this includes; *Multiple service providers* – frequently multiple organizations are involved in different components of service provision; *Specialization* – organizations specialize in delivering only a part of required services; *Professional loyalties* – key actors may face conflicts between professional loyalties and power sharing; *Ambiguous authority* – points of accountability and oversight may be weak, unclear or fractured; *Ideological disagreements* – Professionals and stakeholders may hold widely differing views as to preferred intervention modalities; and *Difficulty of measuring service quality and outcomes* – The complex, and indirect

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nature of mental disorders (and the non-physiological interventions employed) makes the use of traditional outcome methodologies more difficult, if not infeasible in some circumstances. The latter suggests the needs to expand the concept of 'evidence-based' practice to include qualitative assessment methods.

2.8. Participation Process

While participatory governance offers substantial theoretical promise, outcome and process factors may create substantial barriers to implementation. Wagner and Majchrzak (2006) argue that participation in any collective initiative is broadly affected by: *Values* – perceived personal benefits of participating *Expertise* – nature and quality of knowledge that participants contribute; *Governance* – the openness of leadership process together with perceived participant capacity to influence leadership; *Process* – effectiveness and efficient process management; and *Technology* – utilization of task-appropriate and user accessible technologies. Rodriguez (2007) argues that the form of collaboration within public health care networks are mediated by three factors: *Formal authority* – hierarchy-based right to make decisions usually mandated by formal (i.e. government); *Critical or scarce resources-* access to critical information, money, professional expertise; and *Discursive legitimacy* – or representativeness, allows organizations and individuals to speak to issues as representing the opinions of a specific group.

The process of organization may be related to the effectiveness of governance networks. Successful networks tend to be self-organized, where participants have a

high degree of affinity to objectives and processes (Fleury, Mercier, & Denis, 2002). Knights et al (1993) describes these as *convergent networks*; and structures where participants lack a shared vision or have competing agendas as *divergent networks*. One of the critical features of relationships within health care has been trust; due to the potential for harm and vulnerabilities related to asymmetrical information (Hall, 2001). The importance of trust extends to the administrative domain. Fleury, Mercier, & Denis, (2002) argue that externally mandated networks fail to create the collaboration necessary to effectively manage health care systems stating:

"...government mandated inter-organizational collaboration differs from voluntary participation in a network, as it means that participants do not necessarily subscribe to it; share a common vision of an area of intervention; and know or acknowledge a network's potential partners."

Despite the ostensible interest of health authorities several authors have noted a lack of clarity around the strategic objectives, roles, and scope of authority of stakeholders participating in health care governance structures (Stone, 1992; Charles & DeMaio, 1993; Fleury, Mercier, & Denis, (2002) . Charles and DeMaio (1993) argue that process success is contingent on stakeholders and sponsors negotiating: a) *Decision domains* – the areas which fall within the decision making purview of participants; b) *Roles* – the roles participants play in the decision making process; and c) *Level of participation* – the extent to which individuals have control, or authority over the decision making process.

Building upon Charles and DeMaio (1993) and Frankish et al's (2007) discussion of public participation in RHA's the following critical issues form a framework for guiding inquiry into participation in health services governance:

Mandate - Mandates may be vague, leading participants unclear as to whether to focus on operational issues or broader strategic policy setting. In a study of Regional Health Authority governance boards across Canada, Small (1999) noted that needs assessment and service prioritizing were the main areas of focus followed by effectiveness assessments. While a broad mandate may initially unite participants, Frankish et al (2007) argue that major differences may exist between the motives, experiences and understandings of various participants in terms of roles, objectives and processes.

Scope and processes of participation - As noted earlier in this paper, the definition of citizen or public participation is not well defined. It likely involves a continuum ranging from communication to co-production. (Rowe; Boviard, 2007). A host of structural constraints such as limited budgetary authority, uneven professional (i.e. physician) participation in collective decision-making, lack of data, limits stakeholder-driven governance (Lomas, 1997; Tenbensel, 2005). In terms of process, governance structures range from advisory committees through executive boards. These structures commonly claim adherence to promoting deliberative and inclusive process.

Roles and responsibilities of participants – A key issues in implementing participatory governance is delineating the roles and establishing capacities of stakeholders in decision making processes. Stakeholders, as opposed to professionals and administrators, may be better suited to provide expertise about local needs and potential service solutions. Stakeholders may inform what problem areas should be addressed, what services are needed; how these services should be delivered, the form they should take, and the settings in which they should be provided Technical issues, related to 'best practices' methodologies are commonly the role of health professionals (Frankish et al, 2007). Beyond governance issues, several authors have noted a trend towards inclusion of experiential knowledge in formulating medical-scientific 'best practice' guidelines (Dunston et al., 2009). Professionals' attitudes towards participatory health services design and governance may vary. Tenbensel (2005) argues that medical professionalism inherently inhibits collaborative action. Further, some health care organizations may structurally minimize the requirement for cooperation by and between professionals; reinforcing traditional notions of elite autonomy and self-governance.

Participant Composition - Governance boards and other structures of RHA's are typically composed of diverse stakeholders, including: service users, health-care professionals (physicians and nurses), executive managers, union representatives, and provincial government health planners. Frankish et al (2007) note that most Canadian

jurisdictions have sought a broad, as opposed to narrow, representation within RHA governance structures. Effective governance structures appear to place emphasis on: a) participant selection and training, and b) utilizing subject-matter experts including health professionals, academics and bureaucrats to interpret information and advise planning (Lomas 1997; Small, 1999). Successful networks tend to be self-organized, where participants have a high degree of affinity to objectives and processes. Knights et al (1993) describes these as *convergent networks*; and structures where participants lack a shared vision or have competing agendas as *divergent networks*. One of the critical features of relationships within health care has been trust; due to the potential for harm and vulnerabilities related to asymmetrical information (Hall, 2001). The importance of trust extends to the administrative domain. Fleury, Mercier, & Denis, (2002) argue that externally mandated networks, fail to create the collaboration necessary to effectively manage health care systems. Fleury, Mercier, & Denis, (2002) state: "…government mandated inter-organizational collaboration differs from voluntary participation in a network, as it means that participants do not necessarily subscribe to it; share a common vision of an area of intervention; and know or acknowledge a network's potential partners" (p.).

Participant skills and attributes - Frankish et al (2007) report that no agreement exists as to experience, skills and personal attributes best suited to those participating in health systems governance. It is reasonable to assume that basic participatory and group process skills would be required; together with a commitment to inclusive and

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deliberative decision making (Bloomfield et al, 2001; Laws, 1996; Sheedy, 2008). Stone (1992) suggests that participation is frequently based on assumptions that key stakeholders, both as individuals and group representatives share goals, objectives and process values.

Responsibilities of health authorities in facilitating engagement – Within Canada Regional health authorities are typically mandated by Provincial Governments to establish and maintain participatory governance structures. Consequently RHA's should provide boards, committees and other governance structures with access to key personnel, data and other operating resources necessary. Frankish et al (2007) suggest that RHA's may have a role in ensuring that governance structures engage in ongoing mandate review and role self-assessment. Specifically RHA's should ensure that governance structures undertake education in areas such as: Provincial health policy, planning and evaluation processes; and participant communication skills. Further processes for orienting new board members to the work of the board must be in place.

Accountability - Participatory governance structures as government funded entities are publicly accountable for their actions. On one hand, participants often represent key service stakeholder groups. On the other hand, the organizational process must consider broad public needs; acting with respect to the overall jurisdiction. One of the greatest risks in participatory governance is undue influence, or conflict of

interest, by insider stakeholders; vigilance must be maintained to mitigate against this risk (Elson, 2006; Barnett, 2009). Health professionals and administrators can potentially manipulate collectivist governance structures to support policy decisions, especially those involving finances (Reinertsen, 1998). Similarly specific constituencies may seek disproportionate resources. For example, specific disorder services advocates may seek to maximize benefits to their constituency at the expense of other service groups. Further, governance structures cannot reasonably represent the total health care interests of any jurisdiction; leading some stakeholders to be unrepresented (Frankish et al, 2007).

Despite a literature on the theoretical potential of participatory, stakeholder-based governance in health care, less knowledge exists of the process variables associated with effective implementation and sustainability (Frankish et al, 2007). As noted, key factors associated with engagement include: Mandate; The scope of stakeholder decision making; Roles and responsibilities of participants; Appropriate composition and stakeholder mix – including representativeness and legitimacy; Skills and attributes required for effective participation; and Responsibilities of health authorities in facilitating engagement; and Accountability of the engagement process to all stakeholders. As the Government of New Brunswick seeks to establish a Province-wide engagement process structured around Community Advisory Committees (CAC's), better understanding stakeholder expectations of engagement

as multi-factor process is important for both successful implementation and long-term viability.

Chapter 3 – Methodology

The study employed a qualitative approach, utilizing a semi-structured interview schedule (see Appendix) with all participants. A qualitative approach was chosen to better understand individual perceptions via people's own accounts (Richards, 2009). This study sought to examine personal attitudes, beliefs and expectations regarding engagement in health care systems governance; within the mental health sub-sector.

3.1. Participants

A convenience sample was recruited through the Horizon Health Network (New Brunswick) with the assistance of that Agency's staff. No formal advertisements or recruitment materials used. Professional staff were asked to identify and nominate representative members of groups having a strong stake in mental health service delivery within the Health Network's operational Zone 3. In addition a snowball approach was used to further recruit service users and physician stakeholders. Interviewees from these two groups were asked to nominate additional participants; resulting in one additional physician and one additional service user.

Initially, representation was sought from the following groups service users, family members, mental health and primary health care professionals, and representatives of community and public agencies involved with mental health services clients (including Municipal and Provincial Government). Two to 4 participants from of the groups were sought for be interviewed for a total sample size

of 10 to 20 persons. Participation was voluntary with no penalty for withdrawal at any stage. No compensation was provided to participants. One individual (a primary care physician), identified as a potential stakeholder by earlier participants declined to participate; citing a lack of discretionary availability; one senior Provincial Government official was unavailable during the interview period due to vacation.

Participants were categorized based on self-identified primary affiliation to mental health care services within the Fredericton health service area (Horizon Health – Zone 3). Many participants had multiple connections to the mental health care system. For example, one service user/consumer was a member of three community organizations; all of the family members were also members of one or more mental health care advocacy organizations, and all of the community agency representatives were members of various mental health, primary health care and/or homelessness initiatives.

A total of 20 individuals were interviewed. Interviewees are categorized into the following mental health services stakeholder groups (see Table 2).

Table 2

Participant Composition

Service User/Consumer		3
Family Member		2
Mental Health Care Professional	Psychiatrist	2
	Psychologist	1
	Social Worker	2
	Nurse	1
	Other	1
Health Care Professional (Non-Mental Health)	Family Physician	1
	Physician (other)	1
	Nurse	1
Regional Health Authority (RHA) Management		1
Community Agency Representative		4
	Total	20

3.3. Procedure

Candidates identified by RHA (Horizon Health) staff and by peers were contacted by the researcher. After discussing the nature of the study and research process, candidates were invited to participate in a 30-45 minute interview. The research

sought to accommodate interviewee location and timing preferences to increase the likelihood of participation. Each participant was interviewed alone by a single researcher in a setting chosen by the interviewee. Interviews ranged in duration from 40 minutes to over 60 minutes. Responses were recorded in writing and later transposed into MS Word files. Completed interviews were analyzed and aggregated to ensure that no personal identifiers were present within the report text.

3.4. Analysis

Content analysis is used to identify patterns and themes within the data. Patton (2002) describes content analysis as a structured approach to reducing and sense-making, where core consistencies and meanings are identified in qualitative data. Content analysis was undertaken using Richards (2009) three-category coding strategy: *Descriptive coding* – basic participant attributes are categorized; *Topic coding* – topic areas were identified and patterns noted; and *Analytical coding* - Themes were identified based patterns. The process of content analysis included both inductive and deductive processes. Inductive analysis seeks to discover patterns and themes, whereas deductive analysis utilizes existing patterns or themes as an analysis framework (Patton, 2002). Initial analysis of interview material was inductive; focused on building codes, establishing patterns and themes. Latter analyses applied deductive reasoning to test data categorization and generate propositions.

A staged data management process was employed. Firstly, although data were hand-recorded, a verbatim format was used where possible to enhance the fidelity of the interviews. Secondly, hand-written data was transcribed into MS-Word within 24

hours of the completion of interviews. Thirdly, Weft Qualitative Data Analysis

(QDA) software was used to descriptively code and aggregate MS-Word files.

Finally, descriptively coded data was recoded into patterns, topics, and themes.

Although the use of hand-written data has several limitations (see limitations Chapter

5); the researcher sought to reduce bias by recording idiomatic conversation; by

aggregating data around codes; and automating the data analysis with QDA software.

Chapter 4 – Results

This section analyzes responses to semi-structured interviews undertaken with 20 mental health services stakeholders. The seven research questions, established in the literature review section, are used as an analysis framework. Additionally four themes related to process expectations are identified. Exemplary participant responses are presented in italics.

4.1. Research Questions

4.1.1. What should be the mandate of the CAC as a stakeholder engagement process?

Establishing a participant accepted mandate and commensurate roles was widely discussed by respondents. Participants described differing services mandates and related roles for the CAC engagement process. Most participants stated that the mandate and role(s) should result from participant negotiations. Potential mandate and roles include:

Implementing Provincial Mental Health Care Policy - Respondents suggested the process focus on adopting abstract provincial policies to local circumstances.

Focus on adapting Provincial mental health policies to local circumstances.
Make recommendations and advocate. Focus on flexibly adopting centrally
defined program priorities to local needs – opportunities to implement
Provincial MH strategy locally, such as early psychosis. Not enough money
and other resources for CAC's to develop unique, one-off local programs.
(Regional Health Authority Management)

Provide some policy direction. Not at Provincial level. Focus on local
services. Should influence Mental Health Centre's services. Steve Christie
[Director, Mental Health, Horizon Health] *should be involved in a formal way.*
(Framily Member B)

Focus must be right here. Where people live.
(Health Care Professional/Physician A)

System Oversight - The process would monitor local service delivery; identifying
strengths and weaknesses. Several respondents suggested that the oversight function
would be legitimized (see *legitimacy*) by substantively including consumers/users,
family members, and community agency representatives in the process.

Act as a check and balance, providing oversight over local service
delivery.(Regional Health Authority Management)

Must provide oversight to service operations.

(Mental Health Care Professional/Psychiatrist B)

Direct oversight of operations. Front line staff and management should

report, interact with CAC.

(Family Member B)

[The engagement process should] *offer voice to families, clients.*

(Health Care Professional/Nurse)

Resource Coordination – Recognizing service resource limitations, identifying

agency strengths and deficits, and negotiating shared responses. In this role, the

engagement process would also serve to disseminate current target group needs data

among the participants.

Can the CAC be used for resources sharing? How can existing resources be

better shared?

(Community Agency Representative B)

Coordinate existing services and resources for more effective outcomes.

Venue for key players to meet at once. More efficient than individual

telephone discussions. Information sharing, participants take back

information to their organizations. Good news network, sharing what works.

Sharing of non-financial resources, knowledge experience, people. Influence

financial decision making, budgeting at Horizon Health and Government as to

local priorities.

(Mental Health Care Professional/Social Worker A)

Understand resource limitations...understand government resource

limitations.

(Community Agency Representative B)

Provides information to participants; options, what others are doing, what's

going on.

(Community Agency Representative B)

The place where all stakeholders work together for the best mental health

system with everyone recognizing resource limitations.

(Family Member B)

Lobbying and Advocacy - Suggested largely by consumers/service users.

Lobbying...the push for reforms in mental health services should continue.

Example, Homes for Special Care should offer residents more opportunities to

leave on excursions...transportation and places to go should be available.

Residents should connect more with outside world.

(Service User/Consumer B)

Advocacy issues...committee has to identify key issues to work on. Housing

might be a key advocacy issue, especially access to individual units.

Education, work, transition form welfare to work. Avoiding loss of benefits

for people who want to work; Medications, ensuring coverage for those

without insurance.

(Service User/Consumer C)

Focus of advisory: Keep people out of hospital. Make people feel differently

about self, create hope for people. Help people find work. Meaningful

living...beyond just living day to day. Offer people an opportunity to make a

difference.

(Service User/Consumer A)

Advancing Models & Promoting Innovation – Some participants suggested the

engagement process could serve to advance specific service philosophies and models;

such as service integration and health promotion,

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Include addictions...addictions and mental health should be integrated.

(Regional Health Authority Management)

Holistic view of health. Do not separate health and mental health. Needs to take, offer holistic picture.

(Health Care Professional/Nurse)

[Current] *focus is on acute-care, ill-health management. Focus should be on long-term engagement and prevention. Takes 20-40 years to change lifestyles/behavior. Important to teach youth about healthy living. Health, wellness and sports. Current service system not focused on integration.*

(Health Care Professional/Physician)

Education of front line staff...educating advisory group members to govern mental health system.

(Health Care Professional/Nurse)

Governance - The vast majority of respondents likely view any CAC engagement process as part of the jurisdictional mental health care governance structure. In discussing its role within the local governance, responses differ as to whether the CAC should serve an executive or advisory role in mental health services design and

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delivery. In addition some respondents suggested that the governance function should not be limited in scope to the regional health authority (Horizon Health); arguing that the CAC engagement process serve as a broad-scope forum for all formal mental health, related service providers, consumer/users and other stakeholders in the focal jurisdiction (Zone 3).

What are the functions of any committee: is it advisory or is it governance?
(Mental Health Care Professional/Psychiatrist A)

CAC should have a governance as opposed to advisory orientation. Must provide oversight to service operations.
(Mental Health Care Professional/Psychiatrist B)

Helps to tweak existing policy. Operationalize local governance.
(Regional Health Authority Management)

Some influence on budget decisions and priorities [at Horizon Health].
Provide overall direction on what to focus on and what not to focus on.
(Family Member B)

Not owned by Horizon Health. Forum for key people who know what is going

on at front line service level. Process not about any specific person. Helps to

tweak existing policy. Operationalize local governance.

(Community Agency Representative D)

[Facilitate] *advisory group members to govern mental health system.*

(Health Care Professional/Nurse)

Developmental Issues

Niche - Several respondents questioned whether the proposed engagement process

would be different from existing public participation mechanisms. How would it add

value as several mental health related participatory groups and committees currently

exist within the Fredericton area.

What value would it provide? Many committees already exist. Needs a role,

niche – that is not being provided by others.

(Health Care Professional/Nurse)

Must formulate its own agenda. Must avoid parallel agendas and conflict

between groups.

(Mental Health Care Professional/Psychiatrist B)

Important to be clear about mandate. There are many committees. Can any

tasks be accomplished by existing committees?

(Mental Health Care Professional/Psychiatrist A)

Micro or Macro Focus - Respondents questioned to what extent the CAC engagement

process should have a micro (individual) or macro (systems) orientation. While the

two approaches may not be mutually exclusive, respondents suggesting a micro focus

argued that the CAC focus on case-by-case advocacy. Respondents arguing for a

macro oriented approach favored focusing on aggregate issues; adopting policy to

local circumstances. Consequently, some respondents favored substantial front-line

worker participation while other respondents argued for management and executive

level participation.

Micro or Macro. Individual client or systems focused role?

(Health Care Professional/Nurse)

Forum for key people who know what is going on at front line service level.

Process not about any specific person. Helps to tweak existing policy.

Operationalize local governance.

(Community Agency Representative D)

Focus on frontline level. Venue for clinical staff to coordinate and discuss

with stakeholder reps as opposed to high-level policy groups like Minister's

advisory committee on Mental Health.

(Mental Health Care Professional/Social Worker A)

Focus CAC meetings on front-line staff; people providing direct resources.

Focus on knowledge of front-line staff. Local-level. Meetings should offer

opportunity for stakeholder reps to interact with front-line providers.

(Community Agency Representative C)

Scope Ambiguity - Several respondents suggested that mental health was inherently an

ambiguous term. The need to define mental health and mental health services in

terms of the CAC process mandate was discussed.

Unclear who the focus of service should be on. What does mental health mean

from a service perspective? Too many issues defined as "mental health"

issues. Should focus be on more seriously mentally ill?

(Mental Health Care Professional/Psychologist)

4.1.2. What are the scope and processes of participation?

Establishing an agenda and work plan was viewed by several respondents as a critical

initial objective.

Establishing role of CAC must be clear form outset. Many people not sure

what the CAC's role should be.

(Mental Health Professional/Other)

[The participants should]...*try to clarify issues. What are key issues around*

Fredericton area?

(Regional Health Authority Management)

Terms of reference should be negotiated among stakeholders for meaningful

participation.

(Mental Health Professional/Nurse)

Need a core agenda and a fluid, changing working agenda.

(Mental Health Professional/Social Worker)

Several respondents suggested that CAC's scope of authority should be clear from the

outset. The importance of decision-making transparency was also noted.

Participants have to know how decision making happens. How do committees

advance agendas of different communities.

(Mental Health Professional/Psychiatrist A)

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The need for *actionability*, a sense of outcome and achievement was discussed by the

majority of participants. Several respondents stated that the engagement initiative

should be designed from the outset to focus on tangible issues over which participants

had leverage. See *effectiveness,* discussed later in this section.

> *Process should not focus on broad, systems goals such as poverty reduction.*
>
> (Community Agency Representative D)

> *What are tangible issues that groups can address? What issues does group*
>
> *have tangible control over? What does group have ability to change?*
>
> (Regional Health Authority Management)

4.1.3. What are the roles of participants?

This section examines both the general roles of all participants and the role of process

leader.

Respondents suggested that a key role of CAC participants was to actively represent

the views and interested of their constituency within the engagement process.

Participants should not be compliant, not afraid to confront group on key

issues; however also not anxious of group and respectful of others, group

process.

(Mental Health Professional/Nurse)

Respondents discussed participant role in terms of commitment to developing the

engagement process.

New organization. Start small; communicate goal; manage finances; focus on

organization not selves.

(Service User/Consumer C)

In supporting the developing of a CAC participants must be proactive about

promoting participation; agencies must take responsibility for making the

process successful. Assure other community agencies that their contributions

are important; promote a sense of inclusion...for all participants. Assure

other agencies that CAC is action oriented, valuable resource.

(Community Agency Representative C)

Respondents also discussed how participants have a responsibility for identifying how

identify how their respective organizational processes can impede effective outcomes.

Bureaucratic blockages/difficulties stop progress, solutions.

(Community Agency Representative D)

The capacity to change roles, from competitive, agency-centered stance to a collective, resource-sharing stance was noted by several respondents.

Fredericton MH services a close-knit community. In Fredericton most agencies can focus on bigger-picture/client needs; avoid aggressive competition for resources. Pull for greater good. Usually one agency will take a lead with a new concept/program – and others will support rather than compete. Focus on which agency has best capacity to benefit community – with specific project/initiative.

(Community Agency Representative C)

Participants have vested interests. May be rival, adversarial when program survival, or new resources are at stake. Expectations of greater-good, collective action may be unrealistic, especially when resources are stretched.

(Mental Health Professional/Other)

Tension may be caused by discussion of funding priorities. Especially if agencies are competing for money.

(Community Agency Representative C)

Process Leadership

The majority of respondents identified the need for a defined individual to lead the engagement process. The ideal leader is described as a facilitator; a well-known individual, with good communication and group skills, absence of a personal agenda; with a capacity to inspire trust and legitimacy (see Expectations section).

Biggest problem is getting stakeholders to the table.

(Community Agency Representative C)

[Ideal facilitator is] *someone recognized and respected by the community. See big picture. Function as conductor. Independent, without a strong personal agenda. Avoid someone with a known agenda. Must have good process knowledge. Effective at mediation and facilitation. Needs to take group from I to We.*

(Health Care Professional/Physician A)

Chair must be respected community leader. Known, strong reputation. Strong reputation for getting things done. Chair will draw participants. Charismatic; people listen when chair speaks.

(Community Agency Representative A)

People's person. Great social skills. Willing to visit with participants. Very

proactive in understanding wants and needs.

(Mental Health Care Professional/Psychiatrist A)

Facilitators role is to create linkages. The more integration we have in

complex systems the better – move towards shared agendas.

(Health Care Professional/Physician A)

Establish participants expectations at outset. Negotiate expectations among

participants. Some stakeholders may be unsatisfied. Not all expectations can

be addressed, at least initially. Review expectations on regular basis. Some

expectations can be addressed later.

(Mental Health Professional/Social Worker A)

Leader may be outsider at first (good facilitator). Guide the group effectively.

Gradually hand over leadership to participants. Awareness of individual

participant weaknesses (literacy, performance anxiety/group work anxiety)

critical – to make participants feel comfortable. Leader must facilitate the

development of a strong sense of purpose.

(Mental Health Professional/Social Worker A)

Good Chair. Makes issues everyone's issue.

(Community Agency Representative A)

The role of all participants in promoting a conducive environment discussed.

Consumers cannot feel put down in any way – person feels that the issue they

bring up is being addressed. Can't be put down because they have mental

illness.

(Service User/Consumer A)

Some respondents suggested that ensuring an active and productive process was a

collective responsibility.

Need to keep committee dynamic, people get burned out, stale. Need to bring

in new people on regular basis. Many boards struggle to get new members.

(Service User/Consumer C)

4.1.4. What are the roles and responsibilities of the regional health authority in facilitating engagement?

Respondents responses indicate differences regarding role and responsibilities of the

RHA with regard to the CAC process. As noted previously, some respondents

viewed the RHA as one of multiple stakeholders, the process of developing and delivering mental health services.

> [The engagement process is] *Not owned by Horizon Health. Forum for key people who know what is going on at front line service level. Process not about any specific person. Helps to tweak existing policy. Operationalize local governance.*
> (Community Agency Representative D)

From this perspective, participants themselves play key role in facilitating engagement; with the focus being collectively on the local mental health service system, not the RHA.

> *In supporting the developing of a CAC participants must be proactive about promoting participation; agencies must take responsibility for making the process successful. Assure other community agencies that their contributions are important; promote a sense of inclusion...for all participants. Assure other agencies that CAC is action oriented, valuable resource.*
> (Community Agency Representative C)

Respondents also noted that the RHA had significant power in any collective governance process; especially when funding to community agencies was directed through the health authority.

> [Agency X] *has to tread carefully because some funding comes through HH.*
> *Focus on working with Horizon Health as a partner. Give and take, create*
> *solutions together. Quiet advocacy preferred approach.*
> (Community Agency Representative C)

4.1.5. Who should participate?

Several respondents suggested that the lack of a defined target population(s) and/or lack of prioritization made it difficult to establish who was a stakeholder in a future engagement process.

> *Who, what stakeholders, need to be engaged? What is the domain, range of*
> *mental health services for practical engagement purposes?*
> (Family Member B)

> *Difficult to decide priority populations. Should focus be wide scope or*
> *seriously mentally ill. If too narrow, predefined might not serve key*
> *populations/individuals. Must listen to stakeholders to develop focus,*
> *priorities.*

(Mental Health Professional/Other)

Focus of MH services...need to establish priority service populations, triage.

(Community Agency Representative B)

Several respondents suggested that establishing criteria based on priority service populations excluded other, potentially underserved groups. While clear boundaries, prioritization, and narrower scope might help with service development for some targeted groups; reduce focus on other groups might weaken development efforts.

Mental health services may be better focused for Long-term/seriously ill clients. [Mental health services] *not well established for younger and other populations. Schools do not have resources to serve young people with MH issues.*

(Family Member B)

One respondent suggested that defining target populations were not necessary for operationalizing the proposed engagement process. The process could assume the populations currently served by Horizon Health.

Mental health means Horizon Health provided services. Horizon Health has to

provide to everyone. Even to most difficult clients. Have to provide services to

very different people...large range of needs.

(Community Agency Representative B)

Other respondents tended to view stakeholders as service providers, resource

intermediaries.

Should involve many stakeholders including Social Development; Police;

Legal including Crown/Justice, however these can also be represented by

police; and Horizon Health.

(Community Agency Representative A)

Primary stakeholders for the advisory process should include schools

(primary, secondary, post secondary such as the UNB clinic, corrections

facilities and system, First Nations, unique populations with unique needs,

family physicians who are in a black hole with information, better discharge

planning communications required with family physicians, unique populations

with unique needs, Family physicians – who experience information black

holes in terms of information exchange around discharge planning.

Community groups such as the Schizophrenia Society.

(Regional Health Authority Management)

Management should ask for psychiatrist' input. Should plan future committees

to include psychiatrists' input. Committees, groups should have at least one

psychiatrist.

(Mental Health Professional/Psychiatrist A)

4.1.6. What skills and attributes enhance participation?

Respondents generally discussed skills and attributes of participants in functional

terms; relating participant knowledge and skills to capacity to perform expected roles.

Related to role...advocacy function, systems monitoring...or both. Skills and

attributes of participants have to be related to this role.

(Health Care Professional/Nurse)

Group members must have background/experience with governance, group

work. Just being a consumer (having a mental illness) or family member is

not enough. Minimum threshold of participation skills.

(Mental Health Professional/Other)

Leaders must be knowledgeable of their communities and recruit effective,

active people. Participants should not be compliant, not afraid to confront

group on key issues; however also not anxious of group and respectful of

others, group process.

(Mental Health Professional/Nurse)

Medical school/residency does not prepare physicians for collaborative

planning with stakeholders. Some management training should be included in

curriculum. Maybe some exposure to business education – physicians must

learn to think in economic terms. Physicians have to be more comfortable

with management roles. Have to learn to defer to opinions of others, establish

overall plans, and motivate others to be engaged in carrying out plans.

(Mental Health Professional/Psychiatrist B)

Physicians have Type A personality...deal with own issues. Get heard but may

not listen to others.

(Health Care Professional/Physician B)

Service users/consumers may be restricted in activities by low incomes. This may
affect participation.

How do consumers participate. Most have low incomes. Travel and meals

may be difficult.

(Service User/Consumer C)

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Lack of remuneration was cited as an impediment to participation by some professionals.

> *Fee for service makes non-paid activities unattractive. Especially when*
>
> *substantial time commitment is required.*
>
> (Mental Health Professional/Psychiatrist B)

4.1.7. To whom is the CAC process accountable?

One respondent suggested that a key developmental objective should be establishing accountability; understanding how process decisions affect stakeholders.

> *Leaders, participants in advisory group...must recognize who is impacted and*
>
> *how.*
>
> (Mental Health Professional/Social Worker A)

Another respondent suggested that members of the general public be represented on the CAC; as mental health services are accountable to all taxpayers.

> *Public, who pay taxes have a right to ask why services are needed. They need*
>
> *to ask hard questions? Are addictions services needed, do they work? Parent*
>
> *with two kids has a right to ask why putting money into mental*

health/addictions services, as opposed to building a new local hockey rink is

the right thing to do.

(Community Agency Representative B)

Respondents discussed the need for accountability of participants to each other in the CAC engagement process.

Participants must have insight into selves – need to be quiet, listen, consider

others views/opinions; share perspectives. Promote "we" not "I" experience.

(Health Care Professional/Physician A)

[Participants] *Must be open about their competition for scarce resources. At*

same time – work together for collective goals. Participants must feel that

their input is valued – process must demonstrate that stakeholder input is

valued.

(Family Member B)

Agendas of participants must be upfront/transparent. Participants must be

open about differences in agendas. Potential competition for money/other

scarce resources must be transparent.

(Mental Health Professional/Social Worker A)

No grandstanding by stakeholders/community participants. Must be

committed to supporting organization, staff to improve. Not about attacking

administration, blaming.

(Family Member B)

Meetings – in supporting the developing of a CAC participants must be

proactive about promoting participation; agencies must take responsibility for

making the process successful . Assure other community agencies that their

contributions are important; promote a sense of inclusions/being involved for

all participants. Assure other agencies that CAC is action oriented/valuable

resource.

(Community Agency Representative C)

Have to break out of silos. Every agency has to take some responsibility and

share resources

(Community Agency Representative A)

People should not participate from the perspective of – how can I avoid taking

responsibility for solutions. Solution oriented – positive about finding

solutions. Everyone has to bring their piece to the table.

(Community Agency Representative A)

Health authority and Provincial Government to the engagement process (legitimacy).

Participants must not stall process. Too often agencies, especially government stall in meetings, people are afraid to make decisions. Afraid of accountability.

(Community Agency Representative C)

Some participants may have hidden accountabilities, or may seek to avoid accountability.

Turf protection in civil service is serious issue. The way government is structured is not conducive to community participation in decision making.

(Health Care Professional/Physician A)

Participants have vested interests. May be rival, adversarial when program survival or new resources are at stake. Expectations of greater-good/collective action may be unrealistic, especially when resources are stretched.

(Mental Health Professional/Other)

Some participants afraid to commit...as they are expected to deliver what they agree to.

(Mental Health Professional/Social Worker A)

4.2. Process Expectations

Four themes dominate interviewee expectations of the process of stakeholder engagement. These themes are likely related to respondent willingness to participate in the CAC process.

4.2.1. Meaningfulness

The engagement process is perceived to be directly connected to operationalizing personal values, attitudes, and beliefs related to the design and delivery of mental health and related services.

> *What does stakeholder engagement mean. Overused/misused term.*
> *Participation must be meaningful. Inviting people to discuss is not necessarily*
> *engagement.* (Mental Health Professional/Social Worker A)

> *Participants must own the issue*
> (Health Care Professional/Nurse)

Individual values, attitudes, and beliefs vary between participants. Shared purpose is arrived at through knowing other participants, recognizing shared values, negotiating and establishing collective objectives, and performing actions.

Members need to know why organization exists; they need to get a feel for it;

relate to other members.

(Service User/Consumer C)

People around table have different understandings. Consensus must be

negotiated.

(Community Agency Representative D)

Terms of reference should be negotiated among stakeholders for meaningful

participation.

(Mental Health Professional/Nurse)

4.2.2. Trust

Engagement process is transparent, free of hidden interference and unstated agendas;

participant scope of authority explicit; what-you-see-is-what-you-get; a decision-

making process is understood and accepted by all participants.

Rules of the game must be explicit. Participants must know what the scope of

their authority really is and how information will be used. [Participants do not

want to] *talk for the sake of talking when decisions are made by others.*

(Mental Health Professional/Psychiatrist B)

Community advisory must offer stakeholders opportunity to speak the truth.

What's working; what's not working.

(Family Member B)

Participants must have savvy to work together. Must be open about their

competition for scarce resources. At same time work together for collective

goals. Participants must trust process and each other, even if they disagree.

[Cannot] fear being left out of decision, information process, other people are

getting resources. Participants must feel that their input is valued.

(Family Member B)

Trust is critical. Service staff must trust process. OK to talk about negative

experiences/service failures in a supportive, learning, development oriented

environment. Everyone...must trust process, each other. Forum to hear what

works and what does not work. Participants must be willing to face

problems/difficulties in a constructive, non-defensive manner.

(Family Member B)

[XX Agency] does not have an issue with trust; good open communication

with government and other agencies. Some local agencies may be concerned

about trust. Especially those agencies not well connected with mental health

services.

(Community Agency Representative C)

Participants must feel comfortable discussing difficult issues. Process must be

trustworthy - even if participants disagree. Mutual respect. Comfortable that

they will not be later sabotaged. An opportunity for participants to disagree.

(Community Agency Representative C)

Transparency, speak frankly, genuine response. Open to discussing negative

experiences. Don't brush problems under the rug with stakeholders.

(Mental Health Professional/Social Worker A)

4.2.3. Legitimacy

The process is sanctioned by government and agency executives; directly connected

to senior individuals who have resource allocation authority; key stakeholder groups

participate; participants are representative of stakeholder constituencies; participants

solicit, provide and actively listen to a wide range of opinion.

Participants must be focal people including management from Horizon

Health, Health administrators. CAC must be demanded by Minister of Health.

(Community Agency Representative B)

Participants must leave feeling heard. This is not the same as getting what

they want.

(Health Care Professional/Physician A)

Recognize strengths, seek meaningful input. Inclusion, recognition, respect.

May not always agree ...people need to feel that they are being considered.

Participants may not get what they want but feel that they are being listened

to.

Discussion is with human beings. People want to talk to other people face to

face even when others don't have all the answers.

(Mental Health Professional/Social Worker A)

4.2.4. Effectiveness

Stakeholders perceive outputs from the engagement process as improving service

outcomes; the engagement process is directly linked to outcomes.

Has to be action oriented. Too many committees do nothing. Focus on warm

and fuzzy talk but no action, no results.

(Community Agency Representative A)

Currently too many meetings...meeting fatigue. Many meetings not

informative, no sense of progress. Lack of action, benefit can be very

discouraging. Must perceive things being done...important information

exchanged.

(Community Agency Representative C)

Many meetings, groups, committees. Have to leave meetings with a sense of

achievement.

(Mental Health Professional/Social Worker A)

Material/ideas/issues discussed must be actionable by the participants.

Participants must have at least some leverage over issue. Discussion of overly

abstract/complex issues should be avoided.

(Mental Health Professional/Social Worker A)

4.3. Expectations and Congruence

One respondent discussed the need to manage process expectations. Participant

expectations must be in line with mandate, role, scope of authority and group

capacity.

Establish participant expectations at outset. Negotiate expectations among

participants. Some stakeholders may be unsatisfied. Not all expectations can

be addressed, at least initially. Review expectations on regular basis. Some

expectations can be addressed later.

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(Mental Health Professional/Social Worker A)

Expectations of the CAC process may also be shaped by past experience with governance and policy structures. Several participants had served on the New Brunswick Mental Health Commission, a governance structure no longer in operation. One respondent served on an early Community Advisory Committee; and reports a dissatisfying experience.

New Brunswick Mental Health Commission worked well. Felt like pipeline to decision makers. Inspired trust, confidence. Board chair was elected. Although members represented different interests – participants recognized that resources were scarce and decision making had to be fair, democratic, inclusive. Competition between stakeholders was open...between nursing, care homes, families, hospitals, community programs. Participants had trust in Commission process. Not sure why Commission was discontinued.
(Family Member B)

CAC's were to replace the [Mental Health] *Commission. Member of CAC at outset of CAC program. Did not feel that CAC's had same access as Commission. More voluntary in nature; CAC work felt less important. CAC members did not attend regularly. Lower level of commitment than with Commission.* (Family Member B)

4.4. Summary

In summary, a convergence of opinion is noted on interviewee expectations of the process of stakeholder engagement. The themes of meaningfulness, trust, legitimacy and effectiveness are articulated by most participants. Expected outcomes vary between respondents. For example consumers/service users spoke of the need for instrumental outcomes (e.g. housing, employment and education) whereas several community agency representatives discussed the need for a well-functioning collaborative planning and information exchange process – as an apparent outcome. Similarly, while most respondents appear to support the four process constructs described; differences may exist in weighting or prioritizing. For example several mental health professionals appear to emphasize the importance of process effectiveness. Consumers/service users emphasized the importance of inclusiveness; suggesting that user voices be heard, even if this requires more time and financial resources.

Chapter 5 – Conclusions and Recommendations

5.1. Discussion

A key area of respondent focus is mandate and role. A major area of both uncertainty and potential discordance is the future CAC's role within the Regional Health Authority's organizational structure. Whether it is largely (or completely) advisory in function or whether it should posses some degree of executive authority. It is important that the RHA, as process sponsor, establish the role of the CAC process within its governance structure. In addition the parameters of decision making authority must also be clarified.

Establishing mandate and role also raises practical issues of participant capacity. As several respondents noted; the objectives and mechanisms of the engagement process are in-part determined by the skills knowledge, and resources that participants' possess. Process leaders may need to carefully vet participants on the basis of issue knowledge, communications and group work skills. Such a vetting process however also challenges fundamental notions of constituent-determined inclusion and representativeness. As noted in the literature review, group-work, communications skills training and issue knowledge building are potential mechanisms for enhancing the capacity of all participants.

While most participants stated that the mandate and role(s) should result from participant negotiations, actual willingness to compromise on personally 'meaningful'

issues and objectives remains unknown. As noted, 'meaningfulness' appears as a major theme related to motivation to participate. While almost all respondents allude to this construct, a review of proposed mandates and roles suggests potential discordance amongst participants on the what the mental health service system should deliver, who it should serve and how it should be governed. The specific areas of discordance and the extent of difference however remain unclear.

Participation is also contingent on whether stakeholders perceive the engagement process as an effective means of advancing 'meaningful' issues. Willingness to participate is likely to be diminished if existing processes, such as advocacy groups and planning committees, are perceived to be functionally similar to any proposed engagement process.

Finally, separating process and outcome is a further challenge to implementation. While some respondents appear to view the engagement process as a means towards specific instrumental outcomes, such as increasing housing stock, others seem to view the process as an outcome. In the latter case, the CAC serves as a mechanism for negotiating resource sharing, communicating service data, and sharing information about agency activities, among other functions. This view of the CAC process as intermediary, may potentially frustrate those participants seeking more immediate or direct outcomes.

5.2. Limitations

As no comprehensive stakeholder participation process currently exists within the jurisdiction, this analysis is prospective. The findings represent respondent expectations of a potential future process. Actual attitudes and behavior may differ, once respondents participate in an actual engagement process.

The qualitative, non-probability design of the study limits the generalizability of findings across participant groups. Results provide understanding of the attitudes of some stakeholders, from a defined population. However findings do not however indicate whether expressed attitudes are normative or atypical within the specific population. Although several representatives were sought from each identified stakeholder group, the convenience/snow-ball sampling strategy offers little indication of the range of attitudes within each population. The sampling approach employed has several limitations: a) The utilization of the RHA to identify the majority of participants introduces potential selection bias. In addition the data collection methodology has several limitations: a) Hand written summaries are less reliable than to audio recordings in capturing verbal responses; c) Hand written analysis are subject to interviewer recording biases and omissions. The lone coding and analysis of material by the researcher, as opposed to utilizing a group process, introduces further threats to trustworthiness. Finally, the use of hand-written interview notes limited the potential richness and nuance of the presentation of findings. Consequently, the complexity and depth of attitudes may not be as effectively presented as with audio recorded transcripts.

5.3. Managerial Implications

The key management implication from the findings is the need for engagement process sponsors to identify, understand and meet participant expectations. The RHA, the presumed process sponsor, should seek to establish the expectations of potential stakeholder participants along the four motivational dimensions noted in this study: meaningfulness, trust, legitimacy and effectiveness. Meeting expectations does not necessarily require the sponsor to accommodate to all of the potential participants objectives. Instead sponsors and participants enter a dialogue and negotiate what is feasible and what is not within the context of the CAC process. This negotiation process with potential participants will likely be an important shared role for the CAC group leader and RHA management.

5.4. Further Research

Findings suggest a possible link between participant expectations, of process, centered on the constructs of meaningfulness, trust, legitimacy, and effectiveness as potential motivational factors in participation. Future research might involve seeking understanding of expectation and experience gaps in explaining the engagement process successes and failures; especially those within the public services sphere. Such research could build on Zeithaml's (2007) expectations/experience gaps model of service marketing.

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Appendix A – Interview Guide & Questionnaire

Interview Guide

This guide outlines questions and prompts to be used during interviews with four stakeholder mental health services stakeholder groups: service users, family members, health professionals, and administrators. A separate set of open-ended questions has been developed for each stakeholder group. These questions explore the level of stakeholder engagement in the service process.

The questions and prompts in this guide seek to addresses three questions:
1) What is the current level of engagement?
2) What are the main barriers to engagement?
3) What are the main opportunities for increasing engagement?

For the purposes of this study, engagement is operationalized as the perceived participation of fours primary stakeholder groups (service users, family members, health professionals, and administrators) in the design, delivery and evaluation of mental health services; at the micro (individual), mezzo (organizational) and macro (systems) level.

Service Users

Script - I am interested in knowing whether you feel that you have a say in how this place is run. Do you feel that in some big or small way you are helping make [name of program/clinic] better.

1) Is coming to [service/clinic] a big part of your life? If yes – Why is it important for you to come here?

2) Do you feel that you can tell staff here what you like and do not like about this [service/clinic]?

3) Have you ever told staff how this place could be better? If yes – did you feel that they listened to you? Did they do what you suggested?

4) What do think about the following statement - Most staff are open to people who come here for services suggesting ways to make this place better.

5) Do you feel that they listen to your suggestions here – tell me about that. When do you feel listened to/when not?

6) Have you been part of any study or group that looked at ways to make [service/clinic] better? Tell me about that group. What did the group accomplish? In what ways did the group satisfy you?

7) If you had to set up a group to decide how next year's budget [service/clinic] would be spent, who would you include and why?

Family Members

Family members are defined as relatives and close friends of persons using mental health services. Family members have longstanding and substantial involvement with the mental health service system.

Script - I am interested in knowing whether you feel that you have a say in how [name of program/clinic] is run. Do you feel that in some big or small way you are helping make [name of program/clinic] better.

1) Is [service/clinic] a big part of your [relative/friends] life? If yes – Why?

2) Is [service/clinic] a big part of your life? If yes – Why?

3) Do you feel welcome here? What sorts of things make you feel welcome/un-welcome?

4) Thinking about how this place is run; are there things that could be done better?

5) Are there things about this place [name of program/clinic] that bother you, what are they (e.g. where it is located, cleanliness, noise, of of the buildings inside)?

6) Do you feel that you can tell staff here what you like and don't' like about this place?

7) Have you ever told staff how this place could be better? If yes – How did the staff respond?

8) What do think about the following statement - Most staff are open to people (like you - who come here for services) suggesting ways to make this place better.

9) Have you been part of any study or group that looked at ways to make [name of program/clinic] better? Tell me about that group. What did the group accomplish? What did you like about the group? What did you not like?

10) If you had to set up a work group to decide how next year's budget [name of program/clinic] would be spent, who would you include and why?

Health Professionals

Mental Health Professionals are professionally trained care providers. Working directly with service users they seek to treat mental disorders, and/or improve the well-being of people living with persistent mental disorders.

Script - I am interested in knowing whether you feel that you have a say in how [name of program/clinic] is run. Do you feel that in some big or small way you are helping make [name of program/clinic] better.

1) Is [service/clinic] a big part of your life? If yes – How, why?

2) How important is [service/clinic] in the lives of most of your clients? Their families? In what ways is it important?

3) Overall, do you feel, this [service/clinic] allows and their families a say in how things are done? If yes – give examples?

4) Who are the main stakeholders in this [service/clinic]?

5) Do you feel these groups are involved in this [service/clinic]? If yes – describe how they are involved, provide examples? If no – why not?

6) What are the main reasons why families and clients have not been involved in service planning and monitoring?

7) Should any one stakeholder group (e.g. clinical staff, administration, users and their families) have more say in how this program, is run? If yes why?

8) Could stakeholders be better included in service planning and review? How might this be done - be specific (e.g. advisory committee, family council, etc.).

9) What do think about the following statement - Most staff are open to clients and/or family members suggesting ways to make this [service/clinic] better.

10) What do think about the following statement - Clients and/or family members suggestions usually result in real changes to how we work here.

11) Have you been part of any study or group that looked at ways to make [name of program/clinic] better? Tell me about that group – who else (clients, family members, managers) was involved? What did the group accomplish? In what ways did the group satisfy/not-satisfy you?

12) If you had to set up a group to decide how next year's budget [service/clinic] would be spent, who would you include and why?

Administrators

Administrators are program and/or services managers. They are responsible for planning, mananging employees and budgets, and assessing outcomes. This group includes clinical (or service level managers) as well as senior managers, focused on strategic leadership.

Script - I am interested in your opinion as to what extent you feel that clients, family members a say in how [name of program/clinic] is run.

1) How important is [service/clinic] in the lives of most of your clients? Their families? In what ways is it important?

2) Is [service/clinic] a big part of your life? If yes – How, why?

3) Overall, do you feel, this [service/clinic] allows and their families a say in how things are done? If yes – give examples?

4) Who are the main stakeholders in this [service/clinic]?

5) Do you feel these groups are involved in this [service/clinic]? If yes – describe how they are involved, provide examples? If no – why not?

6) What are the main reasons why families and clients have not been involved in service planning and monitoring in the past?

7) Should any one stakeholder group (e.g. clinical staff, administration, users and their families) have more say in how this program, is run? If yes why?

8) Could stakeholders be better included in service planning and review? How might this be done - be specific (e.g. advisory committee, family council, etc.).

9) What do think about the following statement - Most staff are open to clients and/or family members suggesting ways to make this [service/clinic] better.

10) What do think about the following statement - Clients and/or family members suggestions usually result in real changes to how we work here.

11) How comfortable do you think managers at [service/clinic] generally are about sharing decision making with clients (or their representatives) and family members (or their representatives)?

12) Have you been part of any study or group that looked at ways to make [name of program/clinic] better? Tell me about that group – who else (clients, family members, staff) was involved? What did the group accomplish? In what ways did the group satisfy/not-satisfy you?

13) If you had to set up a group to decide how next year's budget [service/clinic] would be spent, who would you include and why?

Appendix B – Consent Form

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