

# Intersectoral action to employ individuals with mental illness: Lessons learned from a local development initiative

Shalini Lal<sup>a,b,\*</sup> and Celine Mercier<sup>c</sup>

<sup>a</sup>*Department of Occupational Science and Occupational Therapy, Faculty of Medicine, University of British Columbia, Vancouver, British Columbia, Canada*

<sup>b</sup>*Rehabilitation Sciences, Faculty of Medicine, University of British Columbia, Vancouver, British Columbia, Canada*

<sup>c</sup>*Department of Social and Preventive Medicine, University of Montreal, Quebec, Canada*

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**Abstract.** *Background:* Intersectoral action is now widely recognized as an effective approach to addressing the social determinants of health. In particular, collaboration between different sectors of the community has been recommended as a strategy for developing employment opportunities for persons diagnosed with mental illness. However, there is limited evidence on the actual implementation of intersectoral action between the employment and mental health sector.

*Methods:* Case study methodology was utilized to examine a unique partnership formed under the principles of public health and local development to create a social enterprise. Stakeholders representing organizations from several sectors of the community, including health and employment, partnered to develop work opportunities for a population that is disadvantaged from the mainstream employment market including (but not exclusive to) persons diagnosed with mental illness. The three main methods of inquiry were: semistructured interviews, participant observation and collected documentation.

*Findings:* Stakeholders experienced several kinds of challenges during the implementation process and used different strategies to manage these challenges. The findings suggest barriers and facilitators to successful intersectoral action initiatives, some of which are directly applicable to the context of employment and mental illness.

*Conclusion:* Several lessons are drawn from these experiences.

Keywords: Employment, mental illness, intersectoral, collaboration, work

## 1. Introduction

Several innovative strategies have been developed to facilitate employment for persons with mental illness. Increasingly, these efforts extend beyond rehabilitation of the individual and address aspects of the social, eco-

nomie, and political environment. Enhanced policy linkages between the employment and mental health sectors, integration of mental health and employment services, and organizational linkages between social enterprises and the health care system are examples of structural approaches that have been adopted internationally. Collaboration between different sectors of the community, otherwise referred to as intersectoral action, is widely recognized as an effective approach to address the unemployment needs of persons with mental illness [5,11,20,21]. However, there is a significant absence in the literature of formalized collab-

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\*Address for correspondence: Shalini Lal, BSc.OT., M.Sc., Ph.D. Student, Rehabilitation Sciences, T-325-2211 Wesbrook Mall, Vancouver, British Columbia, V6T 2B5, Canada. E-mail: lalsha@interchange.ubc.ca.

orations between the mental health and employment sector. Documented case studies of intersectoral action implemented at a local level would provide valuable information for policymakers, administrators, managers, and service providers about how this approach can be adopted in terms of development, implementation and management.

Using case study methodology [18], we examined an intersectoral action initiative, which was formed to create and support employment for persons with mental illness in an integrated work environment. This case exemplifies innovative collaboration between community partners from the mental health, employment, and community development sectors to establish a social enterprise. Research findings provide insight into the kinds of challenges that stakeholders experienced during the implementation process. The discussion highlights lessons learned through this case study and the barriers and strategies to facilitate intersectoral action, both in general terms as well as, specific to the intersection of employment and mental health.

## 2. Literature review

Drawing from the School of Public Health at the University of Sydney, Australia, participants at the 1997 World Health Organization conference utilized the following working definition for intersectoral action in health:

A recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone [22, p. 3].

A sector is a “broad field of activity” such as health, justice, education, employment. Sectors can refer to a group of organizations, actors, and activities that work within specific boundaries defined by the sector’s mission and clientele [21].

Intersectoral collaboration can occur between government sectors at the central and regional levels, as well as local action between agencies representing different sectors in the community. This type of partnership can be comprised of various forms of activities such as policymaking and community development through a continuum of formal to informal organizational relationships. Further, intersectoral action can

occur horizontally (e.g., between the health sector and the employment sector) and/or vertically (e.g., between different levels of government in one sector) [15]. Intersectoral collaboration and intersectoral action are often defined synonymously and/or used interchangeably in policy documentation. For the purpose of this discussion, the terms action, collaboration, and partnership are utilized interchangeably.

Intersectoral action first emerged in the field of public health and is now widely recognized as a critical approach to addressing a diverse range of social determinants [15]. This approach evolved through the influence of principles and driving forces that initiate and sustain local development, a global movement spearheaded by the World Health Organization. Within this perspective, communities are encouraged to develop intersectoral initiatives that target public health determinants, such as poor environment and housing conditions, as well as unemployment [24].

Intersectoral collaboration is characterized as difficult to develop, implement, and maintain [10]. As Huxham [7] articulates, working with others can be complicated enough, whereas when collaboration occurs across organizations it can substantially elevate the complexity. The Public Health Agency of Canada [15, p. vii] identifies three key challenges to intersectoral collaboration: “defining objectives and roles, sustaining momentum, and evaluating results.” Several factors can be considered as barriers to successful collaboration across sectors, these include: poor interpersonal relations; disagreement on target populations; limited communication structures; vague definitions of agency roles and authority [9]; and differences in professional and organizational cultures, philosophies, interests, values, and commitment levels [8]. In addition, intersectoral action is described as “resource-intensive” [15, p. vii]; therefore, poor human and financial resources can limit the time and structures that participants need to sustain contact with other organizations.

There are three major gaps in the literature that pertain to intersectoral action and employment of persons with mental illness. First, the widely documented need to collaborate intersectorally has not produced any evidence of actual participation by the health sector in this regard. This observation is documented in national and international reports on intersectoral action [2,15,20]. Consequently, there is also an absence of literature on stakeholder experiences of “initiating, sustaining, and evaluating the impact of intersectoral efforts for health in a variety of decision-making contexts” [15, p. 1]. The need to examine the lessons learned from failed

and successful intersectoral action initiatives was recognized 10 years ago [12], yet the same absence in the literature continues to be observed today [15]. Third, illustrations of how partnerships between the mental health and employment sector can be implemented are sparse. Thus, the importance of intersectoral collaboration, its complex nature, and limited examination of experiences from the field underscore the need for a contextualized approach to researching these kinds of partnerships. In particular, case studies targeting initiatives for the employment of persons with mental illness would contribute practical information about implementation barriers and facilitators for policymakers, administrators, managers, and service providers.

### 3. Method

We began this study with an interest in understanding what is meant by intersectoral collaboration in the context of employment for persons with mental illness. The main objectives of the case study were to provide insight into the development, organization, and implementation of an intersectoral action work initiative. In this process, we became progressively familiar with stakeholder experiences through observing struggles, constraints, and coping mechanisms. We sought both emic and etic frames of reference and focused on specific issues through repeat interviews and observations.

Case study methodology [18] is a recommended strategy utilized to examine collaborative initiatives between organizations [25]. We adopted the following research principles described by Yin [25] and Stake [18]: multiple sources of evidence, triangulation, and a detailed familiarity of the case and context. In particular, the conceptual basis of the study's design and analysis involved understanding the uniqueness or particularity of the collaboration. Combining the above principles and approaches increase the rigour of the case study [18]. The research protocol was designed in accordance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, and approved by the psychiatric hospital's research ethics board. Informed consent was obtained from the research participants.

#### 3.1. Data collection

There were three main methods of inquiry: 1) documentation review, 2) participant observation, and 3) semi-structured interviews. With respect to the first

method, documentation was obtained and reviewed throughout the data collection phase of the project. This included annual reports, social enterprise documents, statistics, minutes of meetings, e-mails, letters, memos, newspaper articles, government documents, and stakeholder websites. In terms of participant observation, various types of field site visits were conducted [1]: citizen's advisory committee meetings ( $n = 6$ ), administrative/management meetings ( $n = 2$ ), and employee work sites ( $n = 15$ ). Over 25 hours were spent at the employee work sites, which involved taking part in 'native' work activities and engaging in informal conversation with employees and their supervisors. Over 15 hours were spent at stakeholder meetings pertaining to the social enterprise.

The aim of the third method of inquiry, semi-structured interviews, was to elicit information regarding both the structure and the process of the collaboration. In these interviews, participants were invited to express their perspectives, experiences, challenges, and concerns in relation to the development and implementation of the collaborative initiative. A combination of purposive and snowball sampling was used for recruitment. Potential participants were initially contacted through informational letters inviting their participation. Fourteen stakeholder representatives from five<sup>1</sup> of the six different organizations agreed to participate and were interviewed: administrators ( $n = 2$ ), program developers/implementers ( $n = 3$ ), rehabilitation service providers ( $n = 2$ ), horticulture therapists ( $n = 2$ ), specialized employment counsellors ( $n = 2$ ), a mainstream employment counsellor ( $n = 1$ ), an urban developer ( $n = 1$ ), and a municipal councillor ( $n = 1$ ). Interviews ranged from 30–120 minutes with an average duration of 70 minutes.

Data collection lasted for a period of 21 months contributing to the authenticity of the results such that responses, experiences, events and activities could be examined over time. Frequent interactions reduced participants' reaction to an external presence [1] as they became comfortable with the first author and increasingly spoke candidly about their experiences and opinions. In addition, frequent interactions with multiple sources of information enabled the researchers to have a broader perspective of the partnership with respect to stakeholder issues, interorganizational relationships, and impacts.

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<sup>1</sup>We were unable to recruit a participant from the private housing development company.

Table 1  
Overview of initial coding scheme

Primary codes	Secondary codes	Themes
Development	Challenges	Role ambiguities
Organization	Barriers	Differences in stakeholder objectives and priorities
Implementation	Facilitators	
Impact	Advantages	
Other	Other	Unanticipated impacts of partnership

### 3.2. Data analysis

Field notes and interview tapes were transcribed in their entirety and managed with the assistance of NUD-IST Version 4.0 (Nonnumerical Unstructured Data Indexing, Searching, and Theorizing) [16]. Collected documentation was handled through reduction and display activities [6]. For research reliability a separate case study database was also created [25]. All data were examined using an analytical model that combined the methods of case, content, and inductive analysis [14]. First, transcripts and collected documentation were reviewed in their entirety. Then, a list of five primary codes served to divide transcripts, field notes, and documentation into topical sections. These primary codes were based upon the study's objectives, for example how the partnership was developed, organized, implemented, and its impacts. Subsequently, each of these topical sections was reviewed for secondary codes. The final retrieved data was read repeatedly and analyzed inductively for emerging themes, sub-themes, comparisons/contrasts, and the notation of patterns. Table 1 provides an overview of the codes and initial themes generated through this process. The software program assisted in the code and retrieval process described above. Participants were provided with drafts of research reports and then met with to explore perceptions regarding the analysis as well as to elaborate on themes that had emerged. Several discussions also took place between the authors with regards to the interpretation of the results. Triangulation was represented in several facets of the data collection and analytical process which contributes to the credibility of the study.

## 4. Findings

### 4.1. The case

We begin this section with a descriptive narrative of the case as this has been identified to contribute to the trustworthiness of a case study [18]. The case is

situated in a Canadian community of poor socioeconomic status, located within the boundaries of a larger metropolitan area. Stakeholders representing six organizations from several sectors in the community, including health and employment, partnered under the principles of public health and local development to create a social enterprise<sup>2</sup> specializing in horticultural activities. The main objective of this partnership was to develop supported employment opportunities for persons disadvantaged from the mainstream labour market. Participation from the health sector was based on the condition that 30% of these jobs would be reserved for a population diagnosed with mental illness.<sup>3</sup> The six partner organizations were: 1) a regional psychiatric hospital, 2) a local employment agency (provincial employment sector), 3) a specialized employment agency for persons with mental illness (provincial employment sector), 4) a municipal government, 5) a private housing development company, and 6) a community consortium for local development.<sup>4</sup>

Financial, material, and human resources were derived from each of the partners and sectors represented. Money to launch the social enterprise was accessed through the local employment agency from designated provincial funds to fight poverty through employment. This funding helped to subsidize salaries for 26–30 week contracts at minimum wages, for full time work. The municipal government provided land and a greenhouse on the city's riverside where landscaping and maintenance activities could take place. The private housing development company gave permission for landscaping activities to be conducted on land that was not being developed at that time. The psychiatric hospital also provided some of its land, building space, material resources, and one of its greenhouses. In terms of human resources, job support was initially provided by the employment agency specializing in services for individuals with mental illness. Later on in the evolution of the partnership, job support services were shared by the specialized employment agency, the psychiatric hospital, and the community consortium (as will be discussed in further detail below). Clinical management

<sup>2</sup>The Social Enterprise Alliance defines social enterprise as: "An organization or venture that advances its social mission through entrepreneurial, earned income strategies."

<sup>3</sup>Further details regarding the development and structural organization of this social enterprise are presented by Lal and Mercier [13].

<sup>4</sup>The community consortium was a coalition of local organizations from different sectors (e.g., economic, urban development, health, education) operating under the principles of local development and represented by an administrative body.

and psychosocial support continued to be offered by the hospital's outpatient clinics and rehabilitation services. The roles and responsibilities of each stakeholder are summarised in Table 2.

Employees worked in landscaping, maintenance, and horticulture activities, such as: growing organic fruits, vegetables, and herbs; and, landscaping city parks, private yards and gardens. Recruitment was targeted at persons disadvantaged from the mainstream labour market who met one or more of the following criteria: limited education, limited work experience, being a single parent, or diagnosed with a mental illness. In addition to being an integrated, low stigma work environment, employees also benefited from the opportunity to rotate through different work locations due to land sharing by stakeholders. This promoted work diversification and further social integration into the community.

#### 4.2. Challenges

Several challenges in the implementation of this partnership were evident in all three sources of data, that is, documentation, interviews, and participant observation. These challenges are grouped around three major themes and will be discussed as follows: 1) role ambiguity, 2) differences in objectives and priorities, and 3) unanticipated impacts of partnership.

##### 4.2.1. Role ambiguities and uncertainties

Role ambiguities and uncertainties were sources of tension between the psychiatric hospital, the specialized employment agency, and the community consortium. This was observed in several different areas related to the social enterprise and in particular around the issue of job support. Territorial boundaries and competency issues associated with job support, and the meaning of job support became sources of debate between these three stakeholders. Within the first year of the partnership, the responsibility of job support was transferred from the specialized employment agency to the hospital's psychosocial rehabilitation department due to the former undergoing internal changes in staffing and funding. Once changes in staffing stabilized, job support did not automatically transfer back to the specialized employment agency; instead, it was decided to be shared with the psychiatric hospital's psychosocial rehabilitation department.

Hospital management and the administrative staff of the social enterprise were of the opinion that the rehabilitation service providers were more "proactive" in

their new job support roles in comparison to the specialized employment counsellors especially in the context of employees perceived to manifest a range of complex psychosocial issues. In this respect, a number of factors were identified to support continuing the allocation of job support responsibilities to rehabilitation service providers. These included being geographically close to the work sites, and therefore able to provide prompt services with short notice or during crisis situations; and, having the clinical qualifications to address issues such as symptom exacerbation, social and behavioural skills training, and job support groups.

Another factor that added uncertainty around the issue of job support was the creation of a position by the administrative staff of the social enterprise, entitled 'psychosocial worker'. The job description for this position was a person knowledgeable in the field of horticulture who worked on-site, alongside employees. Responsibilities included participating in the evaluation of job performance and the provision of job support to *all* the employees of the social enterprise. Decision makers from the community consortium perceived this role to be advantageous in that it enabled the provision of real time, '*in-vivo*' job support. This was compared to hospital rehabilitation service providers and the specialized employment counsellors who often intervened following the occurrence of an incident. However, other stakeholder representatives held the opinion that some of the employees diagnosed with mental illness would prefer that job support issues be handled by a person external to the social enterprise.

Therefore, the hospital, the community consortium, and the specialized employment agency each had been identified as sources for providing job support for employees with mental illness. Who was most competent in supporting clients with complex psychosocial issues was frequently questioned during the research interviews and identified as a source of tension between the stakeholders. Some aspects of job support were approached differently by each organization; in other respects, stakeholders complemented each other in the services they were offering. Eventually, all three stakeholders were providing some aspect of job support to the employees of the enterprise and this led to some confusion in terms of keeping track of who was supporting which employee, and how. Consequently, this was expressed as a source of uncertainty and frustration by the frontline service providers. During the course of the study, there were limited efforts by stakeholders to explore, discuss, and resolve these differing approaches and points of view.

Table 2  
Sharing of resources, roles, and responsibilities of stakeholders

	Material/financial contribution	Administrative/management functions	Direct services to employees
Psychiatric Hospital	Loan land, greenhouse, office space	Leadership role in setting up committees (citizen's advisory, management, program development)	Evaluation, treatment, follow-up, rehabilitation, job support, referral
Specialised Employment Agency	None	None	Recruitment, assessment, job support
Local Employment Agency	Subsidies and grants through provincial funding	Administer government funds, support in grant application process	Recruitment, determine eligibility for subsidy
Community Consortium	Equipment, office space	Administer and manage social enterprise, seek funding	Job interviews, job support
Municipal Government	Loan equipment, greenhouse, and permission to cultivate city land	Consultation and assistance in urban development	None
Private Housing Development Company	Permission to cultivate private land	None	None

#### 4.2.2. Differences in partnership objectives and priorities

Differences in stakeholder objectives and priorities were observed in relation to opinions around the duration of employment contracts, program evaluation, and target populations. With respect to the duration of employment contracts, participants from the hospital and community consortium expressed discouragement by the fact that the provincial employment sector would not subsidize positions beyond 26 weeks. Participants characterized these short term contracts as "a McDonald type of work insertion" where the priority is to process as many persons as possible in a short period of time; in other words, "quantity versus quality." It was perceived that employees with mental illness would need longer than 26 weeks to reintegrate into the workforce. The community consortium and the psychiatric hospital staff expressed these concerns to the local employment agency and advocated for longer employment subsidies, however to no avail. The ministry had established that the duration of 26 weeks was long enough for an individual to acquire the basic skills and experience necessary to integrate into the labour market and to become marketable for employment in a particular field (e.g., horticulture).

Discrepancies in stakeholder objectives also led to confusion about the relevant outcome indicators to utilize for the evaluation of the social enterprise. Decision makers from the hospital were interested in answering

the following questions: how many employees with mental illness completed their work contracts, what was their employment status after contract completion, and what factors contributed to employees not completing their contracts? Moreover, they were interested in understanding how the employment experience for persons with mental illness could be improved. The administrative staff of the social enterprise was collecting quantitative outcome data on employees; however this did not address the qualitative information sought by the hospital. During our interviews with specialized employment agency counsellors, we learned that related data were collected in accordance with their agency's mandate, but there were no formal arrangements to share this information with the hospital or other stakeholders. Specialized employment counsellors also emphasised that they were no longer the only individuals involved in providing job support for employees with mental illness and therefore could not provide a complete picture of the hospital clientele's employment trajectories.

Differences of opinion on which populations should be targeted by the social enterprise presented another challenge for consensus building at the partnership level. Rehabilitation service providers expressed disappointment that only "higher functioning" patients were being employed by the social enterprise, that is, those who could tolerate full time employment. They held the opinion that priority should be given to patients

in most need of vocational assistance, in other words, those considered to be 'unemployable' by the mainstream market (i.e., due to failed attempts at finding or maintaining a job, lower level of functioning, or lower tolerance for full time work). For these patients, it was hoped that there would be opportunities to participate in part time placements, which would build behavioural and psychological readiness, and eventually facilitate transition to a more demanding worker role.

Representatives from the community consortium were not in agreement with the aforementioned expectations from hospital front line service providers. Part-time placements were considered to be rehabilitative and beyond the mandate of the social enterprise. Factors contributing to this rationale included: no resources for supervision, support, and structure of vocational rehabilitation activities; a perceived risk of turning into a sheltered workshop or being accused of 'ghettoization' through over inclusion of persons with serious mental illness; a perception that such clientele would affect the productivity of the social enterprise due to lack of readiness for full time work. The source of concern for productivity was related to financial pressure for the social enterprise to become viable (i.e., generate funds to cover its running costs).

#### 4.2.3. *Unanticipated impacts of partnership*

The sharing of organizational resources affected four groups of people in a manner that was unanticipated by partnership decision makers. *Neighbourhood residents* were concerned about the horticulture activities taking place on hospital grounds; they complained of an increased risk for: loitering in the area, vandalism, fire, and jeopardising the natural animal habitat. These concerns were voiced to the local newspaper bringing negative publicity to the initiative. The transference of one of the hospital's attached greenhouses to the social enterprise was experienced as a loss for the *horticulture therapy department* as this green house had been used for rehabilitation programs over several years. The *hospital maintenance staff and city workers* expressed concerns that their job activities were slowly being taken over by "cheap labour." A few occasions were noted where city workers expressed their anger regarding the initiative in the presence of employees of the social enterprise.

#### 4.3. *Strategies implemented*

Stakeholders utilized several kinds of strategies to negotiate the challenges they encountered. The imple-

mentation of two committees and informal negotiations increased opportunities for discussion and problem resolution. A citizen's advisory committee was formed to provide a community forum to discuss and help clarify any misconceptions regarding the social enterprise. Shortly after the advisory committee was underway, a management committee was also created to facilitate communication between stakeholders. Administrators, managers, and front line staff from the hospital and the community consortium were invited to participate in the management meetings. Two persons held leadership roles in forming and managing these committees: a program planning and development agent from the hospital's rehabilitation department and a human resources agent from the community consortium. The management committee was perceived as an opportunity for members from the different organisations to get to know each other and their respective organisations better. Committee meetings offered a space to develop rapport and solidarity amongst partners, resolve conflicts, clarify roles and responsibilities, and reduce tensions especially during the arrival of unforeseen events and concerns. However, it is important to note that once issues related to neighbourhood residents were addressed, the advisory committee meetings became less frequent and the management committee stopped meeting for a year.

Informal negotiations occurred between horticulture therapists and supervisory staff of the social enterprise to reduce the risk of negative impacts of collocation. There were two main issues discussed: the use of intermediate space between the two greenhouses and the impact of staff turnover within the social enterprise (supervisory and entry level employees). With respect to sharing space, aspects that were negotiated included: music choice (classical versus contemporary), use of phone, use of bathrooms, use of coffee machine, and overcrowding. Turnover in employee staffing of the social enterprise was perceived to be a source of increased stress, distraction, and anxiety for patients attending horticulture therapy. Moreover, changes in supervisory staff of the social enterprise meant that negotiations for the use of shared space had to be repeated because the new supervisors were ill informed about the agreements that were made prior to their arrival. In our interviews, horticulture therapists expressed disappointment and surprise of not being involved in early partnership agreements related to the sharing of building and land space. They felt that involvement in the planning and early implementation of the partnership would have reduced the negative impacts that were experienced.

## 5. Discussion

This case study examined an intersectoral partnership that was established for the creation of a social enterprise. The focus was on the challenges experienced by stakeholders and the strategies they utilized to negotiate them. There are limitations to the study that must be acknowledged. First, the analysis presented here draws primarily upon the face value of semistructured interviews conducted with stakeholder representatives. In addition, we cannot assume that theoretical saturation was achieved [4] in this study. There were a large number of individuals involved in the case from each stakeholder organization and it was not possible to interview all of them. For example, although attempts were made to recruit representatives from each partner involved, the perspective of one constituent, the private housing development company, is absent from the data. Third, the perspectives of the population targeted by the social enterprise, employees with and without mental illness, are absent from this discussion but could have contributed to issues brought up by the stakeholder representatives; for example, job support, productivity, development of work skills and duration of contracts. Fourth, the focus in this study was on structure and process of the implementation, whereas the need to evaluate the impact of the social enterprise in terms of cost-effectiveness and client outcomes would indeed be beneficial. At the same time, intersectoral action for the employment of persons with mental illness is still in its early stages of application and therefore at this point, it may be more valuable to demonstrate its feasibility.

Nevertheless, as an innovative initiative, the implementation of this social enterprise was exposed to many uncertainties and unanticipated consequences from which several lessons can be learned that may be applicable to other collaborative endeavours. In the sections that follow, these lessons are organized into barriers and facilitating mechanisms. They may be considered to increase the potential for successful intersectoral implementation, reduce the risk of unanticipated impacts, and increase the capacity for problem resolution when challenges do arise.

### 5.1. *Barriers to successful implementation of intersectoral action*

#### 5.1.1. *Philosophical differences*

Philosophical differences between stakeholders implementing an intersectoral action initiative have been

identified in the literature as barriers to success [8]. Individuals from different professional backgrounds and agencies who collaborate with each other can encounter difficulties in communication and decision making due to lack of common language and frames of reference [19]. This case study contributes two examples where philosophical differences existed between stakeholders and which are pertinent to the employment needs of persons with mental illness: job support and employment options offered by a social enterprise. In terms of job support, the hospital, the community consortium, and the specialized employment agency understood and delivered job support in overlapping, yet different ways. The hiring of a psychosocial worker could be perceived as a more normalizing, less stigmatizing, and more preventative approach to job support given that the role of this person was to work daily, alongside all employees and support them. However, this person may not necessarily have the skills to deal with more complex psychosocial issues and needs of employees with mental illness. Lack of conceptual agreement in the literature regarding job support as well as limited stakeholder evidence-based knowledge, may have also contributed to the tensions that occurred around this issue.

Disagreements about the duration of employment contracts reflected philosophical differences between the health sector and the employment sector on the employment needs of persons with mental illness. The Ministry of Employment offered twenty-six weeks of salary subsidisation across all employees of the social enterprise with no consideration of the particular needs of certain groups. The health sector believed that more pathways to employment should be available within the social enterprise, including rehabilitative ones. However, salary subsidization did not allow for alternative options such as part time placements, and the idea of productivity and viability was a mediating factor in this process. The expectations of each stakeholder ranged on a continuum that included vocational rehabilitation (e.g., rehabilitation service providers), employment training (e.g., community consortium), and employment integration (e.g., local employment agency).

#### 5.1.2. *Exclusion of front line providers and community in formal discussions*

There was limited involvement of different groups during the planning and implementation of the partnership. Involving these groups earlier could have provided foresight that would have prepared for or prevented



ed the issues that eventually arose. Further, the lack of involvement of front line workers (e.g., horticulture therapy staff) and neighbourhood residents is an ironic oversight given that this initiative developed from principles of local development and intersectoral action. The results suggest that it is important to carefully consider all stakeholders that can be affected by an intersectoral agreement throughout stages of planning, implementation, and evaluation.

An ongoing forum inclusive of people affected by the partnership can help to provide a global perspective of its procedural impacts. Although such structures (i.e., the management committee) were formed in this case, they were not fully utilized to their potential. The specialised employment agency and the local employment agency were not involved in these meetings. Generally speaking, ongoing management meetings between stakeholders that are inclusive of different groups within each organization can help to resolve important issues and maintain positive relations. For example, this context would have been a useful venue to explore and discuss the issue of job support. Formalized meetings in the presence of management and front line providers may have also been of benefit to the horticulture therapy department staff and the supervisory staff of the social enterprise. In that situation, there was limited involvement from management to resolve the difficulties that were experienced between these two parties leaving front line staff to deal with issues on their own.

#### *5.1.3. Sharing of resources versus exclusive allocation*

Changes that occur in one organization's staffing and funding priorities can have a domino effect on other organizations and the collaborative initiative as a whole. In this case, material and human resources were shared between organizations and even taken away from existing organizational structures and activities. An intersectoral initiative may be vulnerable to shifts in its partner organizations when financial and human resources are not formally allocated to the implementation and management of the collaborative initiative. Collocation of human resources is another factor to consider in this kind of endeavour. For example, the fact that counsellors from the specialized employment agency were operating out of a separate office was perceived as a disadvantage by hospital management staff in terms of the ability to provide job support. Moreover, although the partnership was formalized, the administrative and geographic separation between the organizations added to the communication challenges for those involved in implementing the initiative.

#### *5.1.4. Absence of documented mutual agreements*

Collaboration between organizations may be further compromised when documented agreements are not drafted between stakeholders. In this case, agreements were documented between pairs of stakeholders, but nothing existed which addressed the initiative as a whole, inclusive of all parties concerned. Written documentation is very important for an intersectoral action initiative and should be prepared for the collective group purpose. A central document such as this could address the following: goals of the partnership, human/material/financial resources, roles and responsibilities (e.g., job support), and evaluation. Prior to finalizing such agreements, initial drafts could be distributed to various groups amongst stakeholder organizations for feedback (e.g., front line service providers, community representatives).

#### *5.1.5. Limited continuity in communication mechanisms*

Although committees in this case study were established between partners, they seem to have been utilized in a reactive manner rather than proactively. For example, the management committee appeared to operate as a forum to 'quick fix' problems that were escalated by the neighbourhood residents. Once these concerns were addressed, the committee reduced its meeting frequency and eventually stopped meeting. These meetings could have provided a context for management to offer support for problems experienced by personnel within the organizations and address other stakeholder concerns that were arising.

#### *5.2. Facilitators to intersectoral implementation*

A certain amount of unexpected events, organizational change, and role uncertainties can be expected even with the utmost consideration and anticipation during the planning stages of an intersectoral action initiative. How stakeholders react to such challenges is a determining factor of healthy partner relations and the ultimate outcomes of the stakeholder initiative. Therefore, mechanisms to resolve conflict and reduce tension among stakeholders when such issues arise are important to consider. There are several factors that can facilitate the successful implementation of an intersectoral partnership: socio-political context, communication mechanisms, training, and program logic models.

### 5.2.1. *Socio-political context*

This case illustrates the importance of policy in supporting the development of intersectoral action initiatives for the employment of persons with mental illness. The emergence of this initiative was facilitated by a supportive international and local political context. The impetus behind this community level intersectoral action was an international movement initiated by the World Health Organization and the Public Health Agency of Canada. Locally, mental health policy action plans recognized that social integration of persons with mental illness is facilitated through intersectoral collaboration targeted on life conditions such as employment [5]. In the employment sector, funding was created for intersectoral initiatives targeting the employment of persons disadvantaged from accessing work in the mainstream market and this led to the emergence of a number of local development initiatives.

### 5.2.2. *Communication mechanisms: Boundary spanners, inclusiveness, and continuity*

Having mechanisms in place to maintain open lines of communication prior to the arrival of conflicts can be an important facilitator for the implementation of intersectoral action. Boundary spanners [17] were crucial in facilitating communication and handling negotiations. They stepped out of their respective department's traditional roles to maintain relations between persons within their organization and external to their organization, thereby contributing to the maintenance of positive collaborative relations across the partnership. By working across the boundaries of their organisations and roles, boundary spanners can have a global perspective of the collaborative process and its impacts, especially if they are also in contact with different groups within their organization (i.e., not just management/decision makers). The ability to fulfill the role of boundary spanners is largely dependent on the openness and flexible attitude of an organizational culture.

Other effective communication mechanisms include committees, meetings, minutes of meetings, memos, telephone conversations, and written agreements. In particular, this case study highlights the importance of including different levels of staffing and groups of stakeholders in the communication process. Moreover, results suggest that continuity of communication mechanisms can also support ongoing success in the implementation of intersectoral action.

### 5.2.3. *Training*

The limited experience in intersectoral action that stakeholders brought to the table may have also contributed to the challenges encountered. Training and written documentation on how to collaborate intersectorally could have increased the ability to prevent, troubleshoot, and overcome challenges. Examples of this kind of support include: handbooks to increase skills in intersectoral action, written protocols addressing how to respond to complex issues, inviting speakers experienced in this form of collaboration, and other forms of workshop and training opportunities [23].

### 5.2.4. *Evaluation and program logic models*

The process of creating a program logic model [3] can bring stakeholders together and make explicit their priorities, objectives, and expectations about the partnership; moreover, through a negotiation process, these objectives and priorities can be documented. A logic model can then assist stakeholders in evaluating the ultimate impacts of their partnership process in a less fragmented manner. A program logic model was devised during the course of this study and could serve as a useful template in the planning, implementation, and evaluation of an intersectoral action initiative [13].

Stakeholder representatives expressed that participating in the interviews, discussing findings, and reflecting on the resulting program logic model with the researchers, was helpful in their reflections about the stakeholder partnership.

## 6. **Conclusion**

This initiative illustrates a unique collaboration between organizations from the mental health, employment, and community development sectors to support the employment of persons diagnosed with mental illness in an integrated work environment. The case study provides an example of how intersectoral action can be facilitated through policy making; it also demonstrates how partnership strategies which can be implemented at the local level to reduce the systemic disadvantage that persons with mental illness face from the labour market. Further, social enterprises can benefit from formalized collaborations with the health sector to create integrated and supported work opportunities and environments for populations that are disadvantaged from the labour market due to health concerns.

At the same time, the nature of intersectoral action is complex and there are issues that stakeholders may

need to consider. Many philosophical and structural challenges continue to exist between sectors which have implications for policy. Unfortunately, there is a limited knowledge base on local experiences of intersectoral action which target the social determinants of health. This case study advances understanding on the challenges and barriers encountered in the process of intersectoral partnering; it also proposes mechanisms to facilitate the implementation of these kinds of initiatives. Policymakers, administrators, managers and front-line staff should be cognizant not only of the benefits of intersectoral action, but also of the various challenges that can occur, the barriers to overcoming them, and the mechanisms which can facilitate and sustain collaboration across sectors.

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