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Mental sundhedsfremme på tværs af sektorer

En undersøgelse af implementeringsprocesser og kapacitetsopbygning i partnerskabet ABC for mental sundhed

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Statens Institut for Folkesundhed
Syddansk Universitet

Ph.d.-afhandling

Carsten Hinrichsen

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Maj 2022

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Forord

"*Ingen sundhed uden mental sundhed*"

Sådan har det i lang tid heddet inden for folkesundhedsverdenen. Budskabet skinnede også igennem i min studietid på folkesundhedsvidenskabsuddannelsen. Gang på gang blev jeg og mine medstuderende præsenteret for befolkningsundersøgelser og forskningsresultater, som pegede på, at mental sundhed er essentielt, når det gælder vores risiko for at blive syg, vores chancer for at blive rask igen, vores trivsel, vores livstilfredshed og en lang række andre ønskværdige parametre. Særligt den styrke- og ressourcebaserede salutogene tilgang, som er definerende for mental sundhedsfremme, syntes at have et stort potentiale til at styrke mental sundhed og dermed spille ind.

Lige så tydelig som denne sammenhæng var i litteraturen, vi blev præsenteret for, syntes også fraværet af konkrete indsatser, som eksplicit trak på denne viden og omsatte den til konkrete initiativer og praksisser. Det undrede mig. Og det gjorde mig nysgerrig på at vide mere. Særligt om mental sundhedsfremme. Jeg opdagede, at der godt nok var mental sundhedsfremmende indsatser rundt omkring på tværs af discipliner og fagligheder. Men disse var ofte implicitte og foregik ofte uden, at de involverede aktører vidste, at de arbejdede med at fremme mental sundhed.

Men selvom principperne og værdierne for mental sundhedsfremme er at finde mange steder i vores samfund, er det også en dagsorden, som bliver presset og er i konkurrence med mange andre dagsordener. Jeg synes, det er utrolig spændende at dykke ned i og undersøge, hvordan vi som samfund kan indrette vores hverdag og rammer på en måde, som støtter og gør det muligt, at flere har følelsen af at have noget og nogen at stå op til om morgenen, og at flere trives. Min interesse for denne grundlæggende trivsel og min nysgerrighed på mental sundhedsfremme som disciplin har været centrale drivkræfter for at tage udfordringen op med dette Ph.d.-projekt. Jeg føler mig både heldig og privilegeret over, at jeg har fået lov til at dykke ned i og beskæftige mig med et emne, som jeg brænder for. Og jeg føler mig også heldig og privilegeret over, at jeg kunne gøre det med så mange gode, søde, kloge og støttende mennesker omkring mig.

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Dansk resumé

Baggrund

Nationale og internationale befolkningsundersøgelser viser en tydelig forringelse af den mentale sundhed de seneste årtier. Blandt forskere og eksperter vokser anerkendelsen af at mental sundhedsfremme er et vigtigt supplement til behandling og forebyggelse for at modvirke denne forringelse. Mental sundhedsfremme sigter mod at styrke de positive aspekter af mental sundhed gennem en salutogen tilgang og bør foregå på individ-, gruppe- og befolkningsniveau. På trods af en øget forskningsmæssig interesse for feltet omhandlende udvikling og implementering af interventioner og praksisser inden for mental sundhedsfremme, er litteraturen stadig mangelfuld på en række områder. Der er særligt brug for undersøgelser af operationaliseringen af interventioner og praksisser, som går på tværs af sektorer og professioner, samt processerne for opbygning af kapacitet til at løse opgaverne inden for mental sundhedsfremme.

Det overordnede formål med afhandlingen er at undersøge praksisser samt implementerings- og kapacitetsopbygningsprocesser inden for mental sundhedsfremme i en tværsektoriel kontekst. Afhandlingens empiriske objekt er implementeringen af initiativer og praksisser på tværs af partnerskabet ABC for mental sundhed i perioden 2017-2020. Afhandlingen bygger på tre delstudier med følgende formål:

1. At beskrive overordnede karakteristika af mental sundhedsfremme initiativer, som partnerne i ABC for mental sundhed implementerer, og undersøge lokale koordinatorers og stakeholderes oplevelser af implementeringsprocesserne og virkning af initiativerne.
2. At undersøge hvordan, for hvem og under hvilke omstændigheder processerne i et aktionslæringsforløb kan styrke mental sundhedsfremme kapacitet i og på tværs af organisationer.
3. At udvikle en taksonomi for rollerne, som indgår i praksisser inden for mental sundhedsfremme i en tværsektoriel kontekst, og at undersøge interaktionerne på tværs af rollerne under implementeringen af et aktionslæringsforløb.

Metode

Delstudie 1 er baseret på data fra en formativ procesevaluering af arbejdet i ABC for mental sundhed. Dataproduktionen foregik mellem 2017 og 2020 og indebar indsamling af online evalueringssurvey (i

alt 128) fra partnerorganisationerne, fem individuelle interviews og 12 gruppeinterviews. Informanterne (n=15) var lokale projektkoordinatorer og stakeholdere fra fire udvalgte partnerorganisationer. Andet og tredje delstudie er baseret på data, som blev produceret i forbindelse med pilotafprøvningen af aktionslæringsforløbet. Aktionslæringsforløbet var et samarbejde tværs af tre partnerorganisationer fra ABC for mental sundhed. Data består af 18 individuelle interviews, 10 telefoninterviews, to gruppeinterviews, observationer og dokumenter. Informanterne (n=21) var deltagere fra aktionslæringsforløbet og ledere fra deltagende organisationer.

Resultater

Delstudie 1 viser at partnerorganisationerne overordnet forfulgte tre strategier i deres arbejde relateret til ABC for mental sundhed: kapacitetsopbygning, kampagneaktiviteter og etablere/promovere muligheder for at engagere sig i mentalt sunde aktiviteter. Studiet giver desuden indsigt i en række centrale implementeringsprocesser, bl.a. omkring udfordringer og mulige løsninger relateret til at engagere ikke-sundhedsfaglige professionelle i arbejdet med mental sundhedsfremme. Lokale projektkoordinatorer og stakeholdere oplever, at arbejdet med mental sundhedsfremme kan bygge bro mellem forvaltninger, discipliner og professioner. Dette gør sig særligt gældende, hvis praksisser relateret til mental sundhedsfremme italesættes på en måde, der taler ind i den lokale kontekst og kerneopgaver.

Resultaterne fra delstudie 2 peger på, at aktionslæringsforløbet førte til en opbygning af kapacitet i form af a) udvikling/implementering af initiativer og praksisser inden mental sundhedsfremme, b) øget opmærksomhed på mental sundhedsfremme samt udvikling af viden, færdigheder og kompetencer blandt deltagerne og c) styrkede relationer og samarbejde på tværs af organisationer/afdelinger. Resultaterne beskriver nuanceret samspillet mellem kontekstfaktorer og mekanismer, som forklarer tilblivelsen af de identificerede outcomes. Centrale mekanismer er bl.a. learning-by-doing, individuelle refleksionsprocesser, face-to-face møder, at opleve udbytterige samarbejder, samarbejde på tværs af organisationer/afdeling og at opleve indholdet af aktionslæringsforløbet som relevant. Centrale kontekstfaktorer er bl.a. deltagernes motivation, forhåndsviden og kompetencer, organisatorisk støtte og eksisterende opgavebeskrivelser.

Et fremtrædende tema i arbejdet med de første to delstudier var samarbejde på tværs af organisationer, professioner, discipliner og sektorer. I tråd med litteraturen inden for mental sundhedsfremme peger resultaterne fra delstudierne på behovet for at udvikle et fælles sprog, som kan bruges på tværs af sektorer og professioner, til at forstå, italesætte og arbejde med nøglefunktionerne og tværgående processer inden for mental sundhedsfremme. Denne erkendelse formede rationalet for delstudie 3.

Delstudie 3 præsenterer udviklingen af en taksonomi for centrale roller relateret til implementeringen af mental sundhedsfremme (MSF) i en tværsektoriel kontekst. Taksonomien beskriver fem roller og deres nøglefunktioner. De fem roller er: Leder, MSF-specialist, lokal MSF-koordinator, MSF-praktiker og slutbruger. Delstudie 3 præsenterer også et casestudie af interaktionsmønstre mellem rollerne. Resultaterne illustrerer rollernes gensidige afhængighed ved at belyse sammenhængen mellem handlinger, som finder sted på tværs af interventionsniveauer og sektorer.

Konklusion og implikationer

I afhandlingen viser jeg, at mental sundhedsfremme er et mangefacetteret anliggende, der kalder på nytænkning og (gen)overvejelser af, hvordan et fokus på mental sundhed kan inkorporeres i eksisterende praksisser. Dette gælder både inden for og på tværs af samfundets sektorer. Samlet set illustrerer afhandlingens resultater samspillet på tværs af sektorer og involverede roller. Herigennem præsenterer afhandlingen praksisrelevante indsigter i, hvordan forskellige indsatsområder inden for mental sundhedsfremme hænger sammen og komplimenterer hinanden. Kapacitetsopbygning kan med fordel tænkes ind i arbejdet med at udvikle og implementere initiativer og praksisser, der sigter mod at fremme mental sundhed.

Overordnet peger afhandlingens resultater på behovet for og relevansen af at forholde sig til og forstå forskellige rollers betydning i eksempelvis planlægningen og implementeringen af mental sundhedsfremmende praksisser. Afhandlingens indsigter i kapacitetsopbyggende mekanismer kan med fordel inddrages i planlægning af interventioner og praksisser med fokus på mental sundhedsfremme. Resultaterne peger desuden på, at samarbejde omkring mental sundhedsfremme med fordel kan baseres på fælles konceptualiseringer og forståelser af mental sundhed og mental sundhedsfremme. I tråd hermed kan den udviklede taksonomi ses som et forslag til et fælles sprog, der kan bruges på tværs af sektorer og professioner, og som et redskab til at skabe overblik over, forstå og italesætte nøglefunktioner og tværgående processer. Taksonomien skal bruges med forbehold for, at den bør underkastes undersøgelser af dens overførbarhed til andre kontekster og typer af indsatser inden for mental sundhedsfremme. Der er behov for mere forskning og viden for at forstå det fulde billede af implementeringsprocesserne og hvordan forskellige typer af initiativer spiller sammen og bidrager til at fremme mental sundhed.

Engelsk resumé

Background

In the past few decades, national and international studies have shown significant declines in population mental health and well-being in most parts of the Western world. Among experts and researchers, there is a growing recognition that mental health promotion (MHP), in addition to treatment and prevention, is important to counteract this trend. MHP aims to strengthen positive aspects of mental health by the application of salutogenic approaches on the individual, group, and societal level. Although the research literature on MHP is increasing, there is currently a need for more research and practice-based knowledge on MHP interventions and practices that are implemented across sectors and professions. In particular, there is a need for investigations into the processes of building the capacity of individuals and systems to perform key tasks within MHP.

The aim of this thesis is to investigate practices and processes of implementing and building capacity for MHP in a cross-sectoral setting. The empirical object of the investigation are the practices and implementation of initiatives, conducted between 2017 and 2020, within the partnership ABCs of Mental Health. The thesis is based on three individual research studies with the following aims:

1. To outline the overall characteristics of the MHP initiatives that are based on the ABC-framework, and to explore local coordinator and stakeholder perceptions of the implementation processes and the impact of these MHP initiatives.
2. To explore how, for whom, and under which circumstances the processes of action learning can strengthen MHP capacity in a community setting.
3. To develop a practice-oriented taxonomy of roles within intersectoral MHP practices, and to investigate the interactions across roles within the implementation of MHP practices

Methods

Research study 1 is based on data from a formative process evaluation conducted within the ABCs of Mental Health. Data production ran from 2017 to 2020 and was based on online evaluation questionnaires (a total of 128) from partner organizations, five individual interviews, and 12 group interviews. The informants (n=15) were local project coordinators and stakeholders from four purposefully selected partner organizations. Research study 2 and 3 are based on data produced in relation to the pilot implementation of an action learning program. Data included 18 individual

interviews, 10 telephone interviews, two group interviews, observations, and documents. The informants (n=21) were participants of the action learning program and stakeholders from the participating organizations.

Results

The results of research study 1 show that the partner organizations generally applied three strategies within their work that was related to the ABCs of Mental Health: capacity building, campaign activities, and promoting/establishing mentally healthy activities. Also, the study provides insights into a number of central implementation processes, including challenges and potential solutions to these challenges applied by partner organizations. Among others, these challenges revolve around engaging non-health professionals in tasks related to MHP. Overall, the study participants report that engaging in MHP holds the potential to link and bridge administrative tasks, disciplines, and professions.

The results from the second research study provides insights into how the action learning program generated capacity outcomes. The identified outcomes included implementation of MHP initiatives, personal development among participants, and relational and collaborative development. The study presents nuanced insights into the generation of these outcomes based on the configuration of program mechanisms (e.g. legitimization of specific agendas, learning-by-doing, and collaborations across organizational boundaries) and contextual factors (e.g. participant motivation, organizational support, and existing task descriptions).

The third research study presents the development of a taxonomy of roles within intersectoral MHP practices. The taxonomy consists of five different roles: 1) decision-maker; 2) MHP specialist; 3) MHP co-ordinator; 4) MHP practitioner; and 5) end-user. Through a case study of the implementation of an action learning program, the study elucidates and exemplifies the interactions across roles. The results illustrate the interrelatedness of all five roles, which supports the notion that all roles are relevant to consider for understanding, planning, and researching MHP practices.

Implications and conlusions

Altogether, the thesis shows that MHP is a multi-faceted matter that calls for innovation and re-orientation of how mental health can be embedded in existing practices – within and across sectors. The results of the thesis illustrate the interplay between sectors and involved roles. Further, the thesis provides practice-oriented insights into the workings of different types of MHP initiatives, including

insights into how these initiatives are related and complement each other. Capacity building is suggested to hold much potential for facilitating the development and implementation of MHP initiatives, and therefore should be prioritized in the phases of designing, planning and implementing MHP initiatives.

Overall, the thesis highlights the need for stakeholders and program planners to consider the various roles within MHP when planning and implementing MHP practices. Furthermore, the results of the thesis highlight the importance and potential of applying a common language and conceptualization of MHP when collaborating across professions, disciplines, and sectors. Outlining the key functions of the involved roles, the proposed taxonomy can be seen as a tool to organize and articulate the key actions within MHP. However, the transferability of the taxonomy needs to be investigated. The insights into capacity building processes may inform planning and implementation activities. In terms of future steps, there is a need for more research into the transverse processes of MHP as a means to expand current knowledge of the implementation processes and how different types of initiatives complement each other within MHP.

Introduktion

Mental sundhed og mental sundhedsfremme

Nationale og internationale befolkningsundersøgelser viser en tydelig forringelse af den mentale sundhed de seneste årtier, både i Danmark og internationalt. Det kommer til udtryk ved stigninger i prævalensen af en række psykiske lidelser og dårligt mentalt helbred (GBD 2019 Mental Disorders Collaborators, 2022; Jensen et al., 2022; Jeppesen et al., 2020; WHO, 2017) og et fald i positive aspekter af mental sundhed, såsom livstilfredshed, flourishing og positiv affekt (Helliwell, Huang & Wang, 2019; Santini, Nielsen, et al., 2021). Dårlig mental sundhed indebærer en lang række helbredsmæssige og økonomiske omkostninger både for den enkelte og for samfundet (GBD 2019 Mental Disorders Collaborators, 2022; McDaid, Park & Wahlbeck, 2019; OECD & Union, 2018; Santini, Becher, et al., 2021; Santini, Jose, Koyanagi, et al., 2020; Santini, Jose, York Cornwell, et al., 2020; Santini, Nielsen, et al., 2021) og kan dermed siges at være et omfangsrigt folkesundhedsproblem.

I tråd med WHO (WHO, 2021) definerer Sundhedsstyrelsen i Danmark mental sundhed som:

> ”en tilstand af trivsel, hvor det enkelte menneske kan udfolde sine evner, håndtere dagligdags udfordringer og stress og indgå i fællesskaber med andre mennesker. Mental sundhed er altså ikke kun fraværet af psykisk sygdom, men består også af psykologiske ressourcer og evner, som er nødvendige for at kunne udvikle sig og klare de udfordringer, der dukker op i alle menneskers liv.” (Sundhedsstyrelsen, 2022)

Definitionen rummer et skel mellem positive og negative aspekter af mental sundhed. De positive aspekter dækker eksempelvis over mentalt velbefindende, livstilfredshed og resiliens, mens de negative aspekter dækker over symptomer eller tilstande af dårligt mentalt helbred og psykiske lidelser, for eksempel angst, stress og depression. Ved at sætte fokus på ressourcer og evner rummer Sundhedsstyrelsens definition af mental sundhed også et salutogent perspektiv på mental sundhed (Mittelmark & Bauer, 2022).

Netop den salutogene tilgang er central inden for mental sundhedsfremme, som i de seneste årtier i stigende grad har tiltrukket opmærksomhed fra forskere og politikere såvel som praktikere. Denne øgede opmærksomhed skal ses i sammenhæng med den negative udvikling i mental sundhed på befolkningsniveau og en stigende anerkendelse af, at mental sundhedsfremme bør supplere behandling og forebyggelse for at imødekomme denne negative udvikling (Barry, 2019c; Herrman & Jane-Llopis,

2012; IUHPE, 2021; Kalra et al., 2012; Schotanus-Dijkstra, Ten Have, Lamers, de Graaf & Bohlmeijer, 2017; Wahlbeck, 2015). Mental sundhedsfremme er en særegen disciplin, som adskiller sig fra forebyggelse og behandling ved at have fokus på determinanter for positiv mental sundhed fremfor determinanter for dårlig mental sundhed og psykiske lidelser (Barry, 2019b; Tamminen et al., 2016). Nærmere bestemt indebærer den salutogene tilgang et sigte om at styrke beskyttende faktorer og ressourcer for mental sundhed, hvorimod forebyggelse tager afsæt i en patogen tilgang, hvor fokus er på at reducere risikofaktorer for sygdom og mistrivsel. En central værdi i mental sundhedsfremme er, at mental sundhed ses som et fundamentalt aspekt af sundhed generelt. Derfor anses mental sundhedsfremme som relevant for alle mennesker, uanset sundheds- og sygdomsstatus (Kalra et al., 2012; Tamminen et al., 2016). Mental sundhedsfremme er altså en tilgang til at fremme mental sundhed ved at styrke de positive aspekter af mental sundhed gennem en salutogen tilgang på individ-, gruppe- og befolkningsniveau (Barry, 2019b).

Det er efterhånden velunderbygget, at mental sundhedsfremme har potentialet til ikke kun at fremme de positive aspekter af mental sundhed, men også nedbringe forekomsten af psykiske lidelser og dårlig mentalt helbred (Enns et al., 2016; Santini et al., 2022; Santini, Koyanagi, et al., 2017; Santini et al., 2018; Schotanus-Dijkstra et al., 2017; van Agteren et al., 2021). Derudover har aktiviteter, som kan kategoriseres som mental sundhedsfremme, en positiv effekt på en lang række andre sundhedsrelaterede aspekter (Barry, 2019b; Santini, Jose, Koyanagi, et al., 2020; Santini, Nielsen, et al., 2017).

Mental sundhedsfremme på tværs af sektorer

Determinanterne for positiv mental sundhed findes i et samspil mellem individet og dets omgivelser. Sundhedsstyrelsens beskriver for eksempel, hvordan beskyttende faktorer for mental sundhed fordeler sig på et individuelt, socialt og strukturelt niveau (SST, 2018a). En anden fremstilling af determinanter for mental sundhed præsenteres i en videreudvikling af Urie Bronfenbrenners socio-økologiske model, som opererer med seks niveauer: individ, relationer, organisationer, lokalsamfund (*communities*), policy og samfund (CLEMCPH, 2020). Modellerne gør det tydeligt, at determinanterne findes på tværs af alle samfundets sektorer og arenaer, såsom uddannelse, beskæftigelse, kunst og kultur, fritid, transport og byplanlægning (CLEMCPH, 2020; Herrman & Jane-Llopis, 2012; Wahlbeck, 2015). Det betyder, at mental sundhedsfremme kan foregå i alle samfundets sektorer og arenaer, og blandt eksperter er der bred enighed om, at mental sundhedsfremme bør være et tværsektorielt anliggende og ansvar (Barry, 2009; Wahlbeck, 2015; WHO, 2021).

Initiativer rettet mod at fremme mental sundhed kan foregå parallelt i de forskellige sektorer, men kan med fordel gå på tværs af flere sektorer for at skabe sammenhæng og synergi (Barry, 2009; Corbin, 2017; WHO, 2021). Internationale anbefalinger for mental sundhedsfremme peger samstemmigt på behovet for at styrke samarbejdet på tværs af sektorer og implementeringen af integrerede (tværgående) politikker og praksisser (Barry, 2019c; IUHPE, 2021; Kalra et al., 2012). WHO har eksempelvis fremsat en målsætning om, at 80% af alle medlemslande inden 2030 bør have mindst to aktive nationale, tværsektorielle initiativer med fokus på mental sundhedsfremme og forebyggelse af dårlig mental sundhed (WHO, 2021). Udover at mental sundhedsfremme er et tværsektorielt anliggende, er litteraturen omkring og anbefalinger for mental sundhedsfremme entydige omkring, at ansvaret for mental sundhedsfremme ikke kan placeres hos én specifik profession eller faggruppe. I den sammenhæng peges i stedet på overordnede grupper af aktører, som bør involveres i mental sundhedsfremme (Barry, 2019b; Wahlbeck, 2015). Eksempelvis fremhæver Barry (2019a) vigtigheden af at involvere borgere, sundhedsprofessionelle, offentlige institutioner og NGO'er. Til dato er der stadig kun publiceret få studier og evalueringer, som præsenterer resultater fra og praksiseksempler på effektive måder at organisere nationale indsatser inden for mental sundhedsfremme, som går på tværs af sektorer og grupper af aktører (Barry, 2019c; Herrman & Jane-Llopis, 2012). Der er altså behov for mere viden og erfaringer, som kan hjælp med at konceptualisere og bedre forstå både tværgående praksisser og rollefordelingen omkring mental sundhedsfremme (Barry, 2019a, 2019d).

Når det gælder strategier og typer af indsatser for mental sundhedsfremme, viser forskningslitteraturen på området, at mental sundhedsfremme kan operationaliseres på en lang række forskellige måder (Barry, 2007; Kalra et al., 2012). Fra national lovgivning til lokale initiativer og praksisser, som er indlejret i individuelle aktørers professionelle og private hverdagsliv. Med henvisning til *Ottawa Charter for Health Promotion* peger Margaret Barry på, at mental sundhedsfremme bør trække på både top-down- og bottom-up-strategier (Barry, 2019b). Kombinationen af de to strategier skal sikre samfundsmæssige rammer, hvor de grundlæggende værdier og praksisser for mental sundhedsfremme er indlejret i alle samfundets arenaer og sammenhænge.

Opbygningen af kapacitet, som understøtter initiativer og praksisser, der har til formål at fremme mental sundhed, er et væsentligt fokus inden for mental sundhedsfremmefeltet. I den sammenhæng peger eksempelvis Sundhedsstyrelsen og kommunale aktører i Danmark på behovet for at øge frontmedarbejderes viden og kompetencer (Folker, Madsen, Jensen, Hamburger & Hansen, 2009; SST, 2018a, 2018b). Det gælder både i og uden for sundhedsvæsenet, og i private og offentlige organisationer. Kapacitetsopbygningen indebærer også et fokus på intra- og interorganisatoriske forhold

samt samfundsmæssige strukturer, som kan understøtte de forskellige aktørers praksis (DeCorby-Watson et al., 2018; Leonard & Marquardt, 2010; McLean, Feather & Butler-Jones, 2004). I den sammenhæng er aktionslæring blevet afprøvet som strategi for at opbygge kapacitet på tværs af individuelle, organisatoriske og samfundsmæssige niveauer, og har vist lovende resultater (Jacobs, 2010; Welter, Jacobs, Jarpe-Ratner, Naji & Gruss, 2017). Litteraturen omkring kapacitetsopbygning inden for sundhedsområdet påpeger dog, at de processer og mekanismer, der forventes at føre til kapacitetsopbygning, i dag er underbelyste (DeCorby-Watson et al., 2018; Hawe, Shiell & Riley, 2009; van Herwerden, Palermo & Reidlinger, 2018). Leonard og Marquardt (2010) fremhæver, at der særligt mangler viden om mekanismer og effekter af kapacitetsopbygning på et organisatorisk og inter-organisatorisk niveau. Samlet set mangler der altså en grundlæggende viden om, hvordan kapacitetsopbygningen inden for mental sundhedsfremme kan operationaliseres på en effektiv og hensigtsmæssig måde.

ABC for mental sundhed – afhandlingens empiriske kontekst

Det nationale tværsektorielle partnerskab ABC for mental sundhed har til formål om at omsætte forskningsbaserede anbefalinger for mental sundhedsfremme til praksis (Koushede, Nielsen, Meilstrup & Donovan, 2015). Det overordnede formål med partnerskabet er at styrke indsatsen for at fremme hele den danske befolknings mentale sundhed, hvilket forfølges gennem oplysningskampagner, kapacitetsopbygning, vidensdeling og samarbejde på tværs af sektorer (Koushede, 2018). Organiseringen som partnerskab giver mulighed for at bygge bro mellem sektorer og mellem forskning og praksis i Danmark. Partnerorganisationerne arbejder ud fra en fælles arbejds- og forståelsesramme, ABC-rammen (Koushede & Donovan, 2022). En stor del af aktiviteterne i partnerskabet kredser omkring udvikling og implementering af lokale mental sundhedsfremme initiativer, som er baseret på ABC-rammen. Partnerskabet ABC for mental sundhed blev etableret i 2014 med dengang fem partnerorganisationer. Partnerskabet har løbende udviklet sig og tæller i skrivende stund (primo 2022) over 70 partnerorganisationer (ABCs, 2022; Koushede, 2018).

Formål med afhandlingen

Det overordnede formål med afhandlingen er at undersøge praksisser samt implementerings- og kapacitetsopbygningsprocesser inden for mental sundhedsfremme i en tværsektoriel kontekst. Afhandlingens empiriske objekt er implementeringen af initiativer og praksisser på tværs af

partnerorganisationer i ABC for mental sundhed i perioden 2017-2020. Afhandlingen bygger på tre delstudier, som er formidlet i tre artikler (se oversigt i tabel 1). Delstudierne har følgende formål:

1. At beskrive overordnede karakteristika af mental sundhedsfremme initiativer, som partnerne i ABC for mental sundhed implementerer, og undersøge lokale koordinatorers og stakeholderes oplevelser af implementeringsprocesserne og virkning af initiativerne.
2. At undersøge hvordan, for hvem og under hvilke omstændigheder processerne i et aktionslæringsforløb kan styrke kapaciteten inden for mental sundhedsfremme i og på tværs af organisationer.
3. At udvikle en taksonomi for rollerne, som indgår i praksisser inden for mental sundhedsfremme i en tværsektoriel kontekst, og at undersøge interaktionerne på tværs af rollerne under implementeringen af et aktionslæringsforløb.

	Titel	**Dataproduktion**	**Dataanalyse**
Delstudie/Artikel 1	Implementing Mental Health Promotion Initiatives—Process Evaluation of the ABCs of Mental Health in Denmark (Publiceret)	Interviews, gruppeinterviews og evalueringssurvey (2017-2020)	Tematisk analyse (Template Analysis) og deskriptive statistiske analyser (frekvens)
Delstudie/Artikel 2	The workings of an action learning program for building mental health promotion capacity – A realist evaluation (Publiceret)	Interviews, gruppeinterviews og telefoninterviews, observationer og indsamling af dokumenter (2019-2020)	Analyse af CMO-konfigurationer med afsæt i realistisk evaluering, herunder tematisk analyse og retroduktion
Delstudie/Artikel 3	Intersectoral mental health promotion – a practice-oriented taxonomy of roles and a study of intersectoral dynamics (I review)	Interviews, gruppeinterviews og telefoninterviews, observationer og indsamling af dokumenter (2019-2020)	Tematisk analyse (Template Analysis)

Tabel 1. Oversigt over afhandlingens delstudier og artikler.

Afhandlingens opbygning

Afhandlingen kan betragtes som bestående af to dele: a) tre artikler og b) en kappe. De tre artikler er indsat bagerst i afhandlingen og bør læses som den primære formidling af afhandlingens tre delstudier. Kappen består af otte kapitler, hvor jeg udfolder og reflekterer over væsentlige aspekter af afhandlingen som et samlet ph.d.-studie. I kappen præsenterer jeg de mest grundlæggende aspekter for delstudierne. Jeg har bestræbt mig på at undgå for mange gentagelser på tværs af kappen og artikler. I kappen ønsker jeg særligt at fokusere på aspekter, som ikke har fået plads, eller som jeg synes ikke har fået nok opmærksomhed, i artiklerne. På baggrund heraf vil jeg opfordre læseren, som ikke har læst afhandlingens artikler, til at bladre frem og starte læsningen med artikel 1, 2 og 3. Det giver efter min mening den bedste forståelse for hele afhandlingen.

State of the art – mental sundhedsfremme

Afhandlingen placerer sig i et spændingsfelt mellem interventions- og implementeringsforskning (Bauer, Damschroder, Hagedorn, Smith & Kilbourne, 2015). Fokus i det følgende state of the art-kapitel er operationaliseringen af mental sundhedsfremme i praksis. Formålet med kapitlet er at give et overblik over forskningen og fremtrædende tilgange til mental sundhedsfremme. Herunder vil jeg særligt berøre tematikker omhandlende konceptualisering af og udbredte praksisser inden for mental sundhedsfremme, samarbejde og partnerskaber på tværs af sektorer samt kapacitetsopbygningen. I forbindelse med tematikkerne præsenterer jeg vidensmæssige mangler, som jeg ønsker at adressere i denne afhandling. Disse opsummeres afslutningsvis i en kort beskrivelse af rationalet for afhandlingen.

Konceptualiseringen af mental sundhedsfremme

I denne afhandling defineres mental sundhedsfremme som en tilgang til at fremme mental sundhed ved at styrke de positive aspekter af mental sundhed gennem en salutogen tilgang på individ-, gruppe- og befolkningsniveau (Barry, 2019b). Som nævnt kan mental sundhedsfremme karakteriseres som en særegen tilgang, men overlapper på visse punkter med andre tilgange såsom forebyggelse, behandling og rehabilitering (Barry, 2019b). Eksempelvis deler de nævnte tilgange en overordnet målsætning om at fremme den enkeltes mentale sundhed bredt set, men der vil dog ofte være forskellige vægtninger af de forskellige aspekter af mental sundhed (Kalra et al., 2012). Desuden vil operationaliseringen af tilgangene i nogle tilfælde gøre brug af de samme indsatskomponenter. Barry (2019b) beskriver i den sammenhæng, at begreber som resiliens, self-efficacy og følelse af kontrol (*sense of control*) anvendes på tværs af forskellige tilgange til mental sundhed. Ifølge Barry medfører lighederne et potentiale for fælles læringsprocesser og vidensopbygning, men hun understreger samtidig vigtigheden af at forstå nuancerne og særegenhederne ved at arbejde med de forskellige tilgange hver især.

Mental sundhedsfremme kan siges at være i tråd med de grundlæggende principper for sundhedsfremme (Barry, 2019b; WHO, 2005). For det første fordi mental sundhedsfremme adresserer determinanter for mental sundhed bredt på forskellige niveauer, jf. beskrivelsen af den socio-økologiske model (CLEMCPH, 2020). For det andet fordi mental sundhedsfremme benytter sig af en ressourceorienteret

tilgang til at understøtte individer, organisationer og samfund til at fremme mental sundhed. Med afsæt i tankegangen om sundhedsfremme identificerer Barry (2019b, pp. 27-28) en række essentielle principper for implementeringen af praksisser inden for mental sundhedsfremme. Jeg har i afhandlingen særligt fokus på de følgende tre principper:

I. Anlægge et socio-økologisk perspektiv på mental sundhed for sikre en bred opmærksomhed på determinanterne for mental sundhed på tværs af niveauer (individ, relationer, organisationer, lokalsamfund, policy og samfund).

II. Læne sig op ad en empowerment-tilgang for at fremme aktiv deltagelse af individer, organisationer, lokalsamfund og nationale institutioner, bl.a. ved at styrke aktørers kapacitet i form af viden, færdigheder og kompetencer relateret til mental sundhedsfremme.

III. Samarbejde på tværs af sektorer og indgåelse af partnerskaber for at sikre inddragelse af relevante aktører i forskellige faser af implementeringsprocesserne.

Disse tre principper er centrale i resten af dette kapitel.

Mental sundhedsfremme i praksis

I tråd med Barrys første princip om at anlægge et socio-økologisk perspektiv peger forskning på, at effektive tilgange til at fremme mental sundhed bør indebære flere typer af praksisser samtidigt, og at disse bør foregå på flere niveauer samtidigt (Barry, 2009; Herrman & Jane-Llopis, 2005; Jane-Llopis & Barry 2005). Internationale anbefalinger for mental sundhedsfremme (Barry, 2019b, pp. 21-22; IUHPE, 2021; Kalra et al., 2012; WHO, 2005, 2021) beskriver en række overordnede indsatsområder, som bør prioriteres. Indsatsområderne kan læses som relevante målsætninger for at styrke mental sundhedsfremme, og de kan guide udviklingen og planlægningen af interventioner og implementeringsprocesser. Indsatsområderne dækker over udvikling af politikker, som understøtter fremme af positive aspekter af mental sundhed samt udviklingen af mentalt sundhedsfremmende rammer og strukturer i samfundets forskellige arenaer (Barry, 2019b, pp. 21-22). Desuden kredser indsatsområderne omkring behovet for at udvide og styrke et fokus på positive aspekter af mental sundhed i lokalsamfundet. I den sammenhæng peger Barry (2019b, pp. 21-22) særligt på behovet for at styrke dette fokus i sundhedssektoren. Eksempler på denne type indsatser i sundhedssektoren er afprøvet i England og Canada. Her har man implementeret initiativer med det formål at systematisere og promovere en mental sundhedsfremmende kultur og kommunikation mellem ansatte og borgere (Horn, Rauscher, Ardiles & Griffin, 2014; NICE, N.a.; Rauscher, Ardiles & Griffin, 2013). Indsatser med fokus på lokalsamfundet arbejder for eksempel med målsætninger om at videreudvikle på eller øge udnyttelsen af eksisterende tilbud, ressourcer og rammer for at fremme sociale relationer og mentalt

sundhedsfremmende aktiviteter (Barry, 2019a; Clarke, 2019; McCabe & Davis, 2012). Desuden peger litteraturen på behovet for at styrke individers opmærksomhed på og viden, færdigheder og kompetencer inden for mental sundhedsfremme (Barry, 2019b, pp. 21-22; Kalra et al., 2012). Denne type indsatser kan eksempelvis adressere den enkeltes sundhedskompetencer ved at styrke dennes viden om mentalt sundhedsfremmende adfærd (Anwar-McHenry et al., 2016; K. Smith, 2015). Som nævnt peger forskning på, at indsatser bør være målrettet flere af disse indsatsområder samtidigt for at opnå større effekt (Barry, 2009; Herrman & Jane-Llopis, 2005; Jane-Llopis & Barry 2005). Denne tilgang ses for eksempel ofte i skole-settings, hvor indsatser er målrettet både undervisere og elevers sundhedskompetencer kombineret med et fokus på skolens fysiske rammer og samarbejde med aktører fra lokalsamfundet (Anwar-McHenry et al., 2016; Clarke, 2019).

For at skabe overblik over de forskellige praksisser inden for mental sundhedsfremme kan de med fordel inddeles i to overordnede typer. De to typer kan ses som hver sin ende af et kontinuum. På den ene side findes de praksisser, som er indlejret i daglige rutiner og systemer, og som ikke nødvendigvis er eksplicit kategoriseret som mental sundhedsfremme af de involverede aktører. Et eksempel her kunne være den daglige kommunikation mellem personalet og borgere i sygehusvæsenet (Rauscher et al., 2013). På den anden side finder vi de praksisser, som prøver at fremme handlinger og aktiviteter, der har en mentalt sundhedsfremmende effekt. Denne type praksisser vil typisk blive konceptualiseret som for eksempel indsatser eller interventioner og vil typisk være eksplicit kategoriseret som mental sundhedsfremme. Eksempler på denne type praksis er skoleindsatser, som eksplicit arbejder med at styrke elever og ansattes opmærksomhed på og viden om mental sundhed (Anwar-McHenry et al., 2016) eller deres sociale og emotionelle kompetencer (Nielsen, Meilstrup, Nelausen, Koushede & Holstein, 2015). Begge typer praksisser har været genstand for afhandlingens undersøgelse, men der har særligt været fokus på sidstnævnte type praksis.

Implementeringsprocesser

Som nævnt kan mental sundhedsfremme indsatser trække på både top-down- og bottom-up-strategier (Barry, 2019b). Top-down-strategier indebærer for eksempel policyprocesser, der sikrer ressourcer til at arbejde med mental sundhedsfremme (Kalra et al., 2012; Soldevila-Domenech et al., 2021; Stansfield, 2015b). Bottom-up-strategier indebærer eksempelvis implementeringsprocesser, hvor frontmedarbejdere og borgere bidrager aktivt til udviklingen af nye initiativer og implementeringen af mental sundhedsfremmende initiativer i eksisterende indsatser og praksisser (Barry, 2019b). Studier peger på, at bottom-up-implementeringsprocesser er effektive for at skabe indsatser, som opleves som relevante

og meningsfulde af de involverede aktører i en given kontekst (Annor & Allen, 2009; Barry, Domitrovich & Lara 2005; Jane-Llopis & Barry 2005).

Forskningslitteraturen omhandlende implementeringen af mental sundhedsfremme vokser, men er stadig relativ mangelfuld (Barry, 2019c). Implementeringsstudier, som har beskæftiget sig med sektorer inden for social og sundhedsarbejde, uddannelse og folkesundhed viser en række implementeringsudfordringer forbundet med konceptualiseringen af mental sundhedsfremme, oplevet relevans af indsatser og involverede aktørers kapacitet. Udfordringerne kommer for eksempel til udtryk ved at: beslutningstagere mangler en fælles forståelse af nøglebegreberne for mental sundhedsfremme (Annor & Allen, 2009); praktikere giver udtryk for, at mental sundhedsfremme ligger uden for deres interesseområde eller indflydelse (Barry, 2009; McCabe & Davis, 2012); personale på skoler oplever mental sundhed som et uvant og fremmed begreb, der ofte har negative konnotationer og er svært at definere og operationalisere (Ekornes, Hauge & Lund, 2012); og sundhedskonsulenter og skolelærere mangler viden og kompetencer til at arbejde med mental sundhedsfremme (Christiansen, Holmberg, Hærvig, Illemann Christensen & Hulvej Rod, 2015; Ekornes, 2015). Implementeringsudfordringerne peger på behovet for at styrke den forskningsmæssige viden om organiseringen af effektive implementeringsprocesser, der opleves som meningsfulde af de involverede aktører. I tråd hermed fremhæver Barry (2019a), på baggrund af et litteraturstudie, at der mangler viden og resultater fra integrerede indsatser, som går på tværs af sektorer og indsats niveauer.

Implementeringsforskningen viser, at en tydelig og eksplicit ansvars- og opgavefordeling fremmer en effektiv implementeringsproces (Barry, 2019c; Durlak & DuPre, 2008). Ifølge WHO spiller alle en rolle og alle har et ansvar, når det kommer til mental sundhedsfremme (WHO, 2005). Dette bakkes op af forskere og praktikere, som mener, at mental sundhedsfremme bør være et kollektivt ansvar, som bedst løftes gennem tværsektorielle og tværfaglige tilgange (Barry, 2009; Folker et al., 2009; Forsman et al., 2015; Herrman & Jane-Llopis, 2005; SST, 2018a). Ud fra et implementeringsperspektiv er det dog væsentligt at afklare og præcisere, hvem der har ansvaret for hvad, og hvilken rolle forskellige aktører spiller. Rolle- og ansvarsfordelingen beskrives ofte kun i overordnede vendinger i litteraturen om mental sundhedsfremme. For eksempel peger Barry (2019a) på, at relevante aktører består af aktører i lokalsamfundet, sundhedsprofessionelle samt aktører fra både NGO'er og offentlige institutioner. I forbindelse med udviklingen af et framework, der kan guide kapacitetsopbygning, inddeler Public Health England relevante aktører i følgende kategorier: *leaders*, *public health specialists and senior staff*, *public health practitioners*, and *wider workforce* (Stansfield, 2015a). Generelt tegner der sig et billede af, at disse konceptualiseringer af, hvilke aktører der bør involveres i mental sundhedsfremme, er

relativt fragmenteret. Det vil sige, at de fokuserer på en sektor eller et udsnit af en implementeringsproces, og derfor rummer de i mindre grad den tværsektorielle karakter, som er grundlæggende for mental sundhedsfremme. Desuden er der meget få eller ingen beskrivelser af, hvilke konkrete funktioner enkelte aktører bør varetage i forbindelse med implementeringsprocesserne.

Samarbejde og partnerskaber tværs af sektorer

Som nævnt er samarbejde på tværs af sektorer og indgåelse af partnerskaber for at sikre inddragelse af relevante aktører i forskellige faser af implementeringsprocesserne et essentielt princip for mental sundhedsfremme, jf. Barry (2019b, p. 28). Grundidéen med at organisere mental sundhedsfremme som et tværsektorielt og partnerskabsbaseret samarbejde hviler på hypotesen om, at de enkelte aktører bedre kan løse deres opgaver ved at samarbejde end ved at arbejde for sig selv (Barry, 2019c; Corbin & Mittelmark, 2008; Jones & Barry, 2011). Ifølge Corbin og Mittelmark (2008) opnås en denne effekt, hvis synergien, dvs. merværdien, som opstår i samarbejdet, overstiger de omkostninger, som er forbundet med samarbejdet. Omkostningerne kan for eksempel være relateret til tid og ressourcer, som investeres i at iværksætte og pleje samarbejdet herunder forhandlinger omkring målsætninger, økonomiske ressourcer og mediering af aktørers forskellige interesser (Annor & Allen, 2009; Corbin, Jones & Barry, 2016). Synergieffekter kan opnås ved, at involverede aktører hver især bidrager med komplementerende kompetencer, ressourcer, perspektiver og viden (Jones & Barry, 2011), hvilket fremmer effektive løsninger og praksisser.

Samarbejdet på tværs af sektorer inden for mental sundhedsfremme vedrører i høj grad at bygge bro mellem praksis, forskning og policy (WHO, 2005, 2021). En model til at beskrive, hvordan forskellige ”systemer”, dvs. grupper af aktører, kan samarbejde omkring mental sundhedsfremme, findes i *Interactive Systems Framework* (Barry, 2019c). Den beskriver samarbejdet på tværs af tre systemer, som er essentielle i processen fra forskning til implementering og daglig praksis (Wandersman et al., 2008). Ét system er ansvarligt for at oversætte forskningsbaseret viden til anvendelige og praksisnære formater, for eksempel en konkret intervention eller oplysningskampagne vedrørende mental sundhedsfremme. Et supporterende system har til opgave understøtte en given implementeringsproces ved for eksempel at tilbyde opkvalificering af relevante aktører og sikre tilstedeværelsen af strukturelle faktorer, som er nødvendige for implementeringen. Det tredje system består af de aktører, individer, organisationer og/eller lokalsamfund, som i sidste ende skal føre interventionen og de mental sundhedsfremmende praksisser ud i livet. Barry (2019a) fremhæver, at et effektivt samarbejde mellem de tre systemer er essentielt og et område, der bør prioriteres for at sikre hensigtsmæssige

implementeringsprocesser inden for mental sundhedsfremme. Inden for de seneste årtier er der etableret en række partnerskaber, som arbejder med mental sundhedsfremme på tværs af sektorer. Eksempler herpå er *5 Ways to Wellbeing* (K. Smith, 2015), *Act Belong Commit* (Donovan, James, Jalleh & Sidebottom, 2006; Koushede & Donovan, 2022), *Our healthy Clearence* (Powell et al., 2019) samt det danske partnerskab ABC for mental sundhed (Koushede & Donovan, 2022). På trods af en stigende interesse for og opmærksomhed på tværsektorielle mental sundhedsfremme indsatser, er der stadig kun publiceret få studier og evalueringer, som præsenterer praksiseksempler og -erfaringer samt resultater (Barry, 2019c; Herrman & Jane-Llopis, 2012).

Kapacitetsopbygning

Empowerment-tilgangen, der foroven er beskrevet som et af de fem essentielle punkter for implementeringen af mental sundhedsfremme (Barry, 2019b), indebærer et fokus på kapacitetsopbygning. Kapacitetsopbygningen skal sikre, at individuelle aktører, organisationer og lokalsamfund besidder den fornødne viden, færdigheder og kompetencer til at kunne arbejde med determinanterne for mental sundhed. Kapacitet kan beskrives som kvaliteter eller egenskaber, der gør mennesker eller organisationer i stand til at handle (McLean et al., 2004). Udover kapacitet i form af viden, færdigheder og kompetencer findes kapacitet også på et organisatorisk og interorganisatorisk niveau, hvor det for eksempel kan være samarbejdsrelationer på tværs af organisatoriske grænser. I den sammenhæng fremhæver McLean et al. (2004), at det ofte ikke nok at fremme enkelte individers kapacitet, da disse er situeret i en organisatorisk kontekst, som har betydelig indflydelse på deres mulighed for at realisere og omsætte deres kapacitet til praksis (McLean et al., 2004). Det er således væsentligt at sikre den relevante kapacitet på flere niveauer, fra individniveau til organisations- og samfundsniveau (DeCorby-Watson et al., 2018; Leonard & Marquardt, 2010; McLean et al., 2004). Eksempelvis er det væsentligt, at den organisatoriske kapacitet understøtter eller muliggør, at individuelle medarbejdere videreudvikler eller justerer deres praksis (McLean et al., 2004).

Kapacitetsopbygning er et centralt ben i mental sundhedsfremme (Barry, 2019c; EU, 2016; IUHPE, 2021; Stansfield, 2015b). Forskning peger på, at den rette kapacitet blandt involverede aktører og systemer har stor indflydelse på, hvorvidt en implementeringsproces forløber planmæssigt (Barry, 2019c; Durlak & DuPre, 2008; Wandersman et al., 2008). Opbygningen af kapacitet behøver ikke ske som led i en implementeringsproces. Den kan også være et led i at forbedre en given praksis, dvs. skabe praksisændringer på sigt, uden at en konkret intervention implementeres (McLean et al., 2004; Van den Broucke, 2017). Oversat til mental sundhedsfremme betyder det, at en øget kapacitet i teorien vil føre til

bedre og mere effektiv varetagelse af opgaver relateret til mental sundhedsfremme, hvilket i sidste ende kommer målgruppen i den givne kontekst til gode.

Inden for de seneste år er den forskningsmæssige interesse for kapacitetsbegrebet inden for mental sundhedsfremme vokset. I takt med den stigende interesse er der kommet fokus på behovet for systematisk forskning og viden om kapacitetsopbygning relateret til arbejde med mental sundhedsfremme (Greacen et al., 2012). Udviklingen af et fælles sprog og konceptualisering af mental sundhedsfremme, som netop kan bruges på tværs af sektorer, er et centralt punkt for at styrke kapaciteten for mental sundhedsfremme (Barry, 2019a). Desuden har forskningen fokus på, hvilke former for kapacitet der er nødvendige inden for mental sundhedsfremme. En finsk ph.d.-afhandling (Tamminen, 2021) har på baggrund heraf afdækket kompetencer relateret til mental sundhedsfremme inden for sundhedssektoren (Tamminen et al., 2018) og inden for tværsektorielle samarbejder og partnerskaber (Tamminen, Solin, Barry, Kannas & Kettunen, 2021). Desuden er der interesse for at måle og afdække kapacitetsniveauer (van Herwerden et al., 2018). I en dansk kontekst er der foretaget undersøgelser af kommunernes kapacitet blandt sundhedsfaglige medarbejdere. Her peger resultaterne på, at manglen på viden og kompetencer blandt medarbejdere hæmmer implementeringen af initiativer til mental sundhedsfremme (Christiansen et al., 2015; Friis-Holmberg, Christensen, Zinckernagel, Petersen & Rod, 2013).

Der ses også en øget forskningsmæssig interesse for teorier, modeller og strategier for kapacitetsopbygning (Bergeron et al., 2017; DeCorby-Watson et al., 2018). I den sammenhæng fremhæves participatoriske metoder som relevante tilgange for kapacitetsopbyggende initiativer (Learmonth, 2007; McLean et al., 2004; van Herwerden et al., 2018). Et eksempel herpå er aktionslæring, som er anvendt til at opbygge kapacitet på tværs af organisationer inden for sundhedssektoren (Welter et al., 2017) og til at styrke forskellige praktikeres kapacitet inden for sundhedsfremmeområdet (Jacobs, 2010). Aktionslæring kan ses som en arbejdsfilosofi eller et mindset, frem for eksempelvis en opskrift på et forløb eller en intervention (Hale, 2014; Pedler & Burgoyne, 2015). Kernen i aktionslæring er, at man afprøver ny viden i praksis og efterfølgende reflekterer over sine erfaringer for derigennem at træne og styrke sine kompetencer (Folker & Lauridsen, 2018). Dette gentages optimalt set ad flere omgange, hvor de involverede aktører løbende planlægger og udfører handlinger på baggrund af de erfaringer, de har opnået og udvekslet i tæt samarbejde med øvrige aktører – typisk kollegaer og samarbejdspartnere. Der mangler dog stadig viden på området omkring kapacitetsopbygning. I to relativt nylige litteraturstudier i kapacitetsopbygning inden for sundhedsfremme og folkesundhed fremhæver forfatterne manglen på viden om de underliggende

mekanismer og processer for denne type indsatser (DeCorby-Watson et al., 2018; van Herwerden et al., 2018).

Rationale for afhandlingen

Introduktionen og state of the art-kapitlet illustrer, at mental sundhedsfremme som forskningsfelt er relativt ny, og at tilgangen, særligt i løbet af de seneste to årtier, i stigende grad er blevet genstand for politikeres, forskeres og praktikeres interesse. På trods af en øget forskningsmæssig interesse for feltet omhandlende udvikling og implementering af interventioner og praksisser inden for mental sundhedsfremme, er litteraturen stadig mangelfuld på en række områder (Barry, 2019a). Der er særligt brug for undersøgelser af operationaliseringen af interventioner og praksisser, som går på tværs af sektorer og professioner, samt processerne for opbygning af kapacitet til at løse opgaverne inden for mental sundhedsfremme. Delstudierne i denne afhandling er designet til at bidrage med viden om netop disse tematikker. Inden jeg redegør for delstudiernes design og metoder, beskriver jeg først afhandlingens empiriske kontekst og dernæst afhandlingens videnskabsteoretiske positionering.

Afhandlingens empiriske kontekst

I dette kapitel præsenterer jeg afhandlingens empiriske kontekst. Delstudie 1 er en empirisk undersøgelse af implementeringsprocesser, som fandt sted i partnerskabet ABC for mental sundhed. Delstudie 2 og 3 er empiriske undersøgelser af udviklingen og pilotafprøvningen af et aktionslæringsforløb, der er et delprojekt i partnerskabet ABC for mental sundhed.

Som en kort introduktion til den danske kontekst, hvor både partnerskabet og afhandlingen er situeret, skitserer jeg først formelle (lovgivningsmæssige) rammer for sundhedsfremme- og forebyggelsesarbejdet i Danmark. Herefter præsenterer jeg væsentlige aspekter af udviklingen af, organiseringen af og indsatskomponenter i partnerskabet ABC for mental sundhed og aktionslæringsforløbet. Partnerskabet og aktionslæringsforløbet er desuden beskrevet i artikel 1 og artikel 2.

Mental sundhedsfremme i Danmark

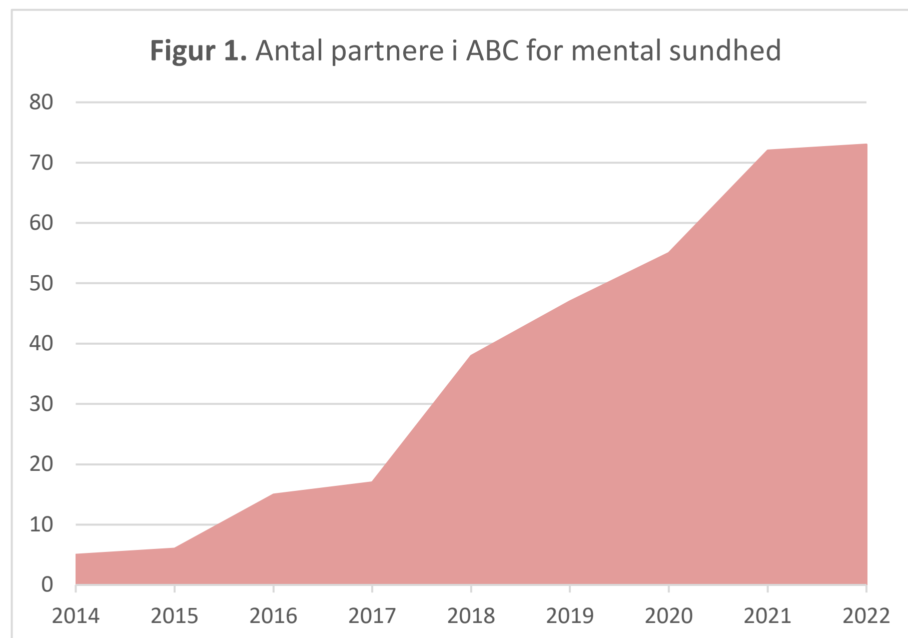
I Danmark er kommunerne lovgivningsmæssigt forpligtiget til at initiere sundhedsfremme- og forebyggelsesindsatser (Civilstyrelsen, 2020; Sundhedsministeriet, 2017). Ifølge Sundhedsministeriet bør dette også indbefatte initiativer inden for mental sundhedsfremme. Sundhedsministeriet beskriver desuden, at disse initiativer bør udvikles og implementeres i lokale arenaer, hvor borgere lever deres hverdagsliv (Sundhedsministeriet, 2017). Da lovgivningen ikke definerer, hvordan lokale tiltag skal udfoldes og implementeres, har kommunerne råderum til at operationalisere initiativer inden for mental sundhedsfremme, herunder om de ønsker at samarbejde med øvrige sektorer såsom regionale aktører og civilsamfundsaktører.

Partnerskabet ABC for mental sundhed

Partnerskabets overordnede formål er at fremme danskernes mentale sundhed ved at styrke sammenhængen mellem partnerorganisationernes indsatser på tværs af sektorer (Koushede, 2018). Én af grundidéerne i partnerskabet er at tilbyde organisationer en fælles forståelses- og arbejdsramme for

mental sundhedsfremme – ABC-rammen. Derudover udgør partnerskabet en platform for samarbejde, sparring og vidensdeling på tværs af sektorer. Overordnet forfølges to spor. Det første indebærer indsatser på individniveau, hvor der arbejdes med oplysnings- og aktiveringskampagner, som skal udbrede en salutogen forståelse af og tilgang til mental sundhed og motivere den enkelte til handling. Det andet spor indebærer indsatser på gruppe- og samfundsniveau, der har til formål at styrke rammer og betingelser, hvor den enkelte borger kan engagere sig i mentalt sundhedsfremmende adfærd (Koushede, 2018). Partnerskabet arbejder således i tråd med princippet om at anvende en socio-økologisk tilgang til udvikling og implementering af initiativer inden for mental sundhedsfremme (Barry, 2019b)

ABC-rammen bruges af partnerorganisationerne til at udvikle og implementere initiativer inden for mental sundhedsfremme. ABC-rammen tager afsæt i tre budskaber, som hver især repræsenterer et domæne for mentalt sundhedsfremmende adfærd: A) Gør noget aktivt, B) Gør noget sammen og C) Gør noget meningsfuldt (Koushede, 2018).[1] Organiseringen af partnerskabet er yderligere uddybet i artikel 1. Figur 1 viser udviklingen af antal partnere fra 2014 til 2022.



Udvikling og pilotafprøvning af aktionslæringsforløb

En løbende procesevaluering af partnerskabets arbejde pegede på, at participatoriske metoder var særligt effektive til at understøtte lokale implementeringsprocesser (artikel 1). På baggrund heraf udviklede en

[1] Baggrunden for udviklingen af ABC-rammen vil jeg ikke uddybe her, da den ikke er genstand for afhandlingens undersøgelser. Flere informationer herom kan findes andetsteds (se fx: ABCs, 2022; Koushede, 2018; Koushede & Donovan, 2022).

række partnere et aktionslæringsforløb som en intensiveret implementerings- og kapacitetsopbygningsindsats. Pilotafprøvningen heraf var genstandsfelt for delstudie 2 og 3.

Aktionslæringsforløbet, som blev undersøgt i denne afhandling, er baseret på de grundlæggende principper for aktionslæring beskrevet af Pedler og Burgoyne (2015) og Zuber-Skerritt (2002). Aktionslæringsforløbet har et todelt formål (Pounder, 2009). Det sigter mod 1) at udvikle nye eller videreudvikle eksisterende praksisser inden for mental sundhedsfremme samt 2) at stimulere organisatorisk og individuel kapacitetsopbygning.

Organisering og samarbejdspartnere

Sammen med min bi-vejleder, Vibeke Koushede (på daværende tidspunkt ansat ved Statens Institut for Folkesundhed (SIF), SDU), var jeg involveret i udviklingen og afprøvningen af aktionslæringsforløbet. Dette arbejde var et samarbejde med aktører fra to partnerorganisationer i ABC for mental sundhed: en leder og en sundhedskonsulent fra sundhedsfremme- og forebyggelsesafdelingen i en kommunal partnerorganisation, og en udviklingskonsulent fra en national paraplyorganisation inden for kultur og fritid. Den deltagende partnerkommune agerede vært (omtales i det følgende som værtskommunen) og havde dermed ansvaret for at rekruttere lokale organisationer, være med-facilitatorer til workshops og sørge for praktikaliteter såsom lokaler og forplejning. Aktørerne fra paraplyorganisationen og SIF havde det primære ansvar for at planlægge og facilitere forløbet – herunder de enkelte workshops.

Rekruttering af deltagere til aktionslæringsforløb

Aktionslæringsforløbet var målrettet lokale organisationer og forskellige kommunale afdelinger fra værtskommunen. Der var ingen krav til deltagernes faglighed eller profession. Aktionslæringsforløbet var altså et tværsektorielt tilbud.

Aktørerne fra værtskommunen var ansvarlige for at rekruttere organisationer og afdelinger, som ønskede at deltage i aktionslæringsforløbet. Dette foregik ved at kontakte relevante afdelinger internt i værtskommunen og organisationer fra lokalområdet. Disse blev udvalgt på baggrund af en vurdering af eksisterende samarbejdsrelationer, interesse for at indgå i et samarbejde om mental sundhedsfremme og timingen ift. øvrige dagsordener.

I alt fem aktionslæringsgrupper deltog i forløbet. Aktionslæringsgrupperne bestod af deltagere, som repræsenterede fire forskellige uddannelsesretninger på en professionshøjskole, et frivilligcenter og

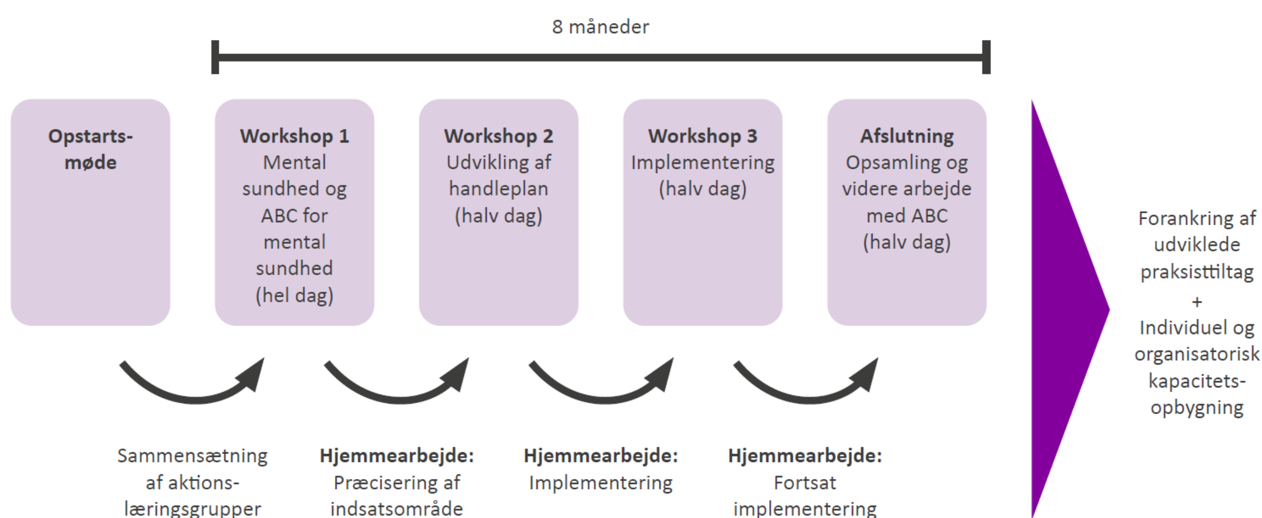
værtskommunens sundhedsfremme- og forebyggelsesafdeling. Deltagerne fra de to sidstnævnte organisationer udgjorde én aktionslæringsgruppe, hvor de arbejdede med udviklingen af et initiativ på tværs af organisationer. Aktionslæringsgrupperne fra professionshøjskolen bestod af både studerende og ansatte (bl.a. undervisere, ledere og en studievejleder).

Rekrutteringstilgangen betød, 1) at jeg kun havde ringe indflydelse på, hvem de deltagende organisationer var, og 2) at jeg ingen indflydelse havde på, hvem deltagerne fra organisationerne var.

Struktur og indhold for aktionslæringsforløbet

Aktionslæringsforløbet forløb over ni måneder og var struktureret omkring fire workshops, der blev afholdt med omkring to til tre måneders mellemrum. Strukturen og indhold af aktionslæringsforløbet er illustreret i figur 2. Strukturen er inspireret af Zuber-Skerritt (2002) og Folker og Lauridsen (2017). Indhold og strukturen for workshopforløbet blev løbende drøftet og justeret i et tæt samarbejde mellem de involverede aktører. Herved kunne der tages hensyn til eksempelvis deltagernes behov og eksterne faktorer såsom coronarestriktioner og -nedlukning. Leder fra interesserede organisationer/afdelinger blev inviteret til et opstartsmøde forud for selve forløbet.

Figur 2. Illustration af struktur og indhold af aktionslæringsforløb.



<u>Opstartsmødets</u> primære formål var at introducere ledere for de grundlæggende tanker bag forløbet og herigennem sikre ledelsesopbakning. Efter mødet var det ledernes opgave at sammensætte en aktionslæringsgruppe, som kunne deltage i de fire workshops. De fik anbefalet at sammensætte grupperne på 2-5 medarbejdere/frivillige og gerne én leder.

Workshop 1 havde til formål at introducere viden om mental sundhedsfremme og ABC for mental sundhed og på baggrund heraf påskynde deltagerne til at identificere mulige indsatsområder. Deltagerne fik til opgave at identificere et endeligt indsatsområde som hjemmearbejde før workshop 2. De blev opfordret til at inddrage deres kollegaer, ledere og andre relevante aktører i dette arbejde.

Workshop 2 havde til formål at guide deltagernes udvikling af praksistiltag, som var målrettet det identificerede indsatsområde. Udviklingen af handleplaner for aktionslæringsgruppernes indsatser var central. Efter workshoppen skulle deltagerne afprøve deres initiativer og løbende videreudvikle deres handleplaner.

Workshop 3 havde til formål tilbyde deltagerne sparring på deres erfaringer med udvikling og afprøvning af deres initiativer. Der var særligt fokus på implementeringsudfordringer og evaluering af deltagernes initiativer som en hjælp til deltagerne med at revidere deres handleplaner. Efter workshop 3 og frem til sidste workshop skulle deltagerne fortsætte med udviklingen og afprøvningen af deres initiativer.

Workshop 4 havde til formål at samle op på deltagernes erfaringer fra det samlede aktionslæringsforløb og at guide deltagerne med at forankre deres initiativer. Til workshoppen var der desuden tid til, at hver aktionslæringsgruppe kunne præsentere dens initiativer og herigennem dele dens erfaringer og initiativer med de andre aktionslæringsgrupper.

Videnskabsteoretisk positionering

I det følgende kapitel præsenterer jeg først afhandlingens overordnede videnskabsteoretiske positionering. Efterfølgende reflekterer jeg over, hvilke implikationer denne positionering har haft for afhandlingens tre delstudier, herunder brugen af teorier og begreber.

Kritisk realisme

Ontologi og epistemologi inden for en kritisk realistisk ramme

Afhandlingen er positioneret i en kritisk realistisk videnskabsteoretisk ramme. Kritisk realisme har et stærkt fokus på at analysere forandringsprocesser og forklare kausale sammenhænge og er derfor særligt egnet til at belyse samfundsmæssige og sociale problemstillinger og pege på løsningsmuligheder (Fletcher, 2017). Min forståelse af kritisk realisme læner sig op af særligt Pawson og Tilley (1997) og Pawson (2013).[2] Ray Pawson og Nick Tilley er inspireret af filosoffer og tænkere som Roy Bhaskar, Margaret Archer, Jon Elster og Robert Merton (Pawson, 2013; Pawson & Tilley, 1997). Kritisk realisme bygger på en lagdelt virkelighedsforståelse, som består af tre ontologiske niveauer (Pawson, 2013; Pawson & Tilley, 1997). ”Det empiriske” niveau (*the empirical*) vedrører individets erfaringer og observationer. ”Det faktiske” niveau (*the actual*) vedrører begivenheder og fænomener, som er observerbare, men som også er virkelige, selvom de ikke observeres. Det tredje niveau, ”det reale” (*the real*), vedrører dybereliggende strukturer og mekanismer, som i langt de fleste tilfælde ikke kan observeres umiddelbart. I denne tredeling ligger der en forståelse af, at der findes en virkelighed, som er uafhængig af individet og dele af den kan observeres.

De epistemologiske antagelser inden for kritisk realisme indebærer en antagelse om, at virkeligheden opleves forskelligt betinget af en række karakteristika og egenskaber hos betragteren. Desuden betyder

[2] I forbindelse med præsentationen af metoden realistisk evaluering, kalder Pawson og Tilley deres udlægning af kritisk realisme for videnskabelige realisme (*scientific realism*) (Pawson & Tilley, 1997). Sidenhen er den videnskabsteoretiske positionering for realistisk evaluering blevet genstand for omfattende diskussion (Pawson, 2013; Porter, 2015) og er beskrevet som bl.a. en balancering mellem positivistiske og konstruktivistiske teoriretninger (Greenhalgh & Manzano, 2021; Ravn, 2020). Pawson skrev i 2013, at han ser sig selv og det paradigme han arbejder med som ”*some kind of realist*” (Pawson, 2013, p. xix). Jeg vil ikke dykke yderligere ned i denne videnskabsteoretiske og navngivningsmæssige diskussion, da det ligger uden for sigtet med afhandlingen.

den tredelte ontologi, at dele af virkeligheden, de dybereliggende mekanismer, ikke nødvendigvis kan observeres med det blotte øje (Ravn, 2020). Netop mekanismerne, som findes på et "det reale" niveau, er centrale i forskningen inden for kritisk realisme. Forskningen har typisk fokus på at afdække eller beskrive forklarende processer og aspekter af et givent fænomen (Pawson, 2013). Viden om verden kan forstås og kommunikeres igennem teorier, som beror på rationelle analyser og bedømmelser af begivenheder og fænomener (Fletcher, 2017). Min rolle som forsker indebar derfor, jf. Mason (2018, p. 226), et krav om at kunne forstå lægmands fortolkninger såvel som at levere videnskabelige fortolkninger og bevæge sig fra disse i retning af mere generelle forklaringer (teorier). Desuden rummer kritisk realisme en antagelse om, at virkeligheden aldrig vil kunne erkendes fuldstændigt, og at forskningen aldrig vil kunne nå frem til absolutte sandheder (Pawson, 2013). Det betyder, at mine resultater skal fortolkes som partielle, og at resultaterne bør læses som et bidrag til en kumulativ vidensopbygning (Frederiksen & Kringelum, 2021; Pawson, 2013).

Kritisk realisme i relation til interventions- og implementeringsforskning

Min afhandling kan som nævnt foroven i dette kapitel placeres i et spændingsfelt mellem interventions- og implementeringsforskningen. Derfor er det væsentligt at forholde sig til implikationerne af mine ontologiske antagelser for, hvordan interventioner og implementeringsprocesser manifesterer sig i den virkelige verden og kan undersøges. Pawson beskriver, at samfundet overordnet set skal betragtes som en ikke-intenderet konsekvens af menneskernes gøren og laden frem for noget, der kontrolleres og styres af mennesker (Pawson, 2013). Inspireret af Margaret Archers begreb *morphogenesis* beskriver han yderligere, at samfundet er i et stadie af konstant udvikling (Pawson, 2013). Uanset om en implementering finder sted, vil samfundet uundgåeligt, ikke-intenderet og selvskabt forandre sig. Implementeringsprocesser vedrører altså introduktionen af eksempelvis interventioner, initiativer og politikker inden for mental sundhedsfremme i et system, der er flydende og i konstant forandring. Det betyder, at implementeringsprocesserne, som jeg har undersøgt i afhandlingen, ikke forsøger at ændre et stabilt status quo i den kontekst, hvor de finder sted. I stedet ændrer de på retningen af en igangværende forandring (Pawson, 2013). Heri ligger en antagelse om, at de virkninger og effekter, som jeg observerer i forbindelse med mine delstudier, aldrig kan tilskrives alene de initiativer eller implementeringsprocesser, som udgør mit empiriske objekt (Fletcher, 2017). Virkninger vil altid være et resultater af en række processer, hvoraf nogen er relateret til og nogen er uafhængige af de implementeringsprocesser, som undersøges (Ravn, 2020).

Interventions- og implementeringsforskere er ofte interesseret i at besvare spørgsmål om, hvorvidt og hvordan aspekter af en intervention fører til forandringer og effekter. For at forstå i hvor høj grad

observerede virkninger og effekter kan tilskrives og linkes til en given intervention eller implementeringsproces, gør kritisk realistisk forskning brug af en generativ kausalitetsforståelse (Mingers & Standing, 2017). Denne kausalitetsforståelse indebærer, at forandring, hændelser, events osv. generes gennem aktiveringen af mekanismer. De underliggende mekanismer, som findes på "det reale" ontologiske niveau, træder kun i kraft eller aktiveres, når bestemte kontekstuelle forhold er til stede (Pawson, 2013). En dybdegående forståelse af kontekstuelle faktorer og deres samspil med en intervention eller implementeringsproces er derfor central inden for kritisk realisme. Det betyder, at formålet med denne type studier bliver at sandsynliggøre, hvorvidt og hvordan en given intervention har bidraget til at skabe den observerede virkninger.

Med afsæt i ovenstående redegørelse for kritisk realisme beskriver jeg i det følgende implikationerne af min videnskabsteoretiske positionering for afhandlingens tre delstudier.

Delstudie 1 – procesevaluering af lokale implementeringsprocesser

Delstudie 1 var indlejret i en større formativ procesevaluering af arbejdet i partnerskabet ABC for mental sundhed. Et overordnet formål med procesevalueringen var at afdække styrker og svagheder ved implementeringsprocesserne. Det vil sige at skabe indsigt i og belyse implementeringsprocesser fremfor at vurdere, hvorvidt arbejdet med ABC-rammen var en succes eller fiasko. Sigtet var at producere viden, som kunne bruges til løbende at justere og videreudvikle praksisser i partnerskabet ABC for mental sundhed (Bauman & Nutbeam, 2013). Delstudie 1 kan ses som en del af denne overordnede procesevaluering, hvor jeg i delstudiet valgte at fokusere særligt på implementeringsprocesserne hos partnerorganisationerne, herunder involverede aktørers subjektivt oplevede virkning (impact) af arbejdet med ABC-rammen. Set i lyset af den tredelte ontologi repræsenterer beretningerne fra studiets informanter "det empiriske" niveau, som giver adgang til at forstå de fænomener og processer (f.eks. implementeringsprocesser og -strategier), som er foregået på "det faktiske" niveau.

I delstudie 1 læner jeg mig op ad Damschroder et al. (2009)'s konceptualisering af implementering. Jf. forfatterne vedrører implementering en kombination af processer, der har til formål at få et initiativ eller en intervention i brug i en organisation eller system. I konteksten af partnerskabet ABC for mental sundhed er implementeringsprocesser altså vejen fra beslutningen om at adoptere ABC-rammen, udviklingen af konkrete initiativer og frem til, at disse bliver til en del af den daglige praksis/rutine i partnerorganisationerne (Damschroder et al., 2009). Som beskrevet foroven tager min afhandling afsæt i en morfogenetisk forståelse af samfundet (Pawson, 2013). Det betyder, at partnerskabet ABC for mental

sundhed og initiativerne, som implementeres af partnerne, uundgåeligt vil mutere og udvikle sig – også efter afslutningen af en given implementeringsproces. Antagelsen om et konstant foranderligt genstandsfelt krævede en særlig opmærksomhed på, hvordan partnerskabet og initiativer konkret manifesterede sig på et givent tidspunkt. Eksempelvis steg antallet af partnerorganisationer løbende, og erfaringer og evalueringer formede løbende partnerskabets organisering.

Delstudie 2 – realistisk evaluering af aktionslæringsforløb

Det overordnede formål med delstudie 2 var at skabe nuanceret og dybdegående viden om, hvordan aktionslæring kan føre til opbygning af kapacitet til at løse opgaverne inden for mental sundhedsfremme (omtales i det følgende også som ”mental sundhedsfremmekapacitet”). Min konceptualisering af mental sundhedsfremmekapacitet er inspireret af kapacitetsbegreber fra folkesundheds- og sundhedsfremmefeltet (McLean et al., 2004; B. J. Smith, Tang & Nutbeam, 2006; van Herwerden et al., 2018). Jeg definerer mental sundhedsfremmekapacitet som evnen til og potentialet for at individer, organisationer eller systemer deliberativt kan praktisere effektiv mental sundhedsfremme. Som nævnt i state of the art-kapitlet (og i artikel 2) findes kapacitet på forskellige niveauer og i forskellige former, herunder bl.a. som viden, kompetencer og samarbejdsrelationer. Kapacitetsopbygning er processen, hvor aspekter af kapacitet styrkes.

Følgeforskningen i aktionslæringsforløbet var oprindeligt designet som en procesevaluering kombineret med et effektstudie (Green & Tones, 2010). Undervejs i dataindsamlingen og udrulningen af aktionslæringsforløbet valgte jeg at ændre mit design og lade det tage afsæt i realistisk evaluering (Pawson & Tilley, 1997) (kaldes også ”virkningsevaluering” på dansk (Ravn, 2020)). Det gjorde jeg på baggrund af et ønske om at kombinere et fokus på aktionslæringsforløbets måder at virke på med et fokus på at afdække dets effekter. Realistisk evaluering har netop fokus på både processer og effekter og kan dermed ses som en brobygger mellem procesevaluering og effektstudie (Pawson & Tilley, 1997; Ravn, 2020). Realistisk evaluering tilbyder en metode og et begrebsapparat til at koble disse foci. Helt konkret gøres det ved at applicere heuristikken ”C+M=O” (*context+mechanism=outcome)*, som dækker over konfigurationen af elementerne kontekst (C), mekanisme (M) og outcome/virkning (O) (Pawson & Tilley, 1997). Inden jeg uddyber, hvad der ligger heri, og udfolder begrebsapparatet, som knytter sig til realistisk evaluering, vil jeg kort redegøre for relationen mellem realistisk evaluering og kritisk realisme.

Realistisk evaluering blev introduceret af Pawson og Tilley (1997) i bogen *Realistic Evaluation*. De placerede realistisk evaluering inden for et realistisk videnskabsteoretiske paradigme (*scientific*

realism). De beskriver paradigmet som værende inspireret af og tæt beslægtet med Roy Bhaskars udlægning af kritisk realisme (Pawson & Tilley, 1997). Jf. Pawson er det grundlæggende sigte med realistisk evaluering at producere viden, som kan informere policy og praksis i den virkelige verden (Pawson, 2013). Desuden beskriver han realistisk evaluering som en praksisnær forskningsstrategi (*workaday research strategy*), der stræber efter at producere forklaringer baseret på nuancerede og grundige undersøgelser og beskrivelser af underliggende mekanismer, som findes på "det reale" ontologiske niveau (Pawson, 2013). Disse grundliggende tanker er i høj grad i tråd med formålet for delstudie 2, hvor jeg ønskede at undersøge mekanismerne for kapacitetsopbygning i aktionslæringsforløbet.

Realistisk evaluering er en teoribaseret tilgang til evalueringsforskningen, hvilket dækker over et immanent teorigenererende sigte (Pawson & Tilley, 1997). Enten ved, at resultater fra en realistisk evaluering bidrager til udviklingen af generelle teorier, såsom beskrivelser af *demi-regularities* og *middle range*-teorier (Pawson & Tilley, 1997) eller bidrager til udviklingen/videreudviklingen af politikker og interventioner. Netop i forhold til sidstnævnte foreslår Pawson og Tilley (1997) brugen af programteorier. Disse består ofte af en række CMO-konfigurationer (Ravn, 2020), som tilsammen giver en teoretisk beskrivelse af, hvorfor og hvordan en given politik eller intervention forventes at virke. En del af det indledende arbejde med realistisk evaluering er ofte at undersøge ligheder med eksisterende programteorier og tidligere erfaringer med lignende tiltag for at udforske, hvor man kan hente erfaringer for at bygge på eksisterende viden. Denne indledende gennemgang af relevant litteratur kan så bidrage til udviklingen af en programteori. I forbindelse med delstudie 2 valgte jeg i stedet at foretage en empirisk undersøgelse af CMO-konfigurationerne for aktionslæringsforløbet med tanke på, at disse kan informere udviklingen af en programteori. Rasmus Ravn beskriver denne tilgang til udvikling af en programteori som en induktiv tilgang (Ravn, 2020). I delstudie 2 fulgte jeg altså ikke "opskriften" på en realistisk evaluering, som den foreslås af Pawson og Tilley (Pawson, 2013; Pawson & Tilley, 1997).

Som nævnt er de forklarende aspekter centrale i resultaterne fra realistisk evaluering. Det er således min opgave som forsker at identificere og forklare de forhold, som muliggjorde, at de identificerede mekanismer havde en generativ effekt (Pawson, 2013). Heri ligger der en opfordring til, at kontekstuelle faktorer underkastes grundige undersøgelser og sættes i relation til mekanismer, dvs. interventionens ressourcer og deltagernes reaktioner herpå (J. Jagosh et al., 2015).

Delstudie 3 – udvikling af taksonomi og undersøgelse af samspil på tværs af roller

Formålet med delstudie 3 kan deles op i to. For det første indebar delstudiet udviklingen af en taksonomi for centrale roller, som er involveret i opgaverne inden for mental sundhedsfremme. I konceptualiseringen af rollebegrebet lod jeg mig inspirere af funktionel rolleteori (Biddle, 1986). På baggrund heraf er roller konstitueret af et udvalg af funktioner, som er relateret til arbejdet med mental sundhedsfremme. Heraf følger, at rollerne ikke er knyttet til en given person, og at én person kan have forskellige roller afhængigt af, hvilke funktioner vedkomne varetager. Taksonomien er udviklet på baggrund af en afdækning af observerbare mønstre for praksisser og sociale interaktioner, som indgår i fænomenet mental sundhedsfremme. Det empiriske objekt er implementeringen af aktionslæringsforløbet som et delprojekt inden for partnerskabet ABC for mental sundhed. Taksonomien skal ses som et forsøg på ordne og forklare regelmæssigheder omkring opgavevaretagelsen relateret til mental sundhedsfremme og bevæger sig herved på tværs af de ontologiske niveauer. For det andet indebærer delstudiet en undersøgelse af dynamikkerne på tværs af roller under implementeringen af det førnævnte aktionslæringsforløb. Til formålet anvendte jeg den udviklede taksonomi for at analysere, hvilke roller der gjorde sig gældende i mit empiriske materiale. På baggrund heraf analyserede jeg sociale interaktioner mellem rollerne for herigennem at beskrive overordnede mønstre i de sociale interaktioner, som karakteriserer praksisserne i den givne implementeringsproces.

Metode

I dette kapitel præsenterer jeg afhandlingens grundlæggende design og metode. Jeg fokuserer her særligt på aspekter og refleksioner vedrørende mine design- og metodemæssige valg, som ikke er beskrevet i afhandlingens artikler.

Design – tre sekventielle studier

Afhandlingens tre delstudier anvender forskellige forskningsdesign og er baseret på forskellige datasæt for at besvare afhandlingens forskningsspørgsmål.

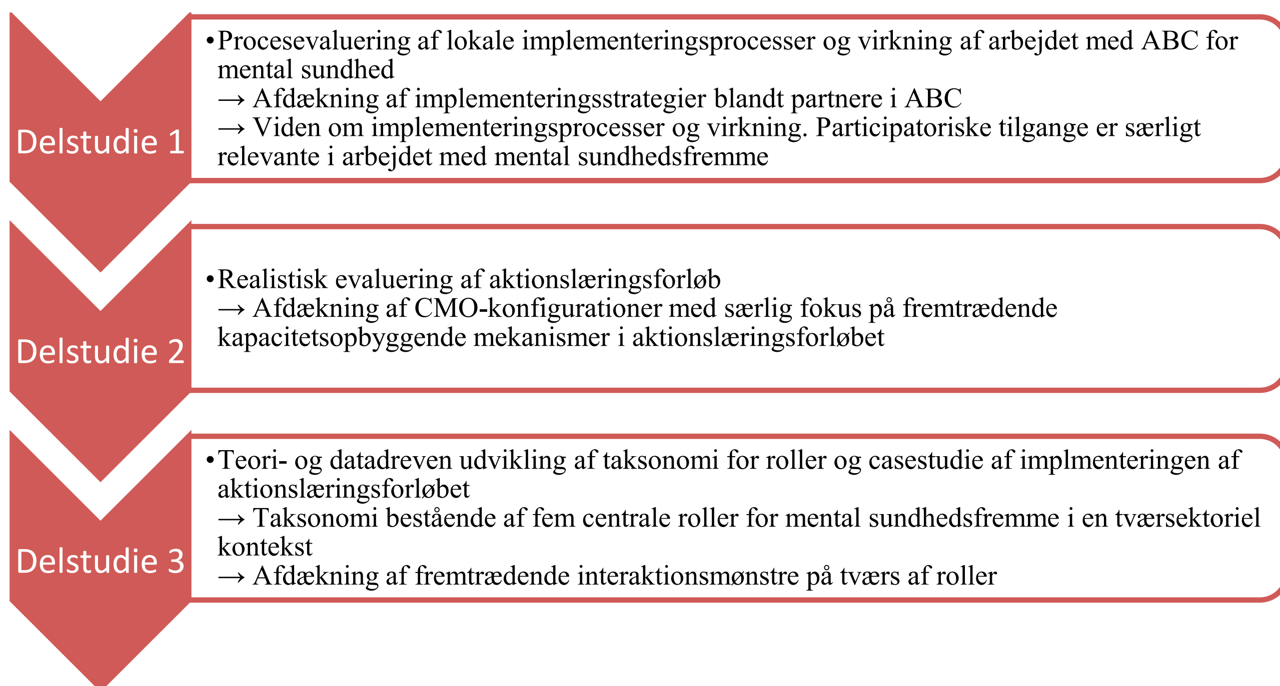
Delstudie 1 er et mixed method-studie og anvender data produceret som led i en formativ procesevaluering (Chen, 1996) af partnerskabet ABC for mental sundhed. Evalueringssurvey med både kvalitative og kvantitative elementer, semistrukturerede interviews og semistrukturerede gruppeinterviews er anvendt til at undersøge ABC-koordinatorers og stakeholders oplevelse af lokale implementeringsprocesser og virkningen af arbejdet med ABC for mental sundhed. Resultaterne fra delstudie 1 informerede udviklingen af aktionslæringsforløbet, som var genstand for en *realistisk evaluering* (Pawson & Tilley, 1997) i delstudie 2.

I **delstudie 2** er formålet at undersøge hvordan, for hvem og under hvilke omstændigheder indlejrede processer i aktionslæring kan styrke mental sundhedsfremmekapacitet i og på tværs af organisationer. Undersøgelsen er baseret på data fra semistrukturerede interviews, gruppeinterviews og telefoninterviews med deltagere og stakeholdere, observationer til workshops og dokumenter produceret af deltagerne i forbindelse med aktionslæringsforløbet. Brugen af forskellige datatyper gjorde det muligt at opnå en dyb og nuanceret indsigt i aktionslæringsforløbets underliggende mekanismer, mekanismernes relation til den givne kontekst og hvordan de kan bidrage til at opbygge mental sundhedsfremmekapacitet. Resultaterne og erfaringerne fra delstudie 1 og 2 spillede en afgørende rolle for fastlæggelsen af forskningsspørgsmål og design af delstudie 3. Her er samarbejde på tværs af organisationer, professioner, discipliner og sektorer et gennemgående tema. Herunder bl.a., at flere praktikere og beslutningstagere oplevede uklare rolle- og ansvarsfordeling inden for mental sundhedsfremme. Denne problematik kan også genfindes i implementeringsstudier med fokus på mental sundhedsfremme (Annor & Allen, 2009; McCabe & Davis, 2012). Litteraturen inden for mental

sundhedsfremme og tværsektorielle tilgange peger desuden på behovet for at udvikle et fællessprog, som kan bruges på tværs af sektorer og professioner til at forstå, italesætte og arbejde strategisk med nøglefunktionerne og tværgående processer inden for mental sundhedsfremme (Annor & Allen, 2009; Barry, 2019a).

Delstudie 3 tager afsæt i ovennævnte erkendelser og data fra delstudie 2. Formålet med dette delstudie er 1) at udvikle en taksonomi for rollerne, som indgår i praksisser inden for mental sundhedsfremme i en tværsektoriel kontekst, og 2) at undersøge interaktionerne på tværs af rollerne under implementeringen af aktionslæringsforløbet. Analysetilgangen for udviklingen af taksonomien er inspireret af Nigel Kings *Template Analysis* (King, 2012), som er en iterativ tematisk analyse. Tilgangen gjorde det muligt at inddrage tidligere evalueringsresultater (bl.a. fra delstudie 1) og relevant litteratur omkring mental sundhedsfremme i analysearbejdet (J. Brooks, McCluskey, Turley & King, 2015). Interaktionerne på tværs af rollerne er undersøgt ved at anvende den udviklede taksonomi i et casestudie af implementeringen af aktionslæringsforløbet. Den sekventielle proces for gennemførelsen af de tre delstudier – afhandlingens samlede design – er illustreret i figur 3.

Figur 3. Afhandlingens samlede design.



I det følgende beskriver jeg først dataproduktionen og mine refleksioner heromkring, efterfulgt af en beskrivelse af mine analytiske tilgange i de tre delstudier. Herefter beskriver jeg mine refleksioner omkring mine positioneringer i forbindelse med dataproduktionen og udarbejdelsen af afhandlingen.

Endelig beskriver jeg mine etiske overvejelser relateret til design og dataproduktion. Delstudiernes design og metoder er yderligere beskrevet i de vedhæftede artikler.

Data

Datagrundlag for delstudie 1 – formativ procesevaluering af ABC for mental sundhed

Datagrundlaget for delstudie 1 er et uddrag af kvalitative og kvantitative data fra en formativ procesevaluering af arbejdet i partnerskabet ABC for mental sundhed. Den formative procesevaluering gennemføres af forskere fra Statens Institut for Folkesundhed. Den blev initieret i 2016 og kører fortsat med årlig indsamling af evalueringsspørgeskema fra alle partnere i ABC for mental sundhed. Data fra procesevalueringen, som indgår i denne afhandling, blev produceret mellem januar 2017 og februar 2020. En del af dataproduktionen lå således forud for påbegyndelsen af afhandlingen. Jeg var involveret i planlægningen og gennemførslen af procesevalueringen som en del af min stilling før jeg blev indskrevet som ph.d.-studerende (indskrivning 01.04.2019).

Evalueringsskemaer blev sendt ud til ABC-koordinatorer i alle partnerorganisationer og indeholdt åbne spørgsmål omkring det lokale arbejde med ABC for mental sundhed. Hen over seks runder blev i alt 141 evalueringsskemaer sendt ud, hvoraf 128 blev returneret. Data fra evalueringsskemaerne blev anvendt til at få indblik i de lokale implementeringsprocesser blandt alle partnerorganisationer, herunder bl.a. hvordan udfordringer og barrierer blev håndteret over tid. I sjette runde af indsamlingen af evalueringsskemaerne indeholdt evalueringsskemaerne desuden 14 spørgsmål til at undersøge virkningen af arbejdet med ABC for mental sundhed (13 items med svarkategorier på en fem-point Likert-skala, og én kategorisk item). Alle items er gengivet i artikel 1.

Udover evalueringsskemaerne indebar procesevalueringen i perioden 2016 til 2018 også interviews med ABC-koordinatorer (n=8) og lokale stakeholdere (n=7) hos fire udvalgte partnerorganisationer. Tabel 2 viser en oversigt over informanterne og tidspunkter for interviews. Organisationerne blev udvalgt med henblik på at sikre variation (Palinkas et al., 2015) i relation til organisationstype (kommune/NGO) og hvordan organisationerne arbejdede med ABC-rammen. De fire organisationer var to kommuner og to NGO'er. De to kommuner repræsenterede kommunale kontekster med varierende størrelse (bl.a. antal medarbejdere og antal indbyggere i kommunen). De to NGO'er repræsenterede organisationer fra den tredje sektor. Strategien for case-udvælgelsen var baseret på et ønske om at opnå viden om forskellige implementeringsprocesser og anvendelsesmuligheder af ABC-rammen samt ligheder og forskelle på

tværs af organisationstyper (Palinkas et al., 2015). Interviewene blev gennemført på tre forskellige tidspunkter i løbet af den toårige periode.[3] Interviewene blev gennemført som fem individuelle interviews og 12 gruppeinterviews, og de var semistrukturerede og guidet af en interviewguide (appendiks A). Formålet med interviewene var at opnå en detaljeret og dybdegående indsigt i det lokale arbejde med at omsætte ABC-rammen til initiativer og praksisser. Valget om at interviewe netop ABC-koordinatorer og lokale stakeholdere er baseret på en antagelse om de to grupper har særligt grundigt kendskab til lokale implementeringsprocesser. Indsigterne fra interviewene supplerede således den mere overordnede viden fra evalueringsskemaerne. Interviewguides var struktureret omkring overordnede temaer, som status for arbejdet med ABC, fremtidig fokus og planer, partnerskabet ABC for mental sundhed og lokal organisering. Før hvert interview blev interviewguides tilpasset de specifikke informanter på baggrund af viden fra bl.a. evalueringsskemaer og tidligere interviews. Eksempler på interviewguides er indsat som appendiks – eksemplerne er interviewguides, som er brugt til interviews i den ene kommunale partnerorganisation på tre forskellige tidspunkter (appendiks A).

Datagrundlag for delstudie 2 og 3 – realistisk evaluering af aktionslæringsforløb

I dette afsnit beskrives dataproduktionen i forbindelse med pilotafprøvningen af aktionslæringsforløbet. Data blev produceret med henblik på at besvare formålet i delstudie 2. Senere blev de selvsamme data også anvendt til at besvare formålet i delstudie 3, men er altså ikke produceret med henblik herpå.

For at opnå en dyb og nuanceret viden om og indsigt i kontekstuelle faktorer, mekanismer og outcomes, og ikke mindst sammenhængen mellem disse elementer, valgte jeg at bruge forskellige metoder i dataproduktionen. Denne foregik fra september 2019, hvor første workshop i aktionslæringsforløbet blev afholdt, og frem til december 2020, dvs. seks måneder efter sidste workshop i aktionslæringsforløbet. Jeg gennemførte observationer ved alle workshops. Ved de første tre workshops bidrog en praktikant også med at lave observationer. Observationerne var styret af observationsguides (Tjørnhøj-Thomsen & Whyte, 2008). Disse blev løbende videreudviklet på baggrund af erkendelser, undren og refleksioner, som opstod i arbejdet med udviklingen og evalueringen af aktionslæringsforløbet. Den deltagende praktikant og jeg læste hinandens observationsnoter og drøftede tematikker og problemstillinger, som gjorde sig gældende i materialet, med henblik på at informere den følgende dataproduktion. For eksempel ved at justere observationsguiden, som skulle bruges i forbindelse med de følgende workshops. Et eksempel på observationsguide findes i appendiks B. Efter anden workshop i aktionslæringsforløbet indsamlede jeg også dokumenter, såsom handleplaner og

[3] Se tidslinjen for dataproduktionen i figur 1 i artikel 1, side 4.

projektbeskrivelser, som aktionslæringsgrupperne havde udarbejdet i forbindelse med deres projektideer og -planer. Dokumenterne gav indsigt i aktionslæringsgruppernes planlagte og gennemførte udviklings- og implementeringsprocesser. Sidst i metodekapitlet uddyber jeg mine refleksioner om min positionering i forbindelse med gennemførelsen af observationerne og interviews.

#	Organisation	Sektor/ fagområde	Stilling	Køn	Interview 1. runde	Interview 2. runde	Interview 3. runde
I.1	K1	Sundhedsfremme og forebyggelse	Leder (ABC-koordinator)	Kvinde	X*	X*	X*
I.2	K1	Sundhedsfremme og forebyggelse	Sundhedskonsulent (ABC-koordinator)	Kvinde	X*	X*	X*
I.3	K1	Sundhedsfremme og forebyggelse	Chef	Kvinde		X	X*
I.4	K2	Ældre og Sundhed	Leder	Kvinde		X	X*
I.5	K2	Ældre og Sundhed	Sundhedskonsulent (ABC-koordinator)	Mand	X*	X*	X*
I.6	K2	Ældre og Sundhed	Sundhedskoordinator (ABC-koordinator)	Kvinde	X*	X*	X*
I.7	K2	Sundhed og forebyggelse	Chef	Kvinde	X		
I.8	K2	Sundhed og forebyggelse	Leder	Kvinde		X	
I.9	O1	Kultur og Fritid	Projektleder (ABC-koordinator)	Kvinde	X*	X*	X*
I.10	O1	Kultur og Fritid	Projektkonsulent (ABC-koordinator)	Kvinde	X*	X*	X*
I.11	O1	Kultur og Fritid	Studentermedhjælper (ABC-koordinator)	Kvinde	X*		
I.12	O1	Kultur og Fritid	Leder	Kvinde	X	X*	
I.13	O1	Kultur og Fritid	Studentermedhjælper (ABC-koordinator)	Kvinde			X*
I.14	O2	Kultur og Fritid	Udviklingskonsulent (ABC-koordinator)	Kvinde	X*	X*	X*
I.15	O2	Kultur og Fritid	Chef	Mand	X*	X*	X*

Tabel 2. Oversigt og informanter og interviews – procesevaluering af ABC for mental sundhed.
1. runde: januar-marts 2017.
2. runde: september-oktober 2017.
3. runde: april-maj 2018.
K 1/2: kommunal partner 1/2
O 1/2: NGO 1/2
*: deltog i gruppeinterview

Alle deltagere, bortset fra to studerende (de ønskede ikke at deltage pga. tidsmangel), og ledere fra de deltagende organisationer blev interviewet efter aktionslæringsforløbets afslutning. Desuden blev de to involverede aktører fra værtskommunen interviewet. Interviewene blev gennemført mellem en og fire uger efter sidste workshop. Formålet med interviewene var at få indblik i deltagernes og ledernes perspektiver på processer og deres egen rolle relateret til aktionslæringsforløbet. Jeg gennemførte i alt 17 individuelle interviews og to gruppeinterviews. Sidstnævnte med henholdsvis to studerende, som havde deltaget i aktionslæringsforløbet. Valget om at invitere de studerende til gruppeinterviews var baseret på min vurdering af, at det ville øge sandsynligheden for, at de ville acceptere invitationen. For det første var jeg bekymret for, at de ville takke nej, fordi de studerende havde givet udtryk for tidsmangel pga. eksamensskrivning. For det andet havde jeg til workshoppene fået indtryk af, at de studerende følte sig mere trygge i selskab med andre studerende. Formålet med gruppeinterviewene var, ligesom med de individuelle interviews, at producere viden om den enkelte informants egne perspektiver og oplevelser (Mason, 2018). Valget om at lave gruppeinterviews var således et kompromis, da gruppeinterviewene gav mulighed for, at informanterne påvirkede hinanden under selve interviewet, som det eksempelvis ofte er hensigten med fokusgruppeinterviews, hvor man ønsker at producere viden om sociale interaktioner og dynamikker (Mason, 2018). Det samlede antal informanter var 21. Tabel 3 og tabel 4 viser en oversigt over informanterne og hvornår de er blevet interviewet. Tre af de individuelle interviews blev gennemført via Skype pga. coronarestriktioner, og de øvrige blev gennemført i informanternes egen organisation. Interviewene tog udgangspunkt i en semistruktureret interviewguide – se et eksempel i appendiks C. For at give plads til informanternes egne perspektiver og uforudsete relevante tematikker havde de indledende spørgsmål til hvert tema en mere sonderende karakter (Tanggaard & Brinkmann, 2010) – såsom *Hvad tænker du, der er kommet ud af aktionslæringsforløbet?*. Efter behov blev disse fulgt op af mere specifikke spørgsmål for at sikre svar, som var relaterede til forskningsspørgsmålene og temaerne fra interviewguiden – såsom *Har forløbet sat sine spor hos dine kollegaer?*.

#	Sektor/ organisation	Stilling	Alder/år	Køn	Interview	TI 1	TI 2
D1	Uddannelse	Underviser	30-50	Kvinde	X		
D2	Uddannelse	Studerende/ studenterrådgiver/ medlem i studieråd	< 30	Kvinde	X	X	X
D3	Uddannelse	Underviser	< 30	Kvinde	X	X	X
D4	Uddannelse	Underviser	> 50	Kvinde	X	X	X
D5	Uddannelse	Studievejleder	30-50	Kvinde	X		
D6	Uddannelse	Studieleder/ Underviser	30-50	Kvinde	X	X	X
D7	Socialområde	Leder	> 50	Kvinde	X	X	X
D8	Socialområde	Aktivitetsmedarbejder	> 50	Kvinde	X		
D9	Socialområde	Frivillig/ bestyrelsesmedlem	> 50	Kvinde	X		
D10	Sundhedsfremme og forebyggelse	Sundhedskonsulent	30-50	Kvinde	X		
D11	Uddannelse	Studerende	< 30	Mand	X*		
D12	Uddannelse	Studerende	< 30	Mand	X*		
D13	Uddannelse	Studerende	< 30	Kvinde	X*		
D14	Uddannelse	Studerende	30-50	Kvinde	X*		

Tabel 3. Oversigt over informanter og interviews – deltagere i aktionslæringsforløb.

*: deltog i gruppeinterview
TI 1: Telefoninterview, april 2020
TI 2: Telefoninterview, december 2020

Jeg gennemførte desuden 10 telefoninterviews med repræsentanter fra aktionslæringsgrupperne, som havde en tovholderfunktion i deres gruppe (tabel 3). Heraf blev fem gennemført to måneder før afslutningen af aktionslæringsforløbet og havde til formål at få indblik i udviklingen af aktionslæringsgruppernes arbejde og indvirkningen af coronarestriktioner herpå. Denne viden er brugt til at besvare mine forskningsspørgsmål og til at planlægge sidste workshop. Seks måneder efter aktionslæringsforløbets sidste workshop gennemførte jeg igen fem telefoninterviews for at få viden om implementeringen af initiativer og praksisser, som var iværksat som resultat af aktionslæringsforløbet. Denne viden var særligt relevant for at vurdere outcome af aktionslæringsforløbet relateret til praksisændringer og implementering af nye initiativer. Telefoninterviewene var struktureret efter interviewguides – se eksempler herpå i appendiks D.

#	Sektor/organisation	Stilling (rolle i ALF)	Alder/år	Køn	Interview
Ø1	Sundhedsfremme og forebyggelse	Afdelingsleder (planlægning af ALF)	30-50	Mand	X
Ø2	Sundhedsfremme og forebyggelse	Sundhedskonsulent (medfacilitator)	30-50	Kvinde	X
Ø3	Uddannelse	Uddannelsesleder	> 50	Kvinde	X
Ø4	Uddannelse	Uddannelsesleder	30-50	Kvinde	X
Ø5	Uddannelse	Uddannelsesleder	> 50	Kvinde	X
Ø6	Uddannelse	Uddannelseschef	> 50	Kvinde	X

Tabel 4. Oversigt over informanter – ikke-deltagere i aktionslæringsforløb

I delstudie 3 valgte jeg at bruge det empiriske materiale, som var produceret i forbindelse med aktionslæringsforløbet, som datagrundlag. Jeg var interesseret i at undersøge roller, funktioner og processer på tværs af roller. Disse tematikker var et fokus for dataproduktionen i forbindelse med aktionslæringsforløbet.

Forsker, evaluator, facilitator …

I forbindelse med udarbejdelsen af afhandlingen har jeg haft forskellige positioner og ageret forskellige roller, alt efter projektets fase og hvilken kontekst jeg har befundet mig i. Min positionering under dataproduktionen, såsom gennemførelsen af observationer og interviews, er relevant at udfolde her, da min positionering har haft afgørende betydning for, hvilke indsigter empirien har indfanget og dermed afhandlingens samlede vidensproduktion (Mason, 2018). Inden for kritisk realisme er forskerens refleksioner over dennes positionering i relation til det fænomen, som undersøges, desuden et væsentligt aspekt for at kunne bedømme resultaternes troværdighed (Danermark, Ekstrom, Jakobsen, Karlsson & Bhaskar, 2001).

Min positionering vedrører de roller, jeg har indtaget som en del af udarbejdelsen af afhandlingen, for eksempel i mødet med informanter i forbindelse med dataproduktion, til workshops afholdt i aktionslæringsforløbet, og til netværksmøder i partnerskabet ABC for mental sundhed. I det følgende vil jeg beskrive refleksioner, som jeg løbende har gjort mig om min balancering mellem mine forskellige positioner. Refleksionerne kredser omkring, hvordan positionerne har påvirket bl.a. mit blik på de fænomener, jeg har undersøgt, informanters og samarbejdspartneres perspektiver på og tilgang til mig, produktionen af data og læsningen af mit empiriske materiale. Det følgende er struktureret efter mine

roller i relation til partnerskabet ABC for mental sundhed og pilotafprøvningen af aktionslæringsforløbet. Afslutningsvis beskriver jeg min notes- og logbogsskrivning.

Partnerskabet ABC for mental sundhed

Datagrundlaget for delstudie 1 blev genereret, før jeg påbegyndte ph.d.-projektet. Dengang var jeg ansat som videnskabelig assistent på SDU og var involveret i partnerskabet ABC for mental sundhed. I den sammenhæng havde mine kollegaer og jeg en rolle som evaluatorer. Derudover udgjorde mine kollegaer og jeg sekretariatet i partnerskabet, hvilket indebar koordinering og planlægning af netværksmøder, og vi indgik i partnerskabet som partnere fra en forskningsinstitution.

Sammen med mine kollegaer var jeg ansvarlig for planlægning og gennemførelsen af dataproduktionen i forbindelse med en formativ procesevaluering af arbejdet i partnerskabet. I den sammenhæng agerede vi primært som evaluatorer, og vores vidensinteresse kredsede omkring muligheder for at justere og videreudvikle arbejdet i og organiseringen af partnerskabet. Under gennemførelsen af interviews var vi opmærksomme på at tydeliggøre vores rolle som evaluator overfor informanterne. I den sammenhæng understregede vi, at deres feedback og input var et væsentligt element af beslutningsgrundlaget i det videre arbejde i partnerskabet. I introduktionen af hvert interview lagde vi særligt vægt på, at informanternes bidrag ville blive afidentificeret, og vi opfordrede dem til at forholde sig kritiske til organiseringen af partnerskabet og at påpege eventuelle forbedringsmuligheder (se interviewguides i appendiks A og C). Hensigten hermed var bl.a. at undgå, at informanterne oplevede, at det var deres individuelle og organisatoriske bidrag til partnerskabet, der skulle bedømmes.

Under min tilstedeværelse og deltagelse netværksmøder (fire årligt) samt sparrings- og rådgivningsmøder, var mine primære roller 1) partner i ABC for mental sundhed og 2) medlem af sekretariat i partnerskabet. Mine opgaver i den forbindelse kredsede omkring at bidrage med forskningsmæssig viden om mental sundhedsfremme og implementeringsprocesser samt praktiske informationer og hjælp til planlægning.

Ved at agere i de forskellige roller fik jeg løbende indsigter i partnernes interesser, udfordringer og engagement i arbejdet med ABC-rammen og mental sundhedsfremme. Indsigterne byggede på både den formelle vidensproduktion i kraft af evalueringsarbejdet og de indtryk og erfaringer, som jeg tog med mig fra interaktionen med partnerskabet. Indsigterne var med til at forme min forståelse af processerne i partnerskabet og var dermed en væsentlig kilde til viden, som informerede den løbende dataproduktion og -analyse. Ifølge (Volkov, 2011) kan denne form for involvering, eller *insider-rolle*, være en fordel i

udarbejdelsen af formative evalueringer pga. evaluators grundige kendskab til arbejdsgange og dynamikker. I tråd hermed påpeger Bachrach og Newcomer (2002), at den indsigt, som opnås gennem rollen som insider, kan styrke de analytiske processer og fremme kontekstsensitive analyser. Ifølge forfatterne er disse fordele særligt frugtbare, når formålet er formativt. Således kan en insiderrolle ses som en styrke i designet i den formative procesevaluering. Bachrach og Newcomer (2002) påpeger dog også, at ovennævnte fordele kan være på bekostning af muligheden for at opnå en kritisk distance til det fænomen, som undersøges (Bachrach & Newcomer, 2002). Ud fra det perspektiv kan min involvering i Partnerskabet ABC for mental sundhed eksempelvis have betydet, at jeg i mine analyser i forbindelse med afhandlingen tog visse hændelser for givet eller overså dem på grund af mit relativt grundige kendskab og mine forudindtagede holdninger til de givne praksisser. Dette vender jeg tilbage til i diskussionen af mine metoder.

Indsigterne fra min involvering i partnerskabet, både før og under ph.d.-forløbet, har påvirket min opmærksomhed og mine refleksioner omkring fænomenet mental sundhedsfremme. Indsigterne har således også bidraget til min undren omkring specifikke aspekter af mental sundhedsfremme og herigennem tilblivelsen af de forskningsspørgsmål, som jeg søgte svar på i min afhandling. Ved at overgå til en stilling som ph.d.-studerende ophørte mine opgaver med den formative procesevaluering og sekretariatsarbejdet formelt set. Men igennem min tilknytning til Statens Institut for Folkesundhed var jeg stadig involveret i planlægning af procesevalueringen og fortolkning evalueringsresultaterne.

Pilotafprøvning af aktionslæringsforløb

Under selve ph.d.-forløbet havde jeg en primær rolle som forsker, men jeg agerede også som projektudvikler og facilitator i forbindelse med aktionslæringsforløbet. Jeg deltog fortsat i netværksmøderne i partnerskabet. Derudover omhandlede min kontakt med partnere primært pilotafprøvningen og følgeforskningen af aktionslæringsforløbet. Samarbejdet om afprøvningen af aktionslæringsforløbet blev etableret på baggrund aktørernes medlemskab i ABC for mental sundhed. Alle involverede parter, som bidrog til udvikling og planlægningen af forløbet, kendte hinanden på forhånd og havde et fælles udgangspunkt i erfaringerne fra partnerskabet. Disse aspekter kan formodes at have haft en positiv indvirkning på samarbejdsprocesserne omkring aktionslæringsforløbet (Durlak & DuPre, 2008).

I forbindelse med afviklingen af aktionslæringsforløbet og den dertilhørende dataproduktion forsøgte jeg bevidst at balancere mine forskellige roller. Til workshoppene bevægede jeg mig mellem rollerne som forsker, facilitator og ”ABC-ekspert”. Til de første tre workshops var min primære rolle at

gennemføre observationer af handlinger og sociale interaktioner, som udspillede sig som del af aktionslæringsforløbet. Jeg forsøgte at tydeliggøre denne rolle og tage afstand fra facilitatorrollen – eksempelvis ved at placere mig mere på "deltagernes side" ved at sætte mig ved bordene sammen med deltagerne fremfor facilitatorerne. Desuden lagde jeg vægt på min rolle som forsker, da jeg præsenterede mig overofre deltagerne. Jeg pointerede, at det ikke var mit ærinde at vurdere deltagernes indsatser over for borgere/studerende og omfanget og effektiviteten af deres arbejde med at udvikle og implementere praksisser. Desuden forsøgte jeg bevidst at begrænse kommunikationen om planlægning af workshops og lignende fra min side. I stedet udgik kommunikationen fra den lokale tovholder fra værtskommunen. Formålet hermed var at fremme en tillidsfuld relation mellem deltagerne og mig.

Min tilstedeværelse ved workshoppene gav mulighed for en række uformelle samtaler relateret til aktionslæringsforløbet og arbejdet med mental sundhedsfremme i aktørernes egne organisationer. Det skete for eksempel i pauserne, hvor jeg bevidst opsøgte uformelle samtaler med deltagerne, hvilket gav relevante indsigter, som var centrale i mine observationer. Jeg forsøgte at fastholde og dokumentere mine indsigter og deraf følgende refleksioner gennem noteskrivning – hvilket jeg vender tilbage til senere.

Min dynamiske positionering og det faktum, at jeg til tider havde en dobbeltrolle, kom særligt til udtryk, da jeg under workshoppene også agerede som "ABC-ekspert" og facilitator. Rollen som ABC-ekspert kom til udtryk i de situationer, hvor deltagere spurgte om min vurdering af deres arbejde eller spurgte om råd om brugen af ABC-rammen og konkrete materialer udviklet i partnerskabet. I de situationer var jeg både med til at hjælpe deltagerne i deres udviklingsprocesser samtidigt med, at jeg producerede data som forsker. Rollen som facilitator var særligt fremtrædende ved forløbets sidste workshop. På grund af coronarestriktionerne var vi nødt til at begrænse det samlede antal personer til workshoppene, og jeg påtog mig derfor rollen som facilitator sammen med en sundhedskonsulent fra værtskommunen. Denne oplevelse gav mig bl.a. indsigt i, hvad rollen som facilitator kræver. Skiftet til facilitatorrollen kan dog ses som værende på bekostning af muligheden for at gennemføre observationer og skrive noter i løbet af workshoppen. For at fastholde mine erfaringer og indtryk skrev jeg efter workshoppen noter. Desuden drøftede jeg oplevelsen med med-facilitatoren fra værtskommunen.

Under gennemførelsen af interviewene ønskede jeg at indfange deltagernes personlige oplevelser af at deltage (såvel positive som negative) samt hensigtsmæssige og uhensigtsmæssige aspekter ved aktionslæringsforløbet. Min forudgående interaktion med deltagerne kan have været fremmende for at opbygge et tillidsfuldt rum i interviewsituationerne. Det var også mit indtryk, at de fleste deltagere var

åbne overfor eksempelvis at kritisere forløbet. Jeg kan selvfølgelig ikke udelukke, at mine forskellige roller som både facilitator og forsker fik deltagerne/informanterne til at holde igen med at kritisere eksempelvis min ageren i forløbet eller andre aspekter af forløbet.

Note- og logbogsskrivning

Under workshoppene forsøgte jeg løbende at skrive feltnoter på papir og på min telefon. Feltnoterne blev efterfølgende skrevet sammen og uddybet, typisk allerede samme eller næste dag. Formålet med mine feltnoter var at producere data, der kunne genbesøges og analyseres (Mason, 2018). I mine noter anvendte jeg to niveauer. Det første var et deskriptivt niveau, hvor jeg forsøgte at indfange situationer og handlinger i "neutrale" beskrivelser. Dette gjorde jeg med en bevidsthed om, at mine ord i min notesbog altid vil indebære et element af fortolkning fra min side. Noterne beskrev typisk processer for arbejdet med at udvikle initiativer til mental sundhedsfremme og udtalelser fra deltagerne. Det andet niveau var en beskrivelse af mine refleksioner over det observerede. Refleksionerne kan siges at have en mere fortolkende karakter, og den del af min noteskrivning var et hjælpemiddel til at formulere mine forståelser af de fænomener, jeg var vidne til, samt til at dokumentere mine analytiske fornemmelser og tentative hypoteser (Mason, 2018). Som et led i at fastholde erfaringer, erkendelser og refleksioner relateret til min afhandling har jeg desuden løbende ført logbog. Her beskrev jeg løbende mine refleksioner omkring studiedesign, anvendelse af metoder samt diskussioner med mine vejledere, kollegaer og øvrige aktører. Logbogen indgik ikke som empiriske data i mine studier, men fungerede som refleksionsredskab og hjælp til at skabe et systematisk overblik over arbejdet med afhandlingen.

Analytisk tilgang

I det følgende præsenterer jeg analytiske skridt og overvejelser – først for afhandlingen overordnet set og efterfølgende for hvert delstudie. Detaljerede beskrivelser af analyseprocesserne for de enkelte delstudier kan læses i afhandlingens artikler.

Som allerede beskrevet i det foregående afsnit omkring dataproduktion, har jeg løbende læst og forholdt mig analytisk til data. Herigennem har jeg løbende lært datamaterialet at kende og identificeret temaer og problemstillinger relateret til mine forskningsspørgsmål. Ifølge Jennifer Mason er dette indledende arbejde et vigtig skridt i den analytiske proces for bedre at kunne organisere data meningsfuldt, "have them at your fingertips", og navigere i data med henblik på uddrage mening og lave fortolkninger (Mason, 2018). I tråd med de kollaborative analyseprocesser beskrevet af Cornish, Gillespie og Zittoun (2014) blev udvalgte temaer og problemstillinger diskuteret med mine kollegaer, dvs. forskere fra SIF

og fagprofessionelle involveret i ABC for mental sundhed. De analytiske processer blev uden tvivl påvirket af min egen og mine medforfatteres involvering i partnerskabet ABC for mental sundhed og aktionslæringsforløbet, men vi havde fokus på at være åbne over for empirien. Eksempelvis blev identificerede temaer og præliminære fund underlagt grundige og kritiske diskussioner i forskningsgruppen bag ABC for mental sundhed og bland medforfattere og mine vejledere.

Delstudie 1 – template-analyse og deskriptive statistiske analyser

Analysetilgangen for delstudie 1 tog afsæt i to delformål. For det første afdækkede vi gennem en datadreven tematisk analyse (Braun & Clarke, 2006), hvilke strategier for mental sundhedsfremme, at partnerorganisationerne i ABC for mental sundhed forfulgte. For det andet undersøgte vi lokale ABC-koordinatorers og stakeholders perspektiver på implementeringsprocesser og virkning af lokale initiativer til mental sundhedsfremme. Analysen fulgte de seks faser for *Template Analysis* beskrevet af J. Brooks et al. (2015). Jeg har anvendt Consolidated Framework for Intervention Research (CFIR) (Damschroder et al., 2009) som et konceptuelt framework i analysen. De fem temaer fra CFIR (Damschroder et al., 2009) blev anvendt som *a priori*-temaer, som var styrende for den indledende kodning af data. Desuden gennemførte jeg deskriptive statistiske analyser af de kvantitative data fra evalueringsskemaerne. Det samlede datamateriale fra evalueringsskemaerne (både det kvalitative og kvantitative) gav indblik i implementeringsprocesserne på tværs af størstedelen af partnerne. Interviewdata gjorde det muligt at undersøge nærmere og opnå en nuanceret forståelse for temaer og problemstillinger, som vi fandt i analysen af data fra evalueringsskemaerne.

Foreløbige resultater blev præsenteret på netværksmøder i partnerskabet ABC for mental sundhed. Formålet var primært at forfølge procesevalueringens formative sigte om at anvende resultaterne til at kunne videreudvikle og justere på arbejdet i partnerskabet (Chen, 1996). Lidt forsimplet skriver jeg i artikel 1, at denne proces var en respondentvalidering (Justensen & Mik-Meyer, 2010). Antagelsen om at kunne styrke validiteten af forskningsresultater kan dog kritiseres for ikke at tage højde for kompleksiteten af de fænomener, som undersøges, og hvilke kompetencer det kræver at gennemføre rationelle bedømmelser af forskningsmæssige slutninger. I den sammenhæng vil jeg igen henvise til Masons pointe om, at analytiske processer inden for et kritisk realistisk paradigme stiller krav om at kunne forstå lægmandsfortolkninger såvel som at levere videnskabelige fortolkninger (Mason, 2018, p. 226). Præsentationen af de præliminære fund gav dog mulighed for at få partnernes tilbagemeldinger på vores slutninger, som vi tog med os, og som vi har integreret i de endelige analyser.

Delstudie 2 – CMO-konfigurationer, tematisk analyse og retroduktion

Analysen i delstudie 2 var inspireret af analysetilgangene beskrevet af Gilmore, McAuliffe, Power og Vallières (2019) og Herens, Wagemakers, Vaandrager, van Ophem og Koelen (2017). Den tog udgangspunkt i en retroduktiv tilgang til at afdække CMO-konfigurationer for aktionslæringsforløbet. Retroduktion er en analyse af generative mekanismer og opbygning af teoretiske argumenter for, hvorfor hændelser manifester sig i den empiriske og observerbare verden (Justin Jagosh, 2020). Retroduktion er tæt knyttet til effektanalyser inden for det kritisk realistiske paradigme. For at kunne drage slutninger om effekter kræver det, at resultaterne præsenterer en sandsynliggørelse af, at det observerede outcome er genereret i et samspil mellem kontekstuelle faktorer og mekanismer (Ravn, 2020). For at bevare sammenhængen mellem kontekstuelle rammer og aktionslæringsgruppernes udviklings- og implementeringsprocesser blev analysen gennemført som en analyse af tre indlejrede (*embedded*) cases (Yin, 2014). Ifølge Ravn (2020) er udviklingen af programteorier og CMO-konfigurationer ofte en kombination af induktive og deduktive undersøgelser. I tråd hermed trak jeg på litteraturen om aktionslæring (bl.a.: Folker & Lauridsen, 2017; Pedler & Burgoyne, 2015; Zuber-Skerritt, 2002) og kapacitetsopbygning (Bl.a.: McLean et al., 2004; van Herwerden et al., 2018) i analysearbejdet i delstudie 2. Selve analysen foregik i 4 faser.

I første fase læste jeg indledningsvist data med henblik på at forstå de overordnede processer i hver case og udarbejdede en narrativ case-beskrivelse for hver af de tre cases. Case-beskrivelserne brugte jeg som analytisk redskab – de blev altså ikke udarbejdet med henblik på at skulle indgå som del af resultaterne. I anden fase lavede jeg først en tematisk kodning af alle interviewdata og case-beskrivelserne, hvor jeg anvendte de tre nøglebegreber inden for realistisk evaluering – kontekst, mekanismer og outcomes – som koder. Efterfølgende tematiserede jeg yderligere de kodede data og udviklede som et led i processen subtemaer under hver af de tre koncepter. I tredje fase startede jeg med at analysere outcome-mønstre for hver case for herefter at afdække, hvordan de forskellige outcomes var blevet genereret. Denne proces var i høj grad datadreven. Men min forhåndsviden og den viden, som jeg løbende havde tilegnet mig om aktionslærings- og kapacitetsopbygningsprocesser, blev brugt som et ”bagkatalog” af viden, som jeg kunne sammenholde med processerne i min empiri og lade mig inspirere af i beskrivelsen af CMO-konfigurationerne (Justin Jagosh, 2020). Eksempelvis var det oplagt for mig at have en særlig opmærksomhed på learning-by-doing-processer – læring gennem aktioner – i læsningen af min empiri, fordi det er en de mest centrale mekanismer i aktionslæring (Pedler & Burgoyne, 2015; Zuber-Skerritt, 2002). Jeg var opmærksom på at lade min konstruktion af CMO-konfigurationer være åben overfor processerne og dynamikkerne mellem CMO-elementer, som jeg læste i data. Det gjorde

jeg ved at forholde mig refleksivt til min læsning af data og de producerede CMO-konfigurationer (Justin Jagosh, 2020; Mason, 2018) og herigennem efterprøve mine foreløbige slutninger på empirien.

Fremgangsmåden i sidste fase af analysen var særligt inspireret af Gilmore et al. (2019) og indebar en sammenligning af foreløbige CMO-konfigurationer på tværs af de tre indlejrede cases. Formålet hermed var at yderligere udvikle og nuancere/forfine CMO-konfigurationerne ved at se på variationer i kontekstuelle faktorer, mekanismer og outcomes på tværs af cases. Med andre ord muliggjorde valget om at organisere min analyse omkring tre cases en intra-programsammenligning (Ravn, 2020) og herved undersøge variationer i outcome-mønstre og mekanismer blandt forskellige deltagergrupper, som alle deltog i samme aktionslæringsforløb. I løbet af de fire faser blev artiklens medforfattere løbende inddraget i diskussioner af analyseresultaterne.

Delstudie 3 – template-analyse

Under analysearbejdet i delstudie 1 og særligt delstudie 2 blev jeg opmærksom på problemstillinger og temaer relateret til rolle- og ansvarsfordelingen inden for tværsektorielt arbejde med mental sundhedsfremme. Dette tilbagevendende tema vakte min interesse for, hvordan funktioner og roller italesættes og operationaliseres, både i praksis og i forskningslitteraturen om mental sundhedsfremme. Min nysgerrighed heromkring indledte mine analytiske refleksioner for delstudie 3, som var af en iterativ proces, hvor jeg bevægede mig mellem data og relevant litteratur relateret til mental sundhedsfremme og tværsektorielt arbejde. Denne proces havde ligheder med en abduktiv analysetilgang (Mason, 2018; Timmermans & Tavory, 2012). En abduktiv analysetilgang er karakteriseret ved, at forskeren forbliver åben overfor overraskende elementer eller aspekter ved det empiriske objekt. Desuden tillader den at forskeren bevæger sig mellem på den ene side det empiriske materiale og på den anden side teori og litteratur. I min analytiske proces var jeg særligt optaget af rolle- og ansvarsfordelingen inden for tværsektorielt arbejde med mental sundhedsfremme. Jeg trak bl.a. på konceptualiseringer af forskellige former for sundhedsfremmende arbejde (Davies, 2013) samt rammer, som forsøger at systematisere og organisere indlejrede funktioner i praksisser inden for mental sundhedsfremme (Barry, 2007; Barry, 2019b; Stansfield, 2015a).

Analysen for delstudie 3 var inspireret af Template Analysis-tilgangen, der muliggjorde inddragelse af forudbestemte temaer/kategorier (Joanna Brooks & King, 2014; King, 2012). Analysearbejdet var informeret af rolle- og funktionsbeskrivelser fra Public Health Englands ramme for kapacitetsopbygning inden for Public Mental Health (Stansfield, 2015a, 2015c). Jeg inddrog desuden erfaringer og resultater fra tidligere evalueringer af arbejdet i partnerskabet ABC for mental sundhed, særligt omkring

varetagelsen af forskellige arbejdsopgaver relateret til implementeringen og udførelsen af mental sundhedsfremme praksisser. Datagrundlaget for delstudie 3 var produceret med henblik på at besvare et andet formål end i det pågældende studie. Derfor kan analysen karakteriseres som en sekundær analyse af data (Heaton, 2008).

Etiske overvejelser

I det foregående har jeg allerede kort berørt forskningsetiske overvejsler, som jeg har gjort mig i forbindelse med udarbejdelsen af afhandlingen. Jeg har bl.a. beskrevet mine refleksioner omkring mine rolle som forsker og min relation til informanter og andre involverede aktører. I det følgende vil jeg uddybe mine forskningsetiske overvejelser og reflektere over principper omhandlende informeret samtykke, frivillighed og fortrolighed (Brinkmann, 2010; Mason, 2018).

Informeret samtykke var et grundlæggende princip i forbindelse med min dataproduktion og indebærer, at deltagere ved, hvad de deltager i (Brinkmann, 2010). Det var min hensigt at gøre mine formål med dataindsamlingen eksplicit og tydelige overfor deltagerne. Deltagerne fik oplysninger herom mundtlig til interviewene og til første workshop i aktionslæringsforløbet. Ved workshoppen informerede jeg deltagerne om, mine forskellige roller i projektet, og herunder, at mine observationer ville indgå i min afhandling. Til workshoppene lå skriftlige deltageroplysninger (appendiks E) synligt fremme på et bord i lokalet. Desuden blev deltageroplysningerne formidlet til deltagerne via mail. Forud for interviewene oplyste jeg informanter om formålet med interviewet, at det er frivilligt at deltage, og at data kun bliver brugt til forskning (fremgår af introduktion i interviewguides, appendiks A og C). Alle interviewdeltagere blev i den sammenhæng præsenteret for deltageroplysninger, som var printet.

Frivillighed var et væsentligt aspekt af mine forskningsetiske overvejelser. I interviewsituationerne og til workshops (i forbindelse med afviklingen af aktionslæringsforløbet) italesatte jeg overfor informanterne og deltagerne, at deres bidrag til dataproduktioner var frivillig. Ved dataindsamlingen i forbindelse med procesevalueringen af partnerskabet ABC for mental sundhed havde deltagerne muligheden for at trække deres samtykke tilbage før publiceringen af resultater.

Fortrolighed var også et nøgleord i min forskningspraksis. Alle resultater og data blev afidentificeret. Deltagerne blev ikke lovet fuld anonymitet, da det kan være vanskeligt at opnå i datasæt med relativt få informanter og detaljerede beskrivelser af praksis. En anden væsentlig faktor, som udfordrede en fuld anonymisering, er at ABC for mental sundhed og aktionslæringsforløbet er enestående i Danmark.

Afidentificeringen indebar, at jeg slettede navne på individer, organisationer og byer i empirien og resultaterne. Jeg har oplyst deltagende organisationer og informanter herom både mundtligt i interviewsituationer og på skrift. Som beskrevet tidligere, var det vigtigt for mig tydeligt at informere om, at mine data ikke ville blive delt med andre og eksempelvis ikke ville være tilgængelig for informanternes kollegaer eller ledere. Denne information blev formidlet sammen med de øvrige informationer, som beskrevet foroven.

Afhandlingens er delstudier har fået en forskningsetisk godkendelse af Research Ethics Committee, Syddansk Universitet (nr. 10.621,01-12-2015 og 15-08-2019; nr. 10-600, 02–08–2019).

Resultater

I dette kapitel opsummerer og præsenterer jeg udvalgte resultater fra afhandlingens tre delstudier. Delstudiernes samlede resultater kan læses i afhandlingens tre artikler (Hinrichsen et al., 2020; Hinrichsen et al., 2022).

Delstudie 1. Implementeringsstrategier, implementeringsprocesser og virkning

Delstudie 1 (Hinrichsen et al., 2020) viser, at partnerorganisationerne overordnet set forfulgte tre strategier i deres arbejde relateret til ABC for mental sundhed:

I. Opbygning af mental sundhedsfremmekapacitet (f.eks. ved at undervise frontpersonale og at styrke tværgående samarbejde omkring mental sundhedsfremmende aktiviteter)
II. Kampagneaktiviteter målrettet slutbrugeres opmærksomhed og viden om mental sundhed og mental sundhedsfremme (f.eks. gennem onlineannoncer og kampagneevents)
III. Etablering/promovering af muligheder for at engagere sig i mentalt sundhedsfremmende aktiviteter (f.eks. folkekøkkener og gå-grupper drevet af frivillige)

Det skal bemærkes, at der kan være overlap mellem de tre strategier, eksempelvis fordi tiltag under de forskellige strategier bygger ovenpå hinanden eller initiativer indeholder elementer fra mere end én strategi. Opdelingen skal ses som en hjælp til at illustrere og skabe overblik over initiativerne, som partnerorganisationerne i ABC for mental sundhed udvikler og implementerer. Resultaterne peger desuden på, at de lokale projektkoordinatorer og stakeholdere generelt er positivt stemte over for de grundlæggende idéer bag tilgang og målsætninger for ABC for mental sundhed (f.eks. den salutogene tilgang og målsætningen om at fremme mental sundhed). De relativt brede rammer for at udvikle og implementere lokale initiativer var der blandede holdninger til. Nogle informanter oplevede det som en styrke, da det gav dem mulighed for at tage højde for lokale ressourcer og udfordringer. Andre informanter oplevede de brede rammer som uoverskuelige og gav udtryk for manglende vejledning.

Delstudiet giver desuden indsigt i en række centrale implementeringsprocesser, herunder bl.a. udfordringer og løsninger relateret til at engagere andre aktører i implementeringen, såsom kollegaer og andre samarbejdspartnere. De lokale projektkoordinatorer oplevede relativt ofte at blive mødt med en afvisning fra praktikere begrundet med: ”*det gør vi allerede i forvejen*”. For at imødekomme udfordringerne med at engagere samarbejdspartnere peger resultaterne på, at arbejdet med mental

sundhedsfremme og ABC for mental sundhed kan italesættes som et middel til at løse samarbejdspartnernes kerneopgaver. Desuden peger resultaterne på, at brugen af participatoriske metoder anses som meningsfulde til udbredelsen af ABC-rammen hos samarbejdspartnere. I tråd hermed giver lokale projektkoordinatorer og stakeholdere udtryk for, at arbejdet med mental sundhedsfremme kan bygge bro mellem forvaltninger, discipliner og professioner. Denne brobyggende funktion underbygges af resultaterne fra de kvantitative spørgsmål, hvor 70% af respondenterne enten er helt eller delvist enige i, at de gennem ABC-rammen har fået et fælles sprog for mental sundhed, der gør det lettere at samarbejde om mental sundhedsfremme med eksterne organisationer eller aktører. Generelt viser resultaterne fra de deskriptive kvantitative analyser, at langt størstedelen af respondenterne oplever, at arbejdet med ABC for mental sundhed har haft en positiv virkning på et individuelt niveau, dvs. for respondenten selv og vedkomnes opgavevaretagelse. Et lignende billede tegner sig for respondenternes vurdering af virkningen på organisationsniveau, hvor størstedelen af respondenterne rapporterer en positiv virkning.

Resultaterne fra procesevalueringen var udslagsgivende for valget om at udvikle og afprøve et aktionslæringsforløb, der sigtede mod at støtte op om lokal kapacitetsopbygning. For det første pegede resultaterne fra delstudie 1 på behovet for at kapacitetsopbygge og at styrke aktiviteter, der kan støtte op herom. For det andet pegede resultaterne på, at participatoriske metoder og bottom-up-tilgange er særligt effektive til at understøtte implementeringsprocesser inden for mental sundhedsfremme.

Delstudie 2. CMO-konfigurationer for kapacitetsopbygning gennem aktionslæring

Delstudie 2 (Hinrichsen et al., 2022) præsenterer en dybdegående analyse af CMO-konfigurationer, som forklarer aktionslæringsforløbets kapacitetsopbyggende virkning. Resultaterne peger på, at aktionslæringsforløbet førte til kapacitetsopbygning i form af a) udvikling/implementering af initiativer og praksisser inden for mental sundhedsfremme, b) øget opmærksomhed på mental sundhedsfremme samt udvikling af viden, færdigheder og kompetencer blandt deltagerne og c) styrkede relationer og samarbejde på tværs af organisationer/afdelinger. Resultaterne beskriver nuanceret samspillet mellem kontekstfaktorer og mekanismer, som forklarer tilblivelsen af de identificerede outcomes. Centrale mekanismer er bl.a. learning-by-doing, individuelle refleksionsprocesser, face-to-face møder, at opleve udbytterige samarbejder, samarbejde på tværs af organisationer/afdeling og at opleve indholdet af aktionslæringsforløbet som relevant. Centrale kontekstfaktorer er bl.a. deltagernes motivation, forhåndsviden og kompetencer, organisatorisk støtte og eksisterende opgavebeskrivelser. Samlet set

bidrager resultaterne med nuanceret viden om samspillet mellem kontekstuelle faktorer og mekanismerne fra aktionslæring i opbygningen af kapacitet, der kan understøtte praksisser inden for mental sundhedsfremme.

Et fremtrædende tema i resultaterne er samspillet mellem forskellige aktører på tværs af organisationer, professioner og sektorer – eksempelvis facilitatorer, der bidrager med ekspertviden til og understøtter deltagernes arbejde med at udvikle initiativer inden for mental sundhedsfremme, og samarbejdet på tværs af faggrupper og på tværs af ansatte og studerende fra samme organisation. Desuden er resultaterne og erfaringerne fra delstudie 1 og 2 sammenfaldende ved at pege i retning af, at flere praktikere og beslutningstagere oplevede en uklar rolle- og ansvarsfordeling inden for mental sundhedsfremme. Disse erkendelser, kombineret med, at litteraturen peger på behovet for at udvikle et fælles sprog inden for mental sundhedsfremme, prægede bestemmelsen af formålet for delstudie 3.

Delstudie 3. Taksonomi for roller i mental sundhedsfremme og interaktioner på tværs af roller

Delstudie 3 (artikel 3) præsenterer udviklingen af en taksonomi for centrale roller relateret til implementeringen af mental sundhedsfremme (MSF) i en tværsektoriel kontekst. Taksonomien beskriver fem roller og deres nøglefunktioner, som er opsummeret nedenfor:

I. **Leder**: Policy og strategisk arbejde relateret til MSF, beslutningstagning, som påvirker MSF-praksis. Advokere for og understøtte MSF-praksisser.

II. **MSF-specialist**: Understøtte udvikling/implementering af MSF-initiativer og praksisser ved at bidrage med teknisk/specialiseret viden og kompetencer.

III. **Lokal MSF-koordinator**: Styrke og lede lokale (typisk interne organisatoriske) MSF-praksisser og implementeringsprocesser.

IV. **MSF-praktiker**: Indlejre grundlæggende værdier og principper for MSF i arbejdsgange og rutiner. Bidrage til lokale implementeringsprocesser.

V. **Slutbruger**: Modtager eller målgruppe for MSF-praksisser og -initiativer. Kan bidrage til lokale implementeringsprocesser og udbrede kendskab til grundlæggende værdier og principper for mental sundhedsfremme.

Distinktionen mellem MSF-specialist, lokal MSF-koordinator og MSF-praktiker muliggør en nuanceret forståelse af centrale funktioner i udviklingen og implementeringen af initiativer indenfor mental sundhedsfremme samt daglige praksisser, som kan karakteriseres som mentalt sundhedsfremmende. Distinktionen kommer også til udtryk i casestudiet, hvor rollernes interaktioner undersøges. Denne del

af studiets resultater illustrerer og giver et indblik i interaktioner og samspil på tværs af rollerne. Her identificeres tre overordnede områder for interaktioner og samarbejde: 1) Ledere og MSF-specialister interagerer om policy og strategisk arbejde, 2) MSF-specialister og MSF-koordinatorer interagerer vedrørende udvikling, planlægning, implementering og evaluering af lokale MSF-initiativer, og 3) MSF-koordinatorer, MSF-praktikere og slutbrugere interagerer vedrørende daglige praksisser inden for mental sundhedsfremme i lokale arenaer. Resultaterne illustrer rollernes gensidige afhængighed ved at belyse sammenhængen mellem handlinger, som finder sted på tværs af interventionsniveauer og sektorer. Handlingerne spænder fra eksempelvis vidensdelingsaktiviteter i partnerskabet ABC for mental sundhed til mental sundhedsfremmende praksisser, som er indlejret i den individuelle lektors undervisningsaktiviteter på en lokal uddannelsesinstitution.

Diskussion

I det følgende kapitel vil jeg udfolde, diskutere og reflektere over tværgående temaer, som repræsenterer centrale aspekter af afhandlingens samlede vidensbidrag. Dernæst diskuterer og reflekterer jeg over styrker og svagheder ved afhandlingens overordnede design og metodiske valg. Afslutningsvis præsenteres refleksioner over afhandlingens implikationer for forskning og praksis.

Tværgående temaer

I det følgende præsenterer og diskuterer jeg tre tværgående temaer omhandlende implementering og kapacitetsopbygning inden for mental sundhedsfremme. Første tværgående tema vedrører de relativt brede og forskelligartede operationaliseringer af praksisser og initiativer – herunder, hvordan denne bredde relaterer sig til en række udfordringer. De næste to tværgående temaer omhandler begge kapacitetsopbygning, da jeg ser afhandlingens vidensbidrag om dette som særlig væsentlig. Andet tværgående tema kredser om forholdet mellem kapacitetsopbygning og implementeringsprocesser – herunder, hvorfor kapacitetsopbygning kan ses som et væsentligt element i at styrke praksisser inden for mental sundhedsfremme. Det tredje tværgående tema berører den målrettede brug af kapacitetsopbyggende mekanismer og aktiviteter i indsatser og implementeringsprocesser.

Den brede operationalisering af mental sundhedsfremme

Resultaterne på tværs af afhandlingens delstudier viser tydeligt, at mental sundhedsfremme favner en bred vifte af indsatser og strategier. Disse praksisser tager overordnet set afsæt i et eller flere af følgende formål: at skabe (fornyet) opmærksomhed (*awareness*) om mental sundhedsfremme blandt forskellige typer af aktører (f.eks. frontpersonale, ledere og slutbrugere), at justere eller videreudvikle eksisterende praksis (f.eks. arbejdsgange, rutiner og organisatoriske systemer) og at implementere nye initiativer eller praksisser.

I delstudie 1 kommer denne brede operationalisering til udtryk i afdækningen af strategier, som partnerne i ABC for mental sundhed forfølger i deres arbejde med at omsætte ABC-rammen til praksis. Delstudie 2 viser ligeledes en vis bredde i initiativer, som udvikles i aktionslæringsforløbet. Tredje delstudie gør det tydeligt, at operationaliseringen af mental sundhedsfremme kan foregå på mange forskellige niveauer (f.eks. i politisk arbejde, strategisk arbejde på organisationsniveau og mødet mellem

borgere og frontpersonale). Resultaterne er i tråd med de indsatsområder, som litteraturen om mental sundhedsfremme peger på som relevante (Barry, 2019b; IUHPE, 2021; Stansfield, 2016; van Agteren et al., 2021). Jf. state of the art-kapitlet indebærer indsatsområderne initiativer og praksisser, som: skaber mentalt sundhedsfremmende rammer og strukturer i samfundets forskellige arenaer; udvider samfundsaktørers fokus til også at indebære positive aspekter af mental sundhed; styrker lokalsamfund til at kunne støtte op om arbejdet med mental sundhedsfremme; og styrker individers sundhedskompetencer (Barry, 2019b, pp. 21-22).

Afhandlingens resultater peger på, at den brede operationalisering er forbundet med udfordringer relateret til udviklings- og implementeringsprocesser, for eksempel blandt praksisaktører. Resultater fra både delstudie 1 og 2 peger nemlig på, at praksisaktører oplever et behov for skabe afklaring om konceptualiseringen og operationaliseringen af mental sundhedsfremme. At dette behov står tydeligt frem i resultaterne, skyldes antageligt den relativt brede konceptualisering og operationalisering af tilgangen til mental sundhedsfremme. Sammenkædningen mellem den brede operationalisering og implementeringsudfordringer kan underbygges med fund fra implementeringsstudier inden for mental sundhedsfremme. Eksempelvis finder Annor og Allen (2009), at implementeringsaktører på forskellige niveauer (policy, planlægning og praksis) oplever, at begreber relateret til mental sundhedsfremme ofte opfattes som uklare og vage. Forfatterne argumenterer for, at det er med til at skabe et (for) bredt og forvirret billede af, hvordan mental sundhedsfremme kan konceptualiseres i praksis, hvilket kan udfordre implementeringsprocesser (Annor & Allen, 2009). Ligeledes viser undersøgelser inden for skoleområdet, at personalet oplever mental sundhed som et uvant og fremmed begreb, der er svært at operationalisere (Cefai & Askell-Williams, 2017; Ekornes et al., 2012). Manglende konsensus om teoretiske definitioner af begreber relateret til mental sundhedsfremme (f.eks. mental velbefindende/well-being) (van Agteren et al., 2021) og konceptuelle overlap mellem sundhedsfremmende og forebyggende tilgange til mental sundhed (Barry, 2019b; Enns et al., 2016; Tamminen et al., 2016) kan yderligere bidrage til forvirring og udfordringer i forbindelse med udvikling og implementering af initiativer inden for mental sundhedsfremme.[4] Omvendt kan den brede ramme, som mental sundhedsfremme tilbyder, også være fremmende for implementeringsprocesser. Som jeg viser i delstudie 1, giver det implementeringsaktører relativt megen frihed og plads til at udfylde rammen med udgangspunkt i de lokale forhold. Dette kræver dog tilstedeværelsen af den rette kapacitet til at udføre denne oversættelse.

[4] Ifølge Kalra et al. (2012) kan sundhedsfremmende og forebyggende tilgange skelnes fra hinanden ud fra, hvorvidt formålsbeskrivelser og strategier fokuserer på fremme af positive aspekter af mental sundhed eller forebyggelse af mentale problemer og lidelser.

I forlængelse af ovenstående tematik er det relevant at fremhæve, at afhandlingens resultater også peger på mulige måder at afhjælpe problematikkerne der kan skyldes den brede operationalisering. Resultaterne peger på, at brugen af en praksisnær, handlingsorienteret konceptualisering og formidling af mental sundhedsfremme kan skabe afklaring om, hvad mental sundhedsfremme er og hvordan specifikke faggrupper kan bidrage til og selv at praktisere mental sundhedsfremme. ABC-koordinatorer og andre involverede aktører oplevede eksempelvis, at brug af ABC-rammen gør kommunikation i forbindelse med mental sundhedsfremme enklere og mere praksisnær. Lignende fund gør sig gældende i delstudie 2, som viser, at deltagerne i aktionslæringsforløbet anvender ABC-rammen som en praksisnær forståelses- og arbejdsramme for mental sundhedsfremme. Deltagerne implementerer for eksempel ABC-rammen i deres undervisningsaktiviteter og workshops omhandlende mental sundhed og trivsel for at konkretisere et ellers abstrakt og vidtfavnende koncept. Lignende resultater er tidligere fundet i evalueringsstudier af implementeringen af det australske projekt Act Belong Commit – som er det projekt, som ABC for mental sundhed er baseret på (Anwar-McHenry et al., 2016). Evalueringen viser, at implementeringsaktører værdsætter en simpel og letforståelig arbejdsramme, der guider konceptualiseringen og operationaliseringen af mental sundhedsfremme. Desuden viser deres resultater, at en positiv og proaktiv begrebsramme for mental sundhedsfremme gør det lettere og mere tryg for lærere at tale med elever om mental sundhed (Anwar-McHenry et al., 2016, p. 573) – og således inkorporere mental sundhedsfremme i deres eksisterende praksis. Mine resultater finder desuden genklang i evalueringer af det engelske projekt *5 ways to wellbeing* (K. Smith, 2015). Projektet er også baseret på en grundlæggende idé om at understøtte praksisser inden for mental sundhedsfremme ved at benytte en praksisnær, handlingsorienteret konceptualisering af mental sundhed.

Når det gælder evaluering og forskning, kan den brede operationalisering af mental sundhedsfremme også skabe udfordringer med at afgrænse mental sundhedsfremme som fænomen og genstandsfelt. Eksempelvis kan der opstå udfordringer med at gennemføre relevante litteratursøgninger og sammenligninger af forskellige initiativer (van Agteren et al., 2021). Udfordringerne med at afgrænse mental sundhedsfremme som genstandsfeltet gjorde sig også gældende i mine delstudier. Udfordringerne bundede bl.a. i, at mental sundhedsfremme ikke nødvendigvis blev operationaliseret som særskilte indsatser eller arbejdsopgaver. Delstudierne viser, at initiativer og praksisser vedrørende mental sundhedsfremme ofte var indlejrede elementer i øvrig praksis, som ikke nødvendigvis var sundhedsrelateret. Dette er særligt tydeligt i delstudie 3 i beskrivelsen af funktionerne for MSF-praktikeren. Funktionerne er i høj grad er centreret omkring indlejringen af værdierne og principperne

for mental sundhedsfremme i eksisterende praksisser – såsom undervisningsaktiviteter og socialt arbejde.

De empiriske eksempler fra mine delstudier viser, at mental sundhedsfremme i nogle tilfælde i højere grad blev brugt eller italesat som en strategi til at løse øvrige problemstillinger – som ikke er relateret til mental sundhed – snarere end som en sundhedsindsats i sig selv. Dette gjorde sig eksempelvis gældende i undervisningssektoren, hvor mental sundhedsfremme blev set som en strategi for at mindske frafald eller øge læringsudbyttet blandt studerende. Denne tilgang har sine fordele, som delstudie 1 også peger på. Ved at mental sundhed italesættes som et sekundært mål eller et middel til at nå et andet mål kan strategien dog risikerer at underminere princippet om, at mental sundhed har en værdi i sig selv (Lehtinen, Ozamiz, Underwood & Weiss, 2005). Delstudie 1 viser desuden, at ABC-koordinatorer bevidst fravalgte terminologi relateret til mental sundhed og mental sundhedsfremme for at målrette deres kommunikation og gøre den appellerende over for udførende og implementerende aktører. Denne strategi kan gøres til genstand for samme kritik som ovenfor. Desuden kan strategien kritiseres for ikke at klæde aktører på til bevidst at styrke deres fokus på mental sundhedsfremme. Således bidrager denne strategi altså ikke til at styrke relevante aktørers muligheder for bevidst at kunne støtte op om arbejdet med mental sundhedsfremme – hvilket Barry (2019d) fremhæver som et centralt ben i at styrke mental sundhedsfremmende praksisser i samfundet.

Kapacitetsopbygning som implementeringsstrategi

Afhandlingens delstudier peger på, at kapacitetsopbygning er et centralt element i udviklingen og implementeringen af praksisser indenfor mental sundhedsfremme. For det første afdækkes kapacitetsopbygning som en central strategi blandt partnerorganisationerne i ABC for mental sundhed i delstudie 1. Her er kapacitetsopbygningen i mange tilfælde et led i en implementeringsproces, der i sidste ende sigter mod at iværksætte kampagneaktiviteter eller andre mentalt sundhedsfremmende aktiviteter. For det andet peger resultaterne fra delstudie 3 også på kapacitetsopbygning som et centralt element i arbejdet med mental sundhedsfremme. Her viser resultaterne, hvordan både MSF-specialister og MSF-koordinatorer bidrager til og faciliterer implementeringsprocesser ved at styrke viden og kompetencer relateret til mental sundhedsfremme blandt andre involverede aktører. Det skete eksempelvis gennem vidensdelingsaktiviteter og workshops for medarbejdere. At kapacitetsopbygning er et centralt aspekt af at udvikle og implementere mental sundhedsfremme praksisser fremgår også af litteraturen inden for feltet (Barry, 2019d; IUHPE, 2021; Stansfield, 2015a; WHO, 2021). Eksempelvis fremhæver Barry (2019d) behovet for kapacitetsopbygning og at styrke fokus på mental sundhedsfremme i lokalsamfund og sundhedssektoren. Public Health England har udviklet en ramme,

der kan guide kapacitetsopbygningen inden for *public mental health*, som også rummer mental sundhedsfremme (Stansfield, 2015a). Som beskrevet tidligere er det op til partnerne selv at operationalisere ABC-rammen til lokale initiativer og praksisser. Disse oversættelses- og udviklingsprocesser kræver en vis form for viden om og kompetencer relateret til mental sundhedsfremme (Wandersman et al., 2008). I den optik er kapacitetsopbygning en relevant og oplagt forudgående aktivitet (Durlak & DuPre, 2008). Den bottom-up-inspirerede tilgang til mental sundhedsfremme, som er central i ABC for mental sundhed, kan være en mulig forklaring på det relativt omfangsrige fokus på kapacitetsopbygning i mit empiriske materiale.

Resultaterne fra delstudie 3 peger på, at implementeringsprocesser kan understøttes ved at sikre den rette kapacitet til at varetage rollen som MSF-specialist. Det betyder, at tilstedeværelsen af aktører med teknisk/specialiseret viden og kompetencer, som er relevante i den givne implementeringssituation, bør sikres. I tråd hermed peger Holt (2016) på, at sundhedssektoren bør bringe sin ekspertise i spil for at understøtte implementeringen af sundhedsfremmende arbejde i øvrige sektorer. Med andre ord bør sundhedssektoren understøtte implementeringsprocesserne ved at bidrage med den nødvendige kapacitet i form af eksempelvis viden og kompetencer. Argumentet om, at stakeholdere bør sikre den rette kapacitet for at rollen som MSF-specialist kan varetages, finder også opbakning i en række implementeringsstudier, som har undersøgt mental sundhedsfremme i skolesektoren (Clarke, 2019; Ekornes, 2015; Mælan, Tjomsland, Baklien, Samdal & Thurston, 2018). Eksempelvis viser Mælan et al. (2018), at lærere efterspørger understøttelse fra eksterne aktører til at opbygge kompetencer relateret til mental sundhed. Det samme argument kan opbygges for rollen som MSF-koordinator. Resultaterne fra delstudie 3 peger på, at implementeringsprocesser styrkes ved at sikre både ressourcer og kompetencer, så rollen som MSF-koordinator kan varetages. Dette underbygges af implementeringslitteraturen, som beskæftiger sig med mental sundhedsfremme (Barry, 2019a). Eksempelvis finder Anwar-McHenry et al. (2016), at tilstedeværelsen af en proaktiv og engageret fortaler for et givent projekt – som dermed kan ses som MSF-koordinatorer – øger sandsynligheden for en succesfuld implementeringsproces. Ovenstående argumenter om, at der bør sikres kapacitet, som er knyttet til rollerne MSF-specialist og MSF-koordinator, finder desuden opbakning i den mere generelle implementeringslitteratur (Damschroder et al., 2009; Durlak & DuPre, 2008; Wandersman et al., 2008).

Overordnet set giver afhandlingen indsigt i det tætte samspil mellem på den ene side implementering af praksisser inden for mental sundhedsfremme og på den anden side kapacitetsopbygning. Eksempelvis viser delstudie 1, at arbejdet med ABC for mental sundhed giver partnerorganisationerne en anledning til at styrke samarbejdet på tværs af afdelinger og projekter, dvs. at opbygge kapacitet. Desuden viser

resultaterne fra delstudie 3, hvordan vidensdeling og -opbygning i partnerskabet ABC for mental sundhed udgør en ressource, som via MSF-specialister bringes i spil i praksisser blandt partnerorganisationerne og deres lokale samarbejdspartnere. Dermed giver resultaterne indsigt i, hvordan der sker en kapacitetsopbygning på tværs af organisationer og sektorer, og hvordan disse processer spiller sammen med udvikling og implementering af lokale praksisser inden for mental sundhedsfremme. I et større perspektiv giver resultaterne anledning til at spørge, hvilken rolle og værdi kapacitetsopbygning tillægges i en indsats. Er kapacitetsopbygning eksempelvis en implementeringsstrategi, der faciliterer implementeringen af en given indsats? Eller er den en selvstændig indsats, der har til formål at ruste involverede aktører og organisationer til at løse fremtidige mere eller mindre specifikke udfordringer? Litteraturen giver forskellige bud og præsenterer eksempler på forskellige perspektiver på kapacitetsopbygning (Aluttis et al., 2014; B. J. Smith et al., 2006; Van den Broucke, 2017; Wandersman et al., 2008). Aktionslæringsforløbet, som er genstandsfeltet i delstudie 2, er et eksempel på, hvordan kapacitetsopbygning kan betragtes som en integreret del af arbejdet med en sundhedsindsats. Kapacitetsopbygningen havde altså en fremtrædende rolle, som blev tænkt ind i designet af indsatsen, fremfor at den blev betragtet som en afledt effekt eller noget, der lå forud for implementeringsprocessen. Således er aktionslæringsforløbet et eksempel, hvordan kapacitetsopbygning både er et mål og et middel. Det ligger imidlertid uden for formålet for dette kapitel at gå ind i en mere detaljeret diskussion af dette. Jeg vil nu i stedet vende blikket mod den målrettede brug af kapacitetsopbyggende mekanismer og aktiviteter inden for mental sundhedsfremme – som er det tredje tværgående tema.

Kapacitetsopbyggende mekanismer og aktiviteter

Ud over at understøtte idéen om, at kapacitetsopbygning er central for at styrke praksisser inden for mental sundhedsfremme, bidrager afhandlingen med dybdegående og nuanceret viden om processer for, hvordan kapacitet kan opbygges. Afhandlingen imødekommer hermed efterspørgslen på viden om kapacitetsopbyggende mekanismer og effekter på et individuelt, organisatorisk og inter-organisatorisk niveau (DeCorby-Watson et al., 2018; Leonard & Marquardt, 2010; Sobeck & Agius, 2007; van Herwerden et al., 2018). Ved at have blik for processerne for kapacitetsopbygning kan vi få øje på flere værdiskabende processer, som er knyttet til udviklingen og implementeringen af praksisser inden for sundhedsfremme (Aluttis et al., 2014). Det kan eksempelvis være i forbindelse med implementeringen af en specifik intervention eller i analysen af samarbejdsprocesser. Kapacitetsopbygningen kan altså ses som en ekstra værdiskabelse, ud over værdien af implementeringen af en given sundhedsintervention (Aluttis et al., 2014). Denne ekstra værdi er relevant at tage i betragtning i for eksempel cost-benefit-vurderinger – det være sig som praktiker, beslutningstager, evaluator eller forsker. Gennem en øget

opmærksomhed på og forståelse for mekanismer for kapacitetsopbygning kan man desuden forestille sig, at bl.a. beslutningstagere og praktikere i højere grad kan tænke kapacitetsopbygningen ind i implementeringsprocesser og daglige rutiner og praksisser. Herved kan der potentielt opnås en forøget effekt af en given implementering eller praksis gennem den værdiskabelse, som kapacitetsopbygningen repræsenterer (Aluttis et al., 2014; Van den Broucke, 2017). I det følgende vil jeg uddybe og diskutere afhandlingens resultater vedrørende kapacitetsopbyggende mekanismer og aktiviteter.

Delstudie 1 peger på, at participatoriske metoder er særligt effektive til at engagere aktører i arbejdet med mental sundhedsfremme. Effektiviteten og det øgede engagement kan forklares ved, at de participatoriske metoder øger aktrørerenes forståelse for de grundlæggende aspekter og potentielle anvendelsesmuligheder af mental sundhedsfremme. Heri ligger der altså en læringsproces og dermed en kapacitetsopbygning. Denne slutning resonerer med udlægningen af kapacitetsopbyggende processer af McLean et al. (2004). Forfatterne fremhæver, at kapacitet kan fremmes effektivt ved at skabe muligheder for at arbejde på meningsfulde projekter og partnerskaber. Netop indsigterne i sammenhængen mellem participatoriske processer og kapacitetsopbygning udgjorde grundlaget for udviklingen af aktionslæringsforløbet og undersøgelsen af, hvordan mekanismerne fra aktionslæring kan bidrage til at opbygge mental sundhedsfremmekapacitet (delstudie 2).

Ved at præsentere CMO-konfigurationer i delstudie 2 bidrager afhandlingen med nuancerede analyser af genereringen af kapacitet på både individ-, organisations- og inter-organisationsniveau. Mekanismerne beskrevet i delstudie 2 dækker bl.a. over learning-by-doing, individuelle refleksionsprocesser, fysiske møder, oplevelse af udbytterige samarbejder og samarbejde på tværs af organisationer/afdeling. Resultaterne er i tråd med resultaterne fra Leonard og Marquardt (2010), som i et litteraturstudie afdækker, hvordan aktionslæring virker. Forfatterne opererer ikke med begrebet ”mekanismer”, men beskriver i stedet væsentlige variabler, operationaliseret som aktive ingredienser. Leonard og Marquardt (2010, p. 134) beskriver i den sammenhæng følgende aktive ingredienser: “Questioning […]; Taking action; Learning from each other; Listening; Diversity of team membership; Feelings of confidence and well-being; Safe environment; and Coach.” Overordnet flugter deres resultater med resultaterne fra delstudie 2. De aktive ingredienser, som forfatterne peger på, kan i høj grad genfindes i mekanismerne i CMO-konfigurationerne. Eksempelvis er det at stille spørgsmål og forholde sig kritisk til noget (*questioning*) et centralt element af refleksionsprocesserne beskrevet i delstudie 2. Desuden kan det at handle (*taking action*) og learning-by-doing antages at være baseret på samme processer. I delstudie 2 finder vi dog ikke, at et trygt miljø (*safe environment*) skulle være en mekanisme for kapacitetsopbygning. Ud fra et realistisk evaluerings-perspektiv kan et trygt miljø ses som en

kontekstuel faktor, som muliggør udfoldelsen eller aktiveringen af de øvrige mekanismer (aktive ingredienser).

Afhandlingens tre delstudier peger alle i retning af, at kapaciteten til at arbejde med mental sundhedsfremme kan øges gennem samarbejde på tværs. Det kan være på tværs af partnerskabet ABC for mental sundhed (delstudie 1 og 3), på tværs af lokale organisationer i forbindelse med aktionslæringsforløbet (delstudie 2 og 3) og på tværs af roller (delstudie 3). Litteraturen inden for kapacitetsopbygning bakker generelt op om, at kapacitet kan opbygges og udnyttes ved, at komplementære ressourcer og kompetencer bringes sammen i samarbejdsrelationer og partnerskaber (Marlier et al., 2015; McLean et al., 2004). For at kunne drage slutninger omkring fordelene ved at arbejde "på tværs" er det dog nødvendigt også at have øje for og vurdere/måle antagonistiske effekter – som vedrører omkostningerne ved at indgå i samarbejde og partnerskaber (Corbin et al., 2016). Dette fokus på antagonistiske processer og effekter har dog ikke været et fremtrædende analytisk fokus i afhandlingens delstudier. I den sammenhæng er et interessant fund fra et studie af partnerskaber, at selv hvis samarbejder og partnerskaber udvikler sig i uhensigtsmæssige retninger, kan der stadig ske en kapacitetsopbygning i form af læring. Dette er påvist i en undersøgelse af partnerskabers problemløsningsevne, hvor forfatterne finder, at aktører i partnerskaber kan drage læring ud af negative oplevelser, som kan bruges til at forbedre fremtidigt samarbejde (Corbin, Mittelmark & Lie, 2013).

Metodiske refleksioner

I det følgende præsenterer jeg refleksioner over afhandlingens overordnede design og metoder. Afsnittet indledes med refleksioner over styrker og svagheder ved de anvendte design og metoder. Herefter følger et afsnit om effekt og kausalitet, og et afsnit med fokus på resultaternes overførbarhed. Refleksionerne kan læses som en kontekstualisering af mine resultater og et oplæg til mine overvejelser om resultaternes implikationer for forskning og praksis.

Styrker og svagheder

Delstudierne er baseret på data produceret fra januar 2017 til december 2020. Denne relativt lange og omfangsrige proces, kombineret med mit arbejde i partnerskabet ABC for mental sundhed, har givet mulighed for at opnå dyb indsigt i praksisser relateret til mental sundhedsfremme. Indsigterne var værdifulde i besvarelsen afhandlingens formålsbeskrivelse. Mine forskellige positioneringer kan dog også være forbundet med ulemper, som kan ses som svagheder ved afhandlingens design. Disse er diskuteret i afsnittet om min positionering i metodekapitlet.

Mine delstudier bygger primært på data produceret via interviews med og observationer af implementeringsaktører og ledere. Implementeringslitteraturen (fx: Barry, 2019c; Durlak & DuPre, 2008) fremhæver netop samspillet mellem ledelsesmedarbejdere og øvrige medarbejdere som et væsentligt aspekt af implementeringsprocesser. Litteraturen påpeger også relevansen af at undersøge og forstå målgruppens og slutbrugernes oplevelse og rolle i implementeringsprocesser. Det er derfor en styrke ved projektet, at der i forbindelse med aktionslæringsforløbet indgik studerende som repræsentanter for målgruppen, i min dataproduktion. En mulig svaghed ved afhandlingens design er, at dette fokus på målgruppens og slutbrugeres holdninger og perspektiver ikke har været baseret på et mere omfangsrigt datagrundlag. En grundig undersøgelse heraf kunne bidrage til at opnå en bredere viden om implementeringsprocesserne, som favner flere led i processen.

Udviklingen og beskrivelsen af CMO-konfigurationer afgøres i høj grad af, hvilke indsigter om den empiriske kontekst, at datagrundlaget indeholder (Pawson, 2013; Pawson & Tilley, 1997) – eksempelvis hvilke elementer af de kontekstuelle faktorer og processerne i implementeringsprocesser, der er forsøgt at opnå viden om i dataproduktionen. I delstudie 2 har mine data givet mulighed for at få indblik i visse aspekter af de kontekstuelle faktorer. I den forbindelse var mine interviews med både deltagere fra aktionslæringsforløbet og ledere fra de deltagende organisationer vigtige datakilder. Det kan ikke udelukkes, at analysen af CMO-konfigurationer i delstudie 2 havde vist andre resultater, hvis jeg i min dataproduktion havde fokuseret på andre kontekstuelle faktorer –eksempelvis deltagende organisationers økonomiske forhold. Inddragelsen af teorier og litteratur under analysen af CMO-konfigurationer er også en væsentlig faktor for de endelige resultater. Således var min og mine medforfatteres faglige baggrund også væsentlige for, hvordan data blev læst, og hvilke elementer vi fokuserede på (Pawson & Tilley, 1997).

Kombinationen af forskellige datakilder gav mulighed for at opnå en nuanceret forståelse af lokale udviklings- og implementeringsprocesser. Det gjorde sig for eksempel gældende i delstudie 2, hvor jeg gennem observationer fik indblik i konteksten for workshoppene. De indsamlede handleplaner gav et indblik i deltagernes processer med at udvikle nye initiativer. Derudover kunne jeg igennem interviews med både deltagere og ledere fra de deltagende organisationer få yderligere viden om kontekst og udviklingsprocesserne. Indsigterne fra observationerne og de indsamlede dokumenter brugte jeg til at informere mine interviewguides. Jeg kunne eksempelvis spørge ind til konkrete hændelser og situationer, som jeg havde beskrevet i mine observationsnoter, hvilket gav mulighed for at forfølge og undersøge præliminære hypoteser omkring for eksempel mulige outcomes af aktionslæringsforløbet.

I mødet med informanter og samarbejdspartnere, både i interview- og observationssituationer, bestræbte jeg mig på at italesætte mental sundhed og mental sundhedsfremme på en måde, der flugtede med modpartens forståelse heraf. Mason (2018) fremhæver sprogbrug som et centralt opmærksomhedspunkt, som intervieweren bør reflektere over. Sproget bør være letforståeligt og meningsfuldt for informanterne, så de engagerer sig i interviewet. I den sammenhæng var min relativt langvarige involvering i partnerskabet ABC for mental sundhed en styrke, da jeg havde opnået indsigt i, hvordan mental sundhed/mental sundhedsfremme italesættes og konceptualiseres i forskellige kontekster og sektorer. Som det fremgår af delstudie 1 var begrebsafklaring (og til tider begrebsforvirring) et tilbagevendende diskussionspunkt i partnerskabet. Diskussionerne med partnerne bidrog for det første til at stimulere min opmærksomhed på, at mental sundhed/mental sundhedsfremme konceptualiseres på mange forskellige måder. For det andet fik jeg herigennem indsigter i, hvordan mental sundhed/mental sundhedsfremme italesættes i forskellige kontekster og sektorer. Denne viden forsøgte jeg at anvende i dataindsamlingen, særligt i interview og observationssituationer. Som et konkret eksempel kan det nævnes, at jeg i dialog med aktører fra uddannelses- og skolesektoren anvendte begreberne ”mental sundhed” og ”trivsel” i flæng. Dette valg om sprogbrug er baseret på min erfaring med, at selvom begrebet ”trivsel” er langt mere udbredt og anvendt end ”mental sundhed”, ser langt de fleste de to begreber som konceptuelt overlappende. På trods af min opmærksomhed på problematikken med forskellige konceptualiseringer af og måder at italesætte mental sundhed og mental sundhedsfremme på, oplevede jeg misforståelser og sammenblandinger af begreber, eksempelvis angående sundhedsfremmende og forebyggende strategier. En mulig svaghed ved dataproduktionen var altsåudfordringerne i forbindelse med at italesætte og indkredse aspekterne af mental sundhedsfremme på en måde, der gav genklang hos informanterne. Samtidig repræsenterer problemstillingen en mere generel udfordring i undersøgelser af fænomenet mental sundhedsfremme.

Størstedelen af de analytiske processer, som indebar organisering og kodning af data, var i høj grad en opgave, jeg varetog alene. Således var mange af mine valg også i høj grad afhængige af mine vurderinger som forsker. Der er altså en vis grad af subjektivitet forbundet med de analytiske slutninger (Mason, 2018). I den sammenhæng har min position (se afsnit om min positionering i metodekapitlet) påvirket mine analytiske læsninger af data og valg. For at øge validiteten af mine slutninger og kongruens mellem mine fund og data har jeg løbende diskuteret mine præliminære fund med mine vejledere og kollegaer. En højere grad af inddragelsen af andre i analyseprocessen, eksempelvis i kodningen, kunne måske have ført til andre valg. Man kunne forestille sig, at en anden person ville læse, studse over og bemærke andre aspekter af dataene (Mason, 2018; Pawson, 2013). Forskellige læsninger

af det empiriske materiale kunne efterfølgende drøftes og herved bidrage til det analytiske arbejde. Min inddragelse og mine løbende drøftelser med mine vejledere, kollegaer og medforfattere har øget min refleksivitet omkring forholdet mellem data og mine fortolkninger. Drøftelserne har desuden været en anledning til, at jeg skulle eksplicitere mine analytiske valg over for mig selv og efterfølgende overfor andre. Ifølge Mason (2018) bidrager denne type proces til at styrke kvaliteten af de analytiske slutninger.

I delstudie 1 benyttede jeg CFIR som et konceptuelt framework til at guide analysen og fremstillingen af resultaterne. Jf. Morgan-Trimmer (2015) er en teoretisk forankring en styrke for procesevalueringsstudier. Morgan-Trimmer (2015) peger på, at procesevalueringer inden for sundhedsvidenskabelige traditioner bør tage ved lære af traditionerne inden for social videnskaberne og sikre en teoretisk forankring eller et teoretisk fokus. Brugen af a priori-temaer i den analytiske proces i delstudie 1 var forbundet med en række fordele, men også udfordringer. Brugen af CFIR-modellen gav en struktur og systematik til det analytiske arbejde, som herved blev funderet i modellens evidensbaserede fundament. Kodningen efter de forudbestemte temaer var også forbundet med udfordringer. Det var udfordrende at adskille nogle af temaerne fra hinanden. Eksempelvis oplevede jeg et vist overlap mellem kategorier, som skulle indfange 1) informanternes attitude overfor interventionen og 2) deres perspektiv på interventionens karakteristika.

Der er nogle begrænsninger forbundet med, at jeg i løbet af dataindsamlingen ændrede studiedesign for delstudie 2. Eksempelvis kan det ses som en begrænsning, at delstudiet ikke bygger oven på en realistisk syntese, som er en form for systematisk litteraturstudie (Mukumbang, Marchal, Van Belle & van Wyk, 2018). En realistisk syntese er baseret på de samme begreber og den samme videnskabsteoretiske positionering som realistisk evaluering og bør jf. Pawson (2013) så vidt muligt gå forud for og informere en realistisk evaluering. Den analytiske proces i delstudie 2 indeholdt dog en række metodiske skridt, som sikrede en forankring i den eksisterende litteratur om aktionslæring og kapacitetsopbygning. For det første er selve udviklingen af aktionslæringsforløbet baseret på en model for aktionslæring, som er baseret på resultater og erfaringer fra en lang række studier (Zuber-Skerritt, 2002). For det andet blev litteraturen om aktionslæring og kapacitetsopbygning samt tidligere evalueringer af ABC for mental sundhed konsulteret i den analytiske proces med at afdække og beskrive CMO-konfigurationer. Denne form for inddragelse af litteratur er i tråd med den retroduktive analysetilgang (Justin Jagosh, 2020). For det tredje blev præliminære resultater og CMO-konfigurationer diskuteret med medforfattere, hvilket åbnede for muligheden for at trække på deres kendskab til relevant litteratur og erfaringer med aktionslæring, kapacitetsopbygning og mental

sundhedsfremme. Det kan dog ikke afvises, at en bred forudgående realistisk syntese kunne have givet viden om relevante interventionsressourcer, mekanismer og relaterede outcome-typer. Et litteraturstudie kan også inddrages i et fremtidigt arbejde med at videreudvikle det afprøvede aktionslæringsforløb og kunne dermed udgøre et opfølgende studie, jf. den cirkulære udviklingsproces for realistisk evaluering (Pawson & Tilley, 1997).

Om mit studiedesign for delstudie 2 kvalificerer til at blive kaldt realistisk evaluering, kan der sættes spørgsmålstegn ved. En læsning af Ray Pawsons senest bog om realistisk evaluering (Pawson, 2013) giver det indtryk, at der er forskel på at arbejde genuint med realistisk evaluering og at lade sig inspirere heraf (Ravn, 2020). Eksempelvis mener Pawson ikke, at studier nødvendigvis kan kaldes for realistisk evaluering, bare fordi der arbejdes med for eksempel CMO-konfigurationer og retroduktion. Jf. Pawson (2013) skal mindst tre centrale aspekter være til stede, før et studie retteligt kan betegnes som realistisk evaluering. De centrale aspekter indebærer, at studiet skal 1) omfavne og praktisere det kritisk realistiske sigte om at producere forklaringer på, hvorfor noget sker, 2) bygge på flere datakilder og 3) kontekstfaktorer, mekanismer og outcomes skal præsenteres konfigureret. Det er min vurdering, at mit studie er i overensstemmelse med de tre punkter. Mine overvejelser om studiedesign bundede dog ikke i et ønske om at gennemføre en realistisk evaluering, men i et ønske om at skabe viden, der er relevant og meningsfuldt i forhold til formålet med afhandlingen og mine forskningsspørgsmål.

Effekt og kausalitet

Både delstudie 1 og 2 berører effektbegrebet og indeholder analytiske slutninger om effekter af interventioner eller praksisser. I delstudie 1 undersøger jeg bl.a. ABC-koordinatorers og stakeholders oplevelse af effekt af lokale initiativer og deres involvering i partnerskabet ABC for mental sundhed. I delstudie 2 undersøger jeg virkningen af aktionslæringsforløbet på forskellige kapacitetsparametre. Effektbegrebet og kausalitetsforståelser er dermed væsentlige aspekter, som relaterer sig til designmæssige og metodiske valg, jeg har truffet i forbindelse med de to delstudier. I det følgende vil jeg derfor udfolde mine refleksioner omkring effekt og kausalitet i relation til afhandlingens delstudier.

Ud fra en kritisk realistisk positionering skal forskningsresultater fortolkes med forbehold for, at viden grundlæggende er usikker (Ravn, 2020). I det perspektiv vil mine resultater og min forskning generelt altså ikke kunne tilvejebringe endegyldige sandheder. Desuden er det vigtigt at slå fast, at sigtet med mine delstudier ikke har været at afsige en endelig dom over, hvorvidt arbejdet med ABC for mental sundhed eller med aktionslæringsforløbet virker eller ej. Formålet var i højere grad at belyse mulige

effekter og (særligt i delstudie 2) at belyse aspekter, som forklarer, hvorfor og hvordan aktionslæringsforløbet har ført til de observerede outcome.

Mit skift i design for delstudie 2 betød også et skift i kausalitetsforståelse. Realistisk evaluering tager afsæt i en generativ kausalitetsforståelse (Pawson & Tilley, 1997), som er forskellig fra kausalitetsforståelsen inden for mere ”klassisk effektevaluering”, der er baseret på en variansbaseret forståelse af kausalitet (Ravn, 2020). En fortløbende diskussion blandt interventionsforskere og evaluatorer handler netop om, hvorvidt realistisk evaluering kan levere en effektevaluering (Ravn, 2020). Et centralt punkt i diskussionen er, hvilken kausalitetsforståelse der ligger til grund for et givent studiedesign. Arbejder man med ”klassiske effektevalueringer”, skal designet indebære målinger på en kontrolgruppe, som det for eksempel ses ved RCT- og kvasi-eksperimentelle design. Herved etableres en kontrafaktisk situation, som bygger på antagelsen om, at man kan sige noget om, hvad der ville være sket med deltagergruppen, hvis den ikke blev udsat for en given indsats (Juul, 2009). Set ud fra et mere traditionelt evaluerings- og effektmålingsperspektiv har mine resultater altså en relativt lavere grad af intern validitet, end hvis jeg havde anvendt eksperimentelle designs (Ravn, 2020). Jf. Ravn (2020) kan analysen af udfald af en given indsats inden for realistisk evaluering også karakteriseres som en form for effektevaluering, hvilket han kalder for outcome-analyse. Han antyder, at begrebet outcome-analyse bruges for at adskille det fra den mere konventionelle forståelse af effektevaluering, som den findes inden for paradigmer, der indebærer en variansbaseret kausalitetsforståelse. Antagelsen om at kunne matche en forsøgs- og kontrolgruppe er i strid med den grundlæggende videnskabsteoretiske positionering inden for kritisk realisme (Ravn, 2020). Effektbegrebet inden for realistisk evaluering er i stedet baseret på en sandsynliggørelse af, at det observerede outcome er genereret i et samspil mellem kontekstuelle faktorer og mekanismer (Ravn, 2020). Til det formål indeholder evalueringsdesigns inden for rammen af realistisk evaluering typisk sammenligningsgrupper for at undersøge variationer i outcome-mønstre (*outcome patterns*) (Pawson & Tilley, 1997). Brugen af sammenligningsgrupperne indebærer ofte intra- og inter-programsammenligning (Ravn, 2020). Valget om at bruge et indlejret (*embedded*) casestudiedesign (Yin, 2014) i analysen i delstudie 2 gav mulighed for at vurdere effekten på tværs af sammenligningsgrupper, altså en intraprogramsammenligning.

Delstudie 2 er baseret på kvalitative data til at udlede CMO-konfigurationer og herigennem drage slutninger om effekten af aktionslæringsforløbet. Som beskrevet handler effektanalysen om at beskrive de generative mekanismers samspil med kontekstuelle faktorer. Jf. Pawson (2013, p. 19) kræver en effektanalyse inden for realistisk evaluering både kvantitative og kvalitative data. Han mener, at outcomes bør afdækkes via kvantitative metoder, og at processerne af en given intervention samt

kontekstuelle forhold bør afdækkes via kvalitative metoder. Pawsons syn på brug af kvalitative data i en effektanalyse har visse ligheder med mere traditionelle tilgange til effektevaluering, hvor argumenterne for behovet for kvantitative data beror på, at replicerbarhed er et kvalitetstegn, og at forskerens subjektive indvirkning på dataproduktion og -analyse helst skal undgås (Ravn, 2020). Som nævnt beror delstudie 2 udelukkende på kvalitative data, og robustheden i dets outcome-analyser kan derfor anfægtes, jf. Pawsons argumenter.

Jeg vil dog argumentere for, at outcome-analyser baseret på kvalitative data også kan være berettiget, og at brugen af kvantitative data ikke nødvendigvis vil medføre en markant højere robusthed af resultaterne. Et væsentligt spørgsmål er her, hvilke typer af outcomes, der ønskes viden om. I delstudie 2 var jeg interesseret i at undersøge outcomes relateret til bl.a. implementering af nye praksisser. Til formålet interviewede jeg alle deltagere umiddelbart efter selve aktionslæringsforløbet, og jeg gennemførte telefoninterviews med udvalgte deltagere seks måneder senere. Et relevant spørgsmål er her, om antallet af informanter, som bekræfter, at en implementering har fundet sted, er afgørende for vores slutning vedrørende det givne outcome? I den sammenhæng mener jeg, at supplerende kvantitative målinger ikke nødvendigvis ville øge validiteten eller robustheden af de slutninger, som vi har draget. Eksempelvis kunne et spørgeskema blandt medarbejdere i de deltagende organisationer give et indblik i, hvor stor en andel af medarbejderne der kender til (eller oplever) en implementering af de initiativer, som udspringer fra aktionslæringsforløbet. Men en højere andel af medarbejdere, der svarer positivt på et sådant spørgsmål, siger ikke nødvendigvis noget om, hvorvidt en given implementering har fundet sted eller graden/succesen af implementeringen. Det kan sige noget om, hvor mange der kender til initiativet og evt. styrke argumentet om, at en implementering har fundet sted. Et højt antal negative svar på et sådant spørgsmål udelukker dog ikke, at implementeringen har fundet sted. En simpel forklaring kunne være, at kun få respondenter kender til eller var involveret i implementeringen. På baggrund heraf vil jeg mene, at spørgsmålet om, hvorvidt kvantitative data er nødvendige for at drage robuste slutninger vedrørende outcome af den given intervention, afhænger af vidensinteressen, dvs. hvilke outcome der ønskes viden om. På baggrund af min argumentation her mener jeg ikke, at der er grund til at anfægte validiteten af mine fund vedrørende implementeringen af konkrete initiativer, som altså beror på interviewdata. Supplerende kvantitative undersøgelser med et relativt højere antal respondenter kunne måske afdække udviklingen og implementeringen af initiativer, som jeg ikke har indfanget viden om i de kvalitative data. Desuden kunne kvantitative undersøgelser med et bredt udsnit af respondenter fra de deltagende organisationer bidrage med viden om, hvorvidt og hvordan øvrige medarbejdere er blevet påvirket af aktionslæringsforløbet. Standardiserede og validerede instrumenter for at måle kapacitet kunne også bruges for at måle udviklingen på forskellige parametre såsom viden,

kompetencer, ledelsesopbakning, tilgængeligheden af ressourcer og relationer (van Herwerden et al., 2018). Litteraturen om kapacitetsopbygning peger dog på, at måling af kapacitet bør være kontekstspecifik og fleksibel, og at den derfor med fordel kan benytte sig af mixed methods (Hawe et al., 2009; van Herwerden et al., 2018)

Overførbarhed og generaliserbarhed – ABC for mental sundhed som empirisk kontekst

I ovenstående diskussion og afhandlingens tre artikler reflekterer jeg over, hvordan mine resultater generelt flugter med international og national litteratur. De identificerede overensstemmelser peger på potentialet for, at mine resultater har implikationer, der rækker ud over min empiriske kontekst. I det følgende diskuterer jeg implikationerne set i lyset af min kritisk realistiske positionering og begreberne overførbarhed og generaliserbarhed.

Inden for kritisk realisme arbejdes der som udgangspunkt ikke med et spørgsmål om, hvorvidt resultater omkring virkning og effekt har en høj ekstern validitet. Ekstern validitet er knyttet til tanken om at kunne generalisere resultater til andre lignende kontekster. Inden for kritisk realisme opereres der i stedet med overførbarhed, hvilket også betegnes teoretisk/analytisk generaliserbarhed (Ravn, 2020). Grunden hertil skal findes i de videnskabsteoretiske antagelser. Inden for kritisk realisme vil overførbarhed være et spørgsmål om at kunne levere en plausibel forklaring på, hvilke kontekstuelle faktorer der skal være til stede for at en mekanisme kan generere en given effekt (Ravn, 2020). Forklaringsmodellerne bevæger sig altså på tværs af de tre ontologiske niveauer, som tegner verdensbilledet inden for kritisk realisme. Der opereres således med et ønske om at opnå teoretisk/analytisk generaliserbarhed. Det betyder, at mine resultater skal betragtes som situeret, jf. kapitlet om afhandlingens empiriske kontekst. Det betyder desuden, at overførbarheden af mine resultater skal vurderes ud fra de kontekstuelle faktorer i den givne setting sammenlignet med konteksten for dette studie.

Mine resultater skal ses som situeret i en dansk kontekst og i partnerskabet ABC for mental sundhed. Mine delstudier beskæftiger sig med initiativer (f.eks. indsatser og praksisser), som mere eller mindre direkte tager afsæt i partnerskabet ABC for mental sundhed og ABC-rammen. Særlige karakteristika ved ABC-initiativer kan have påvirket mine resultater i bestemte retninger. Det kan for eksempel være i forhold til udfordringer med at bruge navnet ABC for mental sundhed, som er beskrevet i første delstudie. Sammensætningen af partnere i ABC for mental sundhed er også en væsentlig faktor. Dynamikker og retningen for arbejdet i partnerskabet bliver uundgåeligt påvirket af

partnerorganisationernes kerneopgaver og organisationstype samt ABC-koordinatorernes professionelle baggrund og faglighed. Således kunne man forestille sig, at en større andel af sundhedsfaglige aktører, for eksempel fra regioner/sygehuse, patientorganisationer og den primære sundhedssektor, kunne bringe et andet fokus og en anden sprogbrug ind i partnerskabet. Sammensætningen af aktører i partnerskabet kan formodes at have haft indflydelse på delstudiernes resultater. Det kunne være i forhold til de strategier og initiativer for mental sundhedsfremme, som er blevet forfulgt og udviklet i partnerskabet og dermed beskrevet i delstudie 1 og delstudie 2. Ligeledes kan det ikke udelukkes, at resultaterne fra delstudie 3, taksonomien og de afdækkede samarbejdsmønstre, kunne se anderledes ud ved en anden sammensætning af partnerorganisationer i ABC for mental sundhed. Som nævnt tidligere kan inddragelsen af relevant litteratur i de analytiske processer øge overførbarheden af mine resultater. Som beskrevet foroven og i artiklerne har resultaterne visse ligheder med øvrige implementerings- og evalueringsstudier af mental sundhedsfremmende initiativer, som er situeret i andre kontekster og har undersøgt andre projekter. Denne kongruens kan læses som, at der er en række grundlæggende forhold eller vilkår i arbejdet med mental sundhedsfremme, som går igen på tværs af kontekster og indsatser.

De næste skridt

I de følgende to afsnit præsenterer jeg refleksioner over, hvilke implikationer resultaterne fra afhandlingen kan have for 1) forskning og 2) praksis relateret til mental sundhedsfremme.

Implikationer for forskning

Afhandlingens resultater bidrager med indsigter, som kan føde ind i yderligere undersøgelser af kapacitetsopbyggende initiativer. Resultaterne bidrager med viden om og indsigter i, hvilke effekter der er relevante at måle på i undersøgelser af initiativernes effekt. Mine resultater belyser desuden, hvordan effekter genereres, dvs. hvad der foregår i ”den sorte boks” (Ravn, 2020). Denne viden kan informere udviklingen af programteorier, som kan undersøges i procesevalueringer og implementeringsstudier. Eksempelvis kan CMO-konfigurationerne fra delstudie 2 bruges til at informere udvikling og videreudvikling af aktionslæringsforløb, der har til formål at styrke praksisser og mental sundhedsfremmekapacitet. CMO-konfigurationer bringes i spil i udviklingen af en programteori. Programteorien kan med fordel også baseres på en realistisk syntese (Pawson, 2013). Efterfølgende kan programteorien testes. Den skitserede fremgangsmåde ville være i tråd med den cirkulære tilgang til interventionsudvikling inden for realistisk evaluering (Pawson & Tilley, 1997; Ravn, 2020).

Morgan-Trimmer fremhæver, at procesevalueringer i højere grad bør have øje for kontekstuelle faktorers påvirkning af implementeringsprocesserne (Morgan-Trimmer, 2015). Procesevalueringer af arbejdet i partnerskabet ABC for mental sundhed (eller lignende initiativer) kunne med fordel trække på komparative designs i undersøgelser implementeringsprocesserne. Sammenligninger på tværs af sektorer, typer af partnerorganisationer eller geografiske områder kunne give indsigt i betydningen af kontekstuelle faktorer, som er relateret til udviklingen og implementeringen af praksisser inden for mental sundhedsfremme. Tilsvarende bør overførbarheden af taksonomien, som er udviklet i delstudie 3, også afprøves i andre kontekster og andre indsatser. Denne viden er relevant for at vurdere, om taksonomien kan bidrage til et fælles sprog for mental sundhedsfremme på tværs af sektorer.

Resultaterne af afhandlingen samt uformelle beretninger fra aktører fra partnerskabet viser, at arbejdet med ABC for mental sundhed kan informere policy- og strategiprocesser. Grundige undersøgelser af disse processer og deres effekter ville være et relevant bidrag til vidensgrundlaget for feltet omkring mental sundhedsfremme. Manglen på forskning med fokus på policy-niveauet understøttes af et litteraturstudie, som fremhæver manglen på undersøgelser af virkning af ”up-stream”-interventioner inden for mental sundhedsfremme (Barry, 2019a).

For at skabe et mere udførligt billede af implementeringsprocesserne relateret til praksisser inden for mental sundhedsfremme er det relevant at supplere afhandlingens resultater med undersøgelser, som fokuserer på et bredere udsnit af aktører, som er involveret implementeringsprocesserne. Det er vigtigt at få belyst målgruppens/slutbrugernes holdninger og oplevelser (Damschroder et al., 2009). Desuden kunne implementeringsstudier fokusere på frontmedarbejdere, som, jf. Lipskys teori om ”street-level-beuraucrats”, har afgørende indflydelse på implementeringen af strategiske og politiske beslutninger i praksis (Lipsky, 2010).

Grundantagelsen bag kapacitetsopbygningstilgangen er, at øget kapacitet vil medføre forbedret service eller opgavevaretagelse (Aluttis et al., 2014). Oversat til afhandlingens kontekst betyder det, at øget mental sundhedsfremmekapacitet vil medføre bedre og mere effektiv varetagelse af funktionerne, som ligger indenfor mental sundhedsfremme. Jeg mener at hypotesen umiddelbart lyder plausibel, men på baggrund af afhandlingens resultater kan jeg ikke sige noget om, hvorvidt hypotesen holder stik. Nickel, Suss, Lorentz og Trojan (2018) pointerer, at der inden for sundhedsfremme og folkesundhed mangler empirisk forskning, som underbygger denne grundlæggende hypotese for effekten af kapacitetsopbygning. Sammenhængen mellem kapacitetsopbygning og effekter relateret til mental sundhed er altså relevant at undersøge i fremtidige studier. Der er behov for at undersøge, om

kapacitetsopbygningsstrategier kan linkes til 1) forbedrede og/eller fastholdelse af praksisser inden for mental sundhedsfremme og 2) forbedringer i målgruppens mentale sundhed på kort og lang sigt. Herunder vil det være væsentligt at undersøge, hvilke former for kapacitet der kan generere relevante og bæredygtige effekter.

Samlet set er der altså behov for mere forskning og viden for at forstå det fulde billede af implementeringsprocesserne og hvordan forskellige typer initiativer kan bidrage til at fremme mental sundhed. Desuden kan forskning om kapacitetsopbygningsinitiativer, som er karakteriseret ved at være baseret på mekanismerne fra aktionslæring, bidrage med relevante indsigter, som er væsentlig for at kunne udbrede og opskalere denne type kapacitetsopbygningsindsatser.

Implikationer for praksis

Tidligere i diskussionen har jeg argumenteret for, at oplevelsen af mental sundhedsfremme som uklar og diffus, sammen med den relativt brede operationalisering heraf, kan udfordre implementeringsprocesser. På baggrund af afhandlingens resultater mener jeg, at aktionslæring, og kapacitetsopbyggende initiativer generelt, har potentialet til at facilitere effektive og succesfulde implementeringsprocesser. Afhandlingens indsigter i kapacitetsopbyggende mekanismer kan derfor med fordel inddrages i planlægning af interventioner og praksisser med fokus på mental sundhedsfremme. De resultater, som omhandler samspillet mellem kontekstuelle faktorer og de identificerede mekanismer, kan guide en vurdering af, hvorvidt mekanismerne forventes at kunne overføres til andre kontekster.

Som jeg har udfoldet tidligere i afhandlingen – og særligt i artikel 1 – er der fordele ved at adressere andre faggruppers kerneopgaver og målsætninger som en strategi for at engagere forskellige implementeringsaktører og frontmedarbejdere i arbejdet med mental sundhedsfremme. Strategien kan dog også være forbundet med en række ulemper, som bør overvejes. Hvis mental sundhedsfremme bliver et middel til at opnå et mål, som ikke vedrører mental sundhed, er der fare for, at de involverede aktørers fokus på mental sundhedsfremme tilsidesættes, hvis kerneopgaver eller målsætninger ændres. Det kunne eksempelvis være i forbindelse med skift i politiske prioriteringer i kommuner eller regioner. Desuden kan det tænkes, at disse faggrupper finder andre og mere effektive midler til at løse deres kerneopgaver og nå deres egne målsætninger. Herved er der fare for, at deres fokus på mental sundhedsfremme tilsidesættes (Holt, 2016). Fraværet af begreber relateret til mental sundhed og målsætninger om rent faktisk at fremme mental sundhed kan derfor underminere de langsigtede målsætninger om at implementere bæredygtig mental sundhedsfremme på tværs af sektorer.

Afhandlingens resultater underbygger, at strategisk samarbejde på tværs af sektorer og organisationer ser ud til at være en farbar vej for at styrke praksisser inden for mental sundhedsfremme. Taksonomien, som er udviklet i delstudie 3, kan muligvis informere og bruges som et redskab i denne type samarbejde. Taksonomien kan både inddrages i planlægningsfasen og under implementeringen, hvor den kan være med til at skabe overblik over og kommunikere om rollerne og potentielle snitflader mellem rollerne. I den sammenhæng er det dog vigtigt at fremhæve, at taksonomien bør bruges med forbehold for, at den bør underkastes undersøgelser af dens overførbarhed til andre kontekster og typer af indsatser inden for mental sundhedsfremme. I ovenstående diskussion og i artikel 3 peger jeg på, at taksonomien i høj grad resonerer med litteraturen inden for mental sundhedsfremme og implementering. På baggrund heraf kan det antages, at taksonomien sandsynligvis har implikation i andre kontekster.

Med afsæt i resultaterne fra delstudie 3 foreslår jeg, at rollen som MSF-specialist bør indgå som et centralt aspekt af iværksættelsen af tværgående samarbejder. Som en strategi for at fremme en dagsorden om mental sundhedsfremme kan sundhedssektoren, som tidligere nævnt, med fordel bidrage med sin sundhedsfaglig ekspertise for at understøtte øvrige sektorer (Holt, 2016). Set i det lys kan rollen som MSF-specialist tænkes ind i organiseringen af for eksempel arbejdet med mental sundhedsfremme i kommunale eller regionale indsatser. I denne type samarbejde bør sundhedssektoren sætte fokus på vedligeholdelsen og bæredygtigheden af samarbejdet frem for sundhedsrelaterede målsætninger (Holt, 2016). Denne tilgang er i høj grad i overensstemmelse med grundantagelserne for mental sundhedsfremme – nemlig, at en lang række sektorspecifikke praksisser har stor indflydelse på determinanter for mental sundhed (Barry, 2019b). Arbejdet med mental sundhedsfremme må dog ikke ske på bekostning af varetagelsen af øvrige sektorers kerneopgaver, da dette kan have uhensigtsmæssige effekter. Eksempelvis kan det tænkes at skabe modstand hos frontmedarbejdere og implementeringsaktører, som det for eksempel er set ved implementeringen af andre sundhedsfremmeinterventioner (Hansen et al., 2015). Overordnet peger ovenstående i retning af, at sundhedssektoren bør tilbyde sin ekspertise til øvrige sektorer, hvor den bør nedtone, men ikke undlade, et fokus på mental sundhed (Holt, 2016). En sådan tilgang vil kunne bidrage til opbygning af kapacitet i form af nye praksisser, samarbejder på tværs og styrket awareness, viden og kompetencer relateret til mental sundhedsfremme på tværs af sektorer.

Konklusion

I afhandlingen viser jeg, at mental sundhedsfremme er et komplekst anliggende, der kalder på nytænkning og (gen)overvejelser af, hvordan et fokus på mental sundhed kan inkorporeres i eksisterende praksisser på tværs af sektorer og fagligheder. Det er væsentligt, at samarbejde omkring mental sundhedsfremme er baseret på fælles konceptualiseringer og forståelser af mental sundhed og mental sundhedsfremme. Overordnet set bidrager afhandlingens resultater med viden om og indsigter i følgende:

I. kapacitetsopbygning er relevant for at understøtte udvikling og implementering af praksisser inden for mental sundhedsfremme.

II. aktionslæring bygger på mekanismer, der har potentialet til at opbygge mental sundhedsfremmekapacitet i og på tværs af organisationer.

III. samarbejde på tværs af sektorer ser ud til at styrke den overordnede agenda med at fremme mental sundhed. En grundig forståelse af de involverede roller inden for mental sundhedsfremme er væsentligt for at kunne arbejde systematisk hermed.

Afhandlingen sætter fokus på relationen mellem kapacitetsopbygning og implementeringsprocesser. I afhandlingen viser jeg, at kapacitetsopbygning med fordel kan tænkes ind i arbejdet med at udvikle og implementere initiativer og praksisser, der sigter mod at fremme mental sundhed. Forskning bør undersøge kapacitetsopbygningsinitiativer, som er karakteriseret ved at gøre brug af mekanismerne fra aktionslæring. Herved kan forskningen bidrage med indsigter, som er væsentlige for at kunne udbrede og opskalere kapacitetsopbygningsindsatser.

Den udviklede taksonomi for de roller, som er involveret i mental sundhedsfremme, giver et overblik over væsentlige funktioner, som indgår i tværsektorielle initiativer. Samlet set illustrerer afhandlingens resultater samspillet på tværs af roller, sektorer og fagligheder. Resultaterne præsenterer praksisrelevante indsigter i, hvordan forskellige indsatsområder inden for mental sundhedsfremme kan (og bør) ses som sammenhængende og kan komplimentere hinanden. Evalueringer af tværgående initiativer kan sikre fælles læring på tværs af organisatoriske og faglige grænser. På baggrund heraf foreslår jeg, at forskningen bør undersøge om den udviklede taksonomi kan overføres til andre kontekster og indsatser, og hermed om taksonomien kan bidrage til at skabe et fælles sprog for mental sundhedsfremme på tværs af sektorer. Samlet set er der behov for mere forskning og viden for at forstå

det fulde billede af implementeringsprocesserne og hvordan forskellige typer af initiativer spiller sammen og bidrager til at fremme mental sundhed. Afhandlingens indsigter i kapacitetsopbyggende mekanismer kan med fordel inddrages i planlægning af interventioner og praksisser med fokus på mental sundhedsfremme.

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Appendiks A

Eksempler på interviewguides anvendt til procesevaluering

Interviewguide

Interview med ABC-tovholder

1. site visit

Forskningsspørgsmål:

- *Hvordan opfatter tovholderen ABC for mental sundhed, og hvordan opfatter han/hun sin rolle som lokal tovholder?*
- *Hvordan arbejder de med ABC for mental sundhed i organisationen? Hvilke forhold har betydning for det lokale arbejde med ABC?*
- *Hvordan oplever tovholderen, at indgå i partnerskabet omkring ABC for mental sundhed? Hvilke forhold har betydning for samarbejdet i partnerskabet?*

Intro

- Tak fordi I tager jer tid.
- Præsentation af interviewer: Vi kommer, som I ved, fra Statens Institut for Folkesundhed.
- Formål med interviewet: Vi gennemfører en procesevaluering af den to-årige afprøvningsperiode af ABC for mental sundhed. Hovedfokus er at følge, hvordan ABC bliver taget imod lokalt, hvordan I bruger ABC, hvad det kan bygge oven på, hvad der er svært osv. Vi vil gerne tale med jer om jeres rolle i ABC, hvordan I arbejder med ABC hos jer og hvilke forhold I mener, har betydning for arbejdet. Vi vil også gerne tale med jer om jeres rolle i det store partnerskab omkring ABC og jeres oplevelser med at samarbejde på den måde – herunder hvad I oplever der fungerer godt, og hvad der fungerer mindre godt.
- Selvom vi er en del af ABC for mental sundhed, er vi interesseret i alle tilbagemeldinger og synspunkter – både positive og negative. Det er den eneste måde, vi kan blive klogere på.
- Vi vil gerne optage interviewet, så vi ikke skal skrive alt det I siger ned. Er det ok?

Informeret samtykke

- Præsenteres af interviewer og underskrives af respondenten

Om procesevalueringen

Vi er interesserede i at undersøge, hvordan ABC for mental sundhed – herunder oplysning, oplysningsmateriale, opkvalificering og organisering af netværket – modtages i praksis. Evalueringen har fokus på borgere såvel som partnere i ABC for mental sundhed.

Evalueringen blandt partnerne sker bl.a. gennem halvårlige evalueringsskemaer, observationer ved møder, løbende tilbagemeldinger osv. Som du ved, har vi derudover valgt at følge fire partnere særligt tæt. Det er foruden jer -------------------. Her vil vi så vidt muligt komme på besøg tre gange i løbet af den to-årige periode. Det her er første runde, og udover jer skal vi tale med -------------------- på torsdag d. 9. marts.

SELVE INTERVIEWET GÅR I GANG

HUSK AT **TÆNDE DIKTAFON**!

Introduktion

Allerførst må I gerne fortælle lidt om jer selv:

- Jeres stillingsbetegnelser og primære arbejdsopgaver
- Hvor længe har I været ansat?

Om ABC for mental sundhed

- I skriver i evalueringsrapporten om hvorfor I valgte at gå med i ABC, og at ABC kobles på jeres eksisterende program, -------. Kan I fortælle lidt mere om processen? Hvorfor valgte I ABC og ikke en anden tilgang?
- Hvad opfatter I som formålet med ABC for mental sundhed?
- Hvordan hænger det sammen med arbejdet i --------?
- Hvordan fungerer det at koble ABC med -----------?
- I skriver også i evalueringsrapporten, at det kan være en udfordring kommunikationsmæssigt at arbejde med ABC som en del af ---------. Kan I sætte lidt flere ord på det?
- Er der et behov for ABC? Hvorfor/hvorfor ikke?

Din rolle som ABC tovholder

- I evalueringsrapporten skriver I også, at ikke har en decideret ABC-koordinator. Hvad mener I med det?
- Hvordan vil I beskrive jeres roller i forhold til ABC?

- Forskel/sammenhæng med tidligere/nuværende arbejdsopgaver?
- Hvordan arbejder I konkret med ABC?
- Er der noget I savner I jeres arbejde med ABC?
- Nu tænker I ikke jer selv som deciderede ABC-tovholder. Alligevel vil vi gerne spørge jer, hvilke kompetencer det, efter jeres mening, vil kræve at være ABC-tovholder?
- Har I på det personlige plan taget noget med jer fra ABC?

Fokus og planer

- I har valgt at arbejde med ABC for mental sundhed, som del af ------. Hvad er de konkrete planer for ABC som en del af ------------ den kommende periode?
- Hvordan er I kommet frem til dette fokus?
- I har også arbejdet med --------- og app'en som en del af jeres fokus på mental sundhed. Hvordan går det med det? Bliver app'en brugt?

Organisering

- I skriver i evalueringsrapporten, at I har organiseret arbejdet med ABC i --------- organisering – hvordan fungerer det?
- Hvordan foregår processen med at få udbredt kendskab til ABC internt i jeres organisation? Udover de afholdte møder, hvordan bliver eksempelvis nye medarbejdere klædt på?
- Hvordan klæder I evt. medarbejdere eller frivillige på til at kunne arbejde ud fra ABC?
- Hvilke forhold kan udfordre eller true organiseringen af --------/ABC?

Ledelse

- Hvordan og hvor ofte taler I med ledelsen /styregruppen for ---------- om arbejdet med ABC?
- Oplever I, at der er ledelsesopbakning? Hvordan kommer det til udtryk?
- Har I nogen bud på, hvad der skal til for at få/bevare ledelsens opbakning til arbejdet med ABC?

Kongruens

- Hvordan passer ABC for mental sundhed med jeres almindelige måder at arbejde på?
- Hvordan passer ABC med andre projekter/satsninger/fokusområder?

Ressourcer

- Hvilke ressourcer er der afsat til arbejdet med ABC for mental sundhed?
- Hvordan indgår arbejdet med ABC i eksisterende projekter/satsninger?

Hjemmeside og Facebook

- Kender I til ABC's hjemmeside og Facebook?
- Bruger I det? Hvad skulle der til for, at I ville bruge det?

Næste skridt

- Hvad skal der ske det næste halve år?
- Hvordan kan I udvide og/eller fastholde fokus på ABC?

Partnerskabet omkring ABC for mental sundhed

- Hvordan oplever I det at indgå i det store partnerskab?
- I skriver i evalueringsrapporten, at I har haft kontakt til --------. Kan I fortælle lidt mere om det?
- Har I haft kontakt til eller samarbejdet med nogle af de andre partnere udover netværksmøderne? Eller har I planer om det?
- Gør I brug af de sparringsmuligheder, der er? (Fx Psykiatrifonden til kommunikation, SIF til faglig sparring, CFP til implementering)
- Hvilke forhold tror I er afgørende for, at partnerskabet kan fungere godt?
- I skriver i evalueringsrapporten, at det er vigtigt at ABC tager højde for de vilkår, der rammesætter den kommunale drift. Hvad mener I med det eller hvordan kan ABC tage højde for det?

Afsluttende

- Er der noget vi ikke har været rundt om, som I gerne vil dele med os?
- Andre kommentarer?

Hvis I kommer i tanke om noget, der kunne være relevant for os at vide, må I meget gerne maile eller ringe til os.

Tusind tak for jeres tid!

Interviewguide

Interview med ABC-tovholder

2. site visit

Forskningsspørgsmål:

- *Hvad er status på arbejdet med ABC i den respektive organisation? Hvad har de været særligt optaget af i første del af afprøvningsperioden og hvilke udfordringer har de mødt?*
- *Hvordan arbejder de med ABC for mental sundhed i organisationen? Hvilke forhold har betydning for det lokale arbejde med ABC? Hvordan opfatter tovholderen sin rolle i det lokale arbejde med ABC?*
- *Hvordan oplever tovholderen, at indgå i partnerskabet omkring ABC for mental sundhed? Hvilke forhold har særlig betydning for samarbejdet i partnerskabet?*

Intro

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- Præsentation af interviewer: Vi kommer, som I ved, fra Statens Institut for Folkesundhed.
- Som I allerede ved gennemfører vi en procesevaluering af den to-årige afprøvningsperiode af ABC for mental sundhed. Hovedfokus er at følge, hvordan ABC bliver taget imod lokalt, hvordan I bruger ABC, hvad det kan bygge oven på, hvad der er svært osv. Evalueringen blandt partnerne sker bl.a. gennem halvårlige evalueringsskemaer, observationer ved møder, løbende tilbagemeldinger osv. Som I ved, har vi derudover valgt at følge fire partnere særligt tæt. Det er foruden jer -------------------. Her vil vi så vidt muligt komme på besøg tre gange i løbet af den to-årige periode. Det er her er andet besøg. Vi har talt med medarbejdere fra -----------------, og vi skal også tale med ------------- (chef i --------------------).
- Formål med interviewet: Vi vil gerne tale med jer om status på jeres arbejde med ABC, hvordan I arbejder med ABC hos jer og hvilke forhold I mener, har betydning for arbejdet. Vi vil også gerne tale med jer om jeres rolle i det store partnerskab omkring ABC og jeres oplevelser med at samarbejde på den måde – herunder hvad I oplever der fungerer godt, og hvad der fungerer mindre godt.
- Selvom vi er en del af ABC for mental sundhed, er vi interesseret i alle tilbagemeldinger og synspunkter – både positive og negative. Det er den eneste måde, vi kan blive klogere på.
- Vi vil gerne optage interviewet, så vi ikke skal skrive alt det I siger ned. Er det ok?

Informeret samtykke

- Præsenteres af interviewer og underskrives af respondenterne.

SELVE INTERVIEWET GÅR I GANG

HUSK AT **TÆNDE DIKTAFON**!

Husk at italesætte overskrifter

Introduktion

- Vi kender jer jo godt i forvejen, men vi vil alligevel starte med at spørge jer om, hvad der er jeres primære arbejdsopgaver?

Status

- Nu er vi ca. halvvejs i den to-årige afprøvningsperiode i ABC for mental sundhed, så vi kunne godt tænke os at starte med at høre, hvad I tænker om, hvordan det første år er gået?

- Hvad har I været optaget af/haft fokus på? Nævnt i evalueringsskema:
  - workshop om samskabelse af sundhedspolitik,
  - sundhedsfremmeambassadør uddannelse under ---------,
  - -----------------

- Hvordan fungerer det at koble ------------ og ABC?
  - Giver ABC mening i den sammenhæng? Hvis ja, hvordan?

- Hvilke udfordringer har I mødt i arbejdet med ----------/ABC?

- Oplever I, at der er interesse for -----------/ABC fra medarbejdernes side?
  - Hvordan kommer det til udtryk?

- Oplever I, at der er interesse for -----------/ABC/mental sundhed fra politisk side?
  - Hvordan kommer det til udtryk?

- Har I oplevet, at jeres syn på ABC og jeres syn på arbejdet med ABC har ændret/udviklet sig?
  - Hvis ja, hvordan har det ændret sig eller udviklet sig?

- Vurderer I, at der (stadig) er et behov for ABC?
  - Hvorfor/hvorfor ikke?

Fremtidig fokus og planer

Nu vil vi gerne spørge til jeres fremtidige fokus og planer med ----------/ABC…

- I evalueringsskemaet fortæller I om -----------t. Er det kommet i brug? Hvordan?
- I nævner også kommunens nye sundhedspolitik, hvor de bærende principper fra ------- skal tænkes ind. Hvor langt er I i den proces?
- Har ABC spillet en rolle i hhv. -------------- og tilblivelsen af den nye sundhedspolitik?

- ABC dagen den 10. oktober. Hvad har I af planer? I nævner en ældremesse, fejring af ny sundhedspolitik og kommunikationskampagne.
  - Kan I fortælle lidt mere om det?
  - Hvordan er I kommet frem til dette fokus?

Jeres roller i forhold til ABC og evt. andre væsentlige medarbejdere

Det næste vi gerne vil tale med jer om, er jeres roller i forhold til ABC og evt. andre væsentlige medarbejderes roller…

- I skriver, at I ikke ser jer som deciderede tovholdere på ABC. Hvordan ser I jeres roller i forhold til ABC?

- Når I ser på jeres rolle som ansvarlige for ABC lokalt i -------------, er der så noget I savner ift. jeres arbejde med ABC?

- Har der været nogen situationer eller henvendelser ang. ABC, hvor I har været i tvivl om, hvordan de skulle håndteres?

Organisering

Nu vil vi gerne tale lidt om, hvordan organisering omkring ---------/ABC er her i -----------…

- Hvordan foregår processen med at få udbredt kendskab til -------------/ABC internt i jeres organisation?
  - Er det her i bruger sundhedsfremmeambassadøruddannelsen?

- Hvilke forhold kan udfordre eller true organiseringen af ABC her hos jer?

Ledelse

Næste punkt handler om ledelsens (og evt. politikernes) perspektiv på --------/ABC…

- I skriver, at der er god opbakning til -----------. Hvordan kommer det til udtryk?

- Har I nogen bud på, hvad der skal til for at bevare opbakningen til det fortsatte arbejde med -------------/ABC?

Ressourcer

Vi har også et par spørgsmål om ressourcer – særligt økonomiske ressourcer – i forhold til ABC…

- Hvordan foregår finansieringen af arbejdet med ABC for mental sundhed?
  - Er der afsat ekstra midler til en medarbejder eller særlige ABC-aktiviteter?
  - Eller er det tænkt ind i eksisterende stillinger eller arbejdsopgaver?

- Hvilke ressourcer er der afsat til arbejdet med ABC for mental sundhed?

Hjemmeside og Facebook

- Kender I til ABC's hjemmeside og Facebook?
  - Bruger I det? Deler I opslag fra Facebook?
  - Hvad skulle der til for, at I ville bruge det eller dele (mere)?
  - Er der noget I savner på hjemmesiden eller Facebook?
- Kommunikeres ----------- til borgere? Hvordan?

Partnerskabet omkring ABC for mental sundhed

Her til sidst vil vi gerne spørge til jeres oplevelse af partnerskabet omkring ABC.

- Hvordan oplever I det at indgå i et partnerskab?

- I har skrevet i evalueringsskemaet, at I har samarbejdet med --------------. Hvordan kom det i stand og hvordan gik det?

- Har I haft kontakt til eller samarbejdet med nogle af de andre partnere eller har I planer om det? (Nævner frivillige centeret i evalueringsskema)

- Vi er optaget af at finde en god måde at vidensdele mellem partnerne, så vi kan inspirere hinanden og dele erfaringer. Har I nogen gode erfaringer med vidensdeling?
    - Hvad tænker I om Filkassen?

- Hvilke forhold tænker I er særligt afgørende for, at partnerskabet omkring ABC fungerer godt?

- Hvad tænker I om den fremtidige organisering af ABC?
    - Hvilke organisationer, som ikke er med i det nuværende partnerskab, kunne I forstille jer at samarbejde med?
    - Hvordan kunne et landsdækkende ABC projekt se ud fra jeres perspektiv? Hvad ville jeres rolle være heri?
    - Er der nogen bestemte organisationer, som I ville synes var oplagte at have med i ABC fremadrettet?

- Når afprøvningsperioden slutter om et års tid, skal næste fase af ABC i gang. Ved I om --------- Kommune fortsat ønsker at være en del af ABC?

Afsluttende

- Er der noget vi ikke har været rundt om, som I gerne vil dele med os?
- Andre kommentarer?

Hvis I kommer i tanke om noget, der kunne være relevant for os at vide, må I meget gerne maile eller ringe til os.

Tusind tak for jeres tid!

Interviewguide

Interview med ABC-tovholder + kommunal leder

3. site visit

Forskningsspørgsmål:

- *Hvad er status på arbejdet med ABC i den respektive organisation? Hvad har de været særligt optaget af i første del af afprøvningsperioden og hvilke udfordringer har de mødt?*
- *Hvordan arbejder de med ABC for mental sundhed i organisationen? Hvilke forhold har betydning for det lokale arbejde med ABC? Hvordan opfatter tovholderen sin rolle i det lokale arbejde med ABC?*
- *Hvordan oplever tovholderen, at indgå i partnerskabet omkring ABC for mental sundhed? Hvilke forhold har særlig betydning for samarbejdet i partnerskabet?*

Intro

- Tak fordi I tager jer tid.
- Som I allerede ved gennemfører vi en procesevaluering af den to-årige afprøvningsperiode af ABC for mental sundhed. Hovedfokus er at følge, hvordan ABC bliver taget imod lokalt, hvordan I bruger ABC, hvad det kan bygge oven på, hvad der er svært osv. Evalueringen blandt partnerne sker bl.a. gennem halvårlige evalueringsskemaer, observationer ved møder, løbende tilbagemeldinger osv. Som I ved, har vi derudover valgt at følge fire partnere særligt tæt. Det er foruden jer ------------. Det her er tredje og sidste besøg i indeværende periode.
- Formål med interviewet**: Vi vil gerne tale med jer om status på jeres arbejde med ABC, hvordan I arbejder med ABC hos jer og hvilke forhold I mener, har betydning for arbejdet.** Vi vil også gerne tale med jer om jeres rolle i det store partnerskab omkring ABC og jeres oplevelser med at samarbejde på den måde – **herunder hvad I oplever der fungerer godt, og hvad der fungerer mindre godt.**
- Selvom vi er en del af ABC for mental sundhed, er vi interesseret i alle tilbagemeldinger og synspunkter – både positive og negative. Det er den eneste måde, vi kan blive klogere på.
- Vi vil gerne optage interviewet, så vi ikke skal skrive alt det I siger ned. Er det ok?

Informeret samtykke

- Præsenteres af interviewer og underskrives af respondenterne.

Underskrift af samtykkeerklæring

SELVE INTERVIEWET GÅR I GANG

HUSK AT **TÆNDE DIKTAFON**!

Husk at italesætte overskrifter

Introduktion

- Vi kender jer jo godt i forvejen, men vil I alligevel starte kort at fortæller lidt om, hvad der er jeres primære arbejdsopgaver og roller ift. ABC for mental sundhed?
    - Er der noget der har ændret sig siden sidst vi var her? (september 2017)

Status

- Nu er det ca. et halvt år siden vi sidst var her, så vi kunne godt tænke os at starte med at høre, hvad der er sket siden sidst vi var her ift. arbejdet med ABC for mental sundhed og ----------?
    - Hvad har I særligt været optaget af/haft fokus på?
    - Har indsatsen med --------- og ABC sat sine spor? Hvordan?

I har tidligere nævnt at --------- er et koncept der primært er rettet mod frontmedarbejderne i kommunen, og at ABC for mental sundhed i højere grad var rettet mod borgere.

- Hvilke erfaringer har I gjort jer med denne opdeling?

- Har I oplevet, at jeres syn på ABC og jeres syn på arbejdet med ABC har ændret/udviklet sig?
    - Hvis ja, hvordan har det ændret sig eller udviklet sig?

- Oplever I, at der er interesse for ---------/ABC fra medarbejdernes side?
    - Hvordan kommer det til udtryk?

- Oplever I, at der er interesse for ----------/ABC/mental sundhed fra politisk side?
    - Hvordan kommer det til udtryk?

- Hvilke udfordringer har I mødt i arbejdet med ------------/ABC?
    - Når I ser på jeres rolle som ansvarlige for ABC lokalt i ---------- Kommune, er der så noget I har savnet ift. jeres arbejde med ABC?

- Vurderer I, at der (stadig) er et behov for ABC?
    - Hvorfor/hvorfor ikke?

Fremtidig fokus og planer

Nu vil vi gerne spørge til jeres fremtidige fokus og planer med ----------/ABC…

- Vil i starte med at fortælle hvordan jeres planer for arbejdet med --------- og ABC for mental sundhed ser ud?
    - Hvorvidt bliver ABC en del af ------- ---- fremadrettet?
    - Ønsker I fortsat at være en del af partnerskabet ABC for mental sundhed?
    - Hvordan er I kommet frem hertil? (Hvad ligger til grund for jeres overvejelser/beslutninger?)

- I nævner i sidste evalueringsskema at 5 nye nærmiljøer skal inkluderes i ----------.
    - Hvor langt er I kommet hermed?
    - Bliver personalet fra de nye nærmiljøer uddannet i ABC-konceptet?

Partnerskabet omkring ABC for mental sundhed

Det næste vi vil komme ind på er jeres oplevelse af partnerskabet omkring ABC.

- Hvordan oplever I det at indgå i partnerskabet?

- Hvilke forhold tænker I er særligt afgørende for, at partnerskabet omkring ABC fungerer godt?
    - Hvad skal der til for at et partnerskab som ABC for mental sundhed er interessant for jer at være en del af?

- *Hvad tænker I om den fremtidige organisering af ABC?*
    - *Hvilke organisationer, som ikke er med i det nuværende partnerskab, kunne I forstille jer at samarbejde med?*
    - *Hvordan kunne et landsdækkende ABC projekt se ud fra jeres perspektiv? Hvad ville jeres rolle være heri?*
    - *Er der nogen bestemte organisationer, som I ville synes var oplagte at have med i ABC fremadrettet?*

Konklusioner: læringspunkter fra afprøvningsperioden

Afslutningsvis vil vi gerne tale med jer om jeres overordnede erfaring fra hele afprøvningsperioden.

- Hvis I kigger tilbage på de sidste halvandet år, hvor vi har været i gang med ABC for mental sundhed, hvad er så jeres vigtigste erfaringer eller læringer?
    - Ift. arbejdet lokalt her i --------?
    - Ift. arbejdet i partnerskabet?

- Hvis i har mulighed for at give nye partnere et par gode råd, når de nu skal i gang med ABC for mental sundhed efter sommeren, hvad skulle det så være?

- Hvad er jeres råd/anbefalinger til sekretariatet, eller andre centrale partnere (Fx Psykiatrifonden, CFP), ift. en ny projektperiode?

Afsluttende

- Er der noget vi ikke har været rundt om, som I gerne vil dele med os?
- Andre kommentarer?

Hvis I kommer i tanke om noget, der kunne være relevant for os at vide, må I meget gerne maile eller ringe til os.

Tusind tak for jeres tid!

Appendiks B

Eksempler på observationsguides anvendt under aktioslæringsforløb

Generelle spørgsmål

- Hvad sker der?
- Hvad tænker jeg?
- Hvordan reagerer de på mig?

Det materielle	Fysisk rum, inventar, objekter osv.
Personer	Hvem? Deres relationer?
Adfærd/interaktioner	Hvad de tilstedeværende? Hvem med hvem? Hvem er ikke med? Interaktioner med det materielle? Noget akavet? Brydes stemningen? Hvordan kommunikeres? Hvem taler (ikke)? Interaktion med mig/Vibeke/Hanna/Heidi?

Fokuserede spørgsmål

1	Hvad er deltagerne optaget af?	Specifikke temaer/problemstillinger? Indhold i ALF/ABC? Implementering?
2	Hvordan reagerer deltagerne?	På oplæg? ABC? Øvelser? MSF? Salutogenese? Relevant? Anvendeligt?
3	Hvilke problemstillinger går deltagerne videre med?	
4	Opbygning/forløb af WS1?	Hvilke elementer? Form? Indhold?

Appendiks C

Eksempel på interviewguide anvendt efter aktionslæringsforløb

Interviewguide - deltager ALF

Deltager oplysninger

- Præsenteres af interviewer
- Er det ok at optage interviewet?

Intro

- Tak fordi du vil mødes med mig i dag …
- Interview som en del af PhD med fokus på mental sundhedsfremme og mental sundhedsfremme.
- I interviewet kommer til at kredse om to temaer: 1) Selve aktionslæringsforløbet, dvs. hvordan det udspillede sig, og hvordan du som deltager vurderer forløbet og udbyttet heraf, og 2) mere generelt om mental sundhedsfremme, dvs. hvordan din organisation arbejder med trivsel og mental sundhedsfremme.
- Jeg er interesseret i din personlige perspektiver herpå og dine oplevelser
- Selvom jeg er en del af ABC for mental sundhed, er jeg interesseret i alle tilbagemeldinger og synspunkter – både positive og negative. Det er den eneste måde, vi kan blive klogere på.

<u>SELVE INTERVIEWET GÅR I GANG</u>

<u>HUSK AT **TÆNDE DIKTAFON**!</u>

Interviewspørgsmål

Tema	Interviewspørgsmål
Introduktion af informant (opvarmning)	**Vi har mødt hinanden før.. Men vil du alligevel starte med kort at fortælle kort om dig selv, og hvad dine primære arbejdsopgaver er?** **Hvordan er du kommet til at deltage i aktionslæringsforløbet?** - Interesse for MS, behov for MSF, udpeget af leder/medarbejder …

Oversættelsen af ABC-rammen til praksis	**Kan du kort forklare, hvordan I kom frem til at arbejde med Den gode velkomst/survey undersøgelsen?** - I har nævnt DK's bedste studiemiljø som målsætning. Kan du sætte nogle flere ord på, hvad du forstår herved? - Var der noget særligt der fik jer til at gå den vej? - Synes du personligt, at det er et relevant tiltag/projekt? - Oplever du opbakning til at arbejde med de her tiltag/projekter? (kollegaer, ledere, studerende) **Hvad driver dig til at beskæftige dig med trivsel og mental sundhed og at gå ind i de her projekter?** - frafald, MS, trivsel … **Hvilken rolle spillede ABC-rammen i arbejdet med jeres projekter?** - Hvordan har I brugt ABC-rammen? - Har rammen hjulpet dig/jer? Hvordan? - Er det sandsynligt at du kommer til at bruge ABC-rammen på en eller anden måde i fremtiden? **Hvad er for dig formålet med at anvende ABC-rammen og budskaberne?** - oplyse om hvad man kan gøre for sig selv, for andre, udvikle interventioner… **Hvordan er jeres arbejde blevet påvirket af Corona-situationen?**
Aktionslæring som tilgang	**Hvordan var det at arbejde i jeres aktionslæringsgrupper?** - Strukturen på forløbet, hvor I både mødtes til workshops og imellem workshops? - Hvilken rolle havde du i jeres gruppe? Hvilke rolle havde de andre i gruppen? - Hvordan var det at arbejde sammen med de studerende? - Hvordan var det at arbejde på tværs af udd.? - Er der nogen faldgruber ved at arbejde med den her type forløb? **Hvordan oplevede du faciliteringen af forløbet?** - var materialerne (handleplanskabeloner osv.) brugbare? **Var der noget der var særligt godt ved forløbet?** **Var der noget der fungerede mindre godt?**

<table>
<tr>
<td></td>
<td>I forløbet var der deltagere fra en række forskellige typer organisationer. Er det noget du har tænkt over?
- Har det haft indflydelse på forløbet?
- Hvad har det betydet for dig/din gruppe at ---------- Kommune var med? --------? ----------?
- Er der andre organisationer, der kunne være interessante at inddrage i sådan et forløb?

Hvad tænker du, der er kommet ud af aktionslæringsforløbet?
- Har forløbet sat sine spor på -------? Hos dine kollegaer/studerende? Hvordan?
- Hvad tænker dine kollegaer om projektet?
- Er forandringerne holdbare over længere tid?
- Hvad tager du med dig fra forløbet?
- viden, kompetencer, motivation og resurser, samarbejdsrelationer, praksisændringer?
- Hvad er det vigtigste du tager med dig fra forløbet?</td>
</tr>
<tr>
<td>Kapacitet til at arbejde med MSF</td>
<td>Hvad tænker du, er de væsentligste faktorer for at vedligeholde/øge de studerendes trivsel?
- Hvem har ansvaret for at sikre trivslen blandt de studerende på ------?
- Hvilken rolle har du som underviser i dette arbejde?

Hvilke organisatoriske strukturer/foranstaltninger har I her på -------, som kan være med til at sikre (eller sætte fokus på) de studerendes trivsel?

Hvilken rolle har du som underviser i dette arbejde med at sikre/fremme trivsel/MS?
- Hvad tænker du der skal til for at engagere medarbejdere i dette arbejde?

Hvilken rolle spiller de studerende i dette arbejde med at sikre/fremme trivsel/MS?
- Hvad tænker du der skal til for at engagere studerende i dette arbejde?

Er der ledelsesopbakning til at sætte fokus på og arbejde med de studerendes mentale sundhed?
- Har du drøftet projektet med dine ledere? Har du indtryk af, hvad de tænker herom?
- Hvordan kommer det til udtryk?</td>
</tr>
</table>

	- Hvad er deres interesse/motivation herfor? **Har I samarbejde med eksterne organisationer/partnere omkring arbejdet med de studerendes trivsel?** - Hvem? Hvordan? **Hvad ser du som de største udfordringer ift. at fremme/arbejde med de studerendes trivsel?** **Har det her ALF været med til at klæde dig og de andre fra din gruppe bedre på til fremover at arbejde med trivsel?** - Er der noget der har været særligt relevant/brugbart for dig? - viden, kompetencer, motivation og resurser, samarbejdsrelationer, praksisændringer? **Føler du, at I ved hvad de næste skridt er for jeres projekter?**
Forslag til forbedringer	**Kunne du forestille dig at deltage i et lignende forløb i fremtiden?** **Har du forslag til hvordan sådan et forløb i højere grad kan klæde dig (og din organisation) på til at arbejde med mental sundhedsfremme? Og skabe vedvarende forandringer?** - Indhold, viden, metoder, strukturen af forløbet, tidshorisonten, sammensætning af deltagere …

Afsluttende

- Er der noget vi ikke har været rundt om, som du gerne vil dele med mig?
- Andre kommentarer?

Hvis du kommer i tanke om noget, der kunne være relevant for mig at vide, er du velkommen til at kontakte mig.

Tusind tak for din tid!

Appendiks D

Eksempel på interviewguide anvendt til telfoninterview under aktionslæringsforløbet

Interviewguide – telefoninterview april 2020

Intro

Hvorfor dette opkald?

- Vi skal planlægge den sidste workshop
- Ser ud til, at der er for mange usikkerheder forbundet med at regne med at vi kan gennemføre den 13. maj som planlagt.
- Derfor overvejer vi alternativer, måske rykke den til juni eller køre den online..
- For at kunne finde den løsning der passer bedst for de fleste af jer deltagere, er jeg interesseret i at høre, hvad status er hos jer.

Spørgsmål

- Hvilke konsekvenser har covid-19 for jer? (nedlukninger, arbejde hjemme, online undervisning osv.)

- Hvordan påvirker det jeres arbejde i aktionslæringsgruppen?
  - Hvor langt er I nået med jeres målsætninger, som I har sat op?
  - Se skema over aktiviteter og målsætninger i dataindsamlingsprotokol
  - Hvad er ikke blevet til noget?

- Ville det give mening for jer at mødes til en afsluttende workshop inden sommerferien?
  - Oprindeligt var formålet med den sidste workshop at følge op på forløbet og jeres aktiviteter, og tale om forankring/videreudvikling. Er det relevant for jer?
  - interviews

<u>Eksempel på interviewguide – Telefoninterview 6 måneder efter aktionslæringsforløbet</u>

Interviewguide Telefon/skype-interview

Informanter: én tovholder fra hver aktionslæringsgruppe (5 i alt)

Anslået varighed: 15-30 min

Formål: at indsamle viden om, hvorvidt der i andet halvår 2020 er gennemført (planlagt) aktiviteter, tiltag og praksisændringer, som et resultat af eller relateret til deltagelsen i ALF.

Introduktion

- Tak fordi du vil mødes med mig i dag …
- Interview som en del af PhD med fokus på mental sundhedsfremme og hvordan vi kan bruge aktionslæring som tilgang hertil.

- Jeg er interesseret i at undersøge, hvilke spor eller aftryk aktionslæringsforløbet har efterladt i jeres organisation. I interviewet her i dag er jeg særligt interesseret i at høre om konkrete aktiviteter, tiltag eller praksisændringer, der direkte er et resultat af aktionslæringsforløbet, eller på anden vis er relateret til forløbet.
- Jeg kommer altså til at spørge ind til 1) Hvordan det er gået/går med de aktiviteter og tiltag som I har planlagt under selve ALF. Og 2) om forløbet på andre måder har sat sine spor hos jer..
- Jeg er interesseret i dine personlige perspektiver herpå
- Som jeg også har sagt før, er jeg interesseret i alle tilbagemeldinger og synspunkter – både positive og negative. Det er den eneste måde, vi kan blive klogere på.

- Er det ok at optage interviewet?

Spørgeguide

Tema	Spørgsmål	Noter
Status på aktiviteter planlagt under ALF	**Til at starte med vil jeg gerne spørge ind til de aktiviteter og tiltag, som blev planlagt under aktionslæringsforløbet (dvs. før sommeren).** 1. Workshop for studerende 2. Workshop for undervisere 3. Undervisningsmodul om mental sundhedsfremme 4. Implementering af ABC-ramme som grundværdi for studierådets trivselsarbejde (--- og --- projekt)	

	- Gentages disse? - Hvorfor blev de ikke til noget? - Sparring med ----- ?	
Øvrige aktiviteter/tiltag affødt af ALF (udført/planlagt)	**Udover de aktiviteter/tiltag vi har været inde på, har aktionslæringsforløbet så ført til konkrete aktiviteter, tiltag eller ændringer i jeres organisation?** - Det kan både være noget, som er ført ud i livet eller som pt bare er planlagt. - Gentages disse?	
Øvrig outcome af ALF	**Det at I har deltaget i aktionslæringsforløbet, har det ellers sat sine spor på ------?** - Hos dine kollegaer - Ledelsen? - Studerende? - Dig personligt?	
Evt.		

Afrunding

- Er der noget vi ikke har været omkring, som du gerne vil dele med mig?

Hvis du kommer i tanke om noget, der kunne være relevant for mig at vide, er du velkommen til at kontakte mig.

Tusind tak for din tid!

Appendiks E

Eksempel på deltageroplysning – brugt i forbindelse med aktionslæringsforløb

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Statens Institut for Folkesundhed

Oplysning om deltagelse i aktionslæringsforløb

I forbindelse med aktionslæringsforløbet omhandlende mental sundhed og trivsel, der forløber fra september 2019 til maj 2020, indsamles data til følgeforskning, bl.a. et Ph.d.-projekt. Dataindsamlingen gennemføres af forskere fra Statens Institut for folkesundhed, SDU. I det følgende kan du læse nærmere om, hvilke data der indsamles og hvordan disse anvendes.

Formål
Formålet med følgeforskningen er at undersøge, hvordan og med hvilket udbytte aktionslæring anvendes til at facilitere oversættelsen af ABC-rammen til konkret praksis blandt de deltagende organisationer. Desuden undersøges, hvordan aktionslæring og arbejdet med ABC-rammen påvirker deltagernes og de deltagende organisationers kapacitet til at arbejde med mental sundhedsfremme.

Data indsamles på følgende måder:

- Spørgeskemaer. Invitationer hertil udsendes via mail
- Observationer til de fire workshops, som afholdes i forbindelse med aktionslæringsforløbet
- Indsamling af skriftlige materialer, som udarbejdes i forbindelse med aktionslæringsforløbet
- Interviews og fokusgruppeinterviews med deltagere fra aktionslæringsforløbet

Sådan bruger vi oplysningerne
Det er kun forskere fra Syddansk Universitet som har adgang til de indsamlede data og personoplysninger behandles fortroligt - i overensstemmelse med gældende ret. Oplysningerne vil kun blive brugt til forskning og formidling af forskningsresultater. Vi sørger for at opbevare data sikkert, så det kun er relevante forskere fra Statens Institut for Folkesundhed, der har adgang til dem. Oplysningerne bliver gemt så længe, de er relevante for projektet. Herefter vil de blive slettet – dette sker senest den 31.12.2023. Syddansk Universitet er ansvarlig for beskyttelsen af de indsamlede data.

Deltagelse i forskningsprojekt
Når der skal bruges personoplysninger til forskningsprojekter, er der nogle særlige bestemmelser i lovgivningen, som giver mulighed for at indsamle og bruge personoplysninger uden at indsamle samtykke fra deltageren. Den findes i databeskyttelseslovens § 10 og databeskyttelsesforordningens art. 6, stk. 1, litra e.

Bestemmelsen giver os lov til at bruge dine personoplysninger til forskning uden dit samtykke, men forbyder også, at bruge oplysningerne til andre formål end forskning og statistik. Du risikerer derfor ikke, at dine oplysninger vil blive brugt til andre formål.

Databeskyttelseslovens § 10 og databeskyttelsesforordningens art. 6, stk. 1, litra e giver også mulighed for, at vi kan anvende oplysningerne i andre delprojekter. Du vil modtage information, hvis dette sker.

Ved at deltage i aktionslæringsforløbet, indvilliger du i, at vi må indsamle oplysninger, som nævnt ovenfor, og anvende dem i følgeforskningen. Skulle du, på et tidspunkt i forløbet, ikke længere have lyst til at deltage, kan du give os besked herom – se nedenstående kontaktoplysninger. Sker dette, vil vi ikke længere indsamle nye oplysninger om dig, men vi har fortsat lov til at bruge de oplysninger, vi allerede har fået.

Yderligere information
Hvis du har spørgsmål til undersøgelsen kan du kontakte Carsten Hinrichsen på tlf. +45 6550 7837 eller cahi@si-folkesundhed.dk.

Hvis du har spørgsmål omkring databeskyttelse og dine rettigheder kan du kontakte vores databeskyttelsesrådgiver, Simon Kamber på tlf. 6550 3906 eller dpo@sdu.dk. Ønsker du at klage over behandlingen af personoplysninger kan du gøre det hos Datatilsynet på www.datatilsynet.dk.

Artikel 1

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MDPI

Article

Implementing Mental Health Promotion Initiatives—Process Evaluation of the ABCs of Mental Health in Denmark

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Abstract: Treatment and prevention alone are unlikely to make a significant difference in reducing the burden of poor mental health and mental illness. Therefore, mental health promotion (MHP) initiatives are advocated. In 2014, the ABCs of mental health (ABCs) partnership was established in Denmark; in the partnership, partner organisations, e.g., municipalities and NGOs, use a research-based framework for MHP, the ABC-framework, to develop and implement MHP initiatives. This paper has two aims: (1) to outline the overall characteristics of these MHP initiatives; and (2) to explore local coordinator and stakeholder perceptions of the implementation processes and the impact of the MHP initiatives. Questionnaire surveys, individual interviews and group interviews were conducted during 2017–2020. The MHP initiatives were grouped according to three strategies: building MHP capacity, campaign activities to promote mental health awareness and knowledge and establishing and promoting opportunities to engage in mentally healthy activities. The ABC-framework was positively received and viewed as providing relevant knowledge for working with MHP as well as fostering intersectoral and interprofessional collaborations. However, using a bottom-up approach to develop and implement MHP initiatives can be time-consuming and resource demanding, and it requires a deliberate balancing of local adaptability and concrete guidance when engaging stakeholders and implementers. Overall, using the ABC-framework to develop and implement MHP initiatives holds great promise for advancing and promoting MHP practice.

Keywords: mental health promotion; well-being; salutogenesis; implementation; partnership; process evaluation; mixed methods

1. Background

Mental health problems constitute one of the major global burdens of disease with wide ranging negative consequences at the individual, community and societal level [1–5]. Within the World Health Organization (WHO) and The European Commission and among international researchers from the fields of public health, psychology and psychiatry, there is a growing recognition that targeted prevention and treatment alone are unlikely to make a significant difference in reducing the burden of disease caused by poor mental health. They argue that there is a need for promoting public mental health through effective mental health promoting initiatives [6–8].

The WHO defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is

able to make a contribution to his or her community" [4]. Thus, mental health is more than the absence of mental illness and comprises terms such as well-being and resilience [6,9]. In this paper, MHP is conceptualised as "any action taken to maximise mental health and well-being among populations and individuals that focuses on improving social, physical and economic environments that affect mental health, and enhancing the coping capacity of communities as well as individuals." [10]. The focus of MHP is on strengthening and promoting resources and protective factors for mental health, as opposed to prevention where the focus is on reducing risk factors for mental ill health—i.e., "what can be done to keep people healthy or to become even healthier?", rather than "what can be done to avoid illness?" [6]. Thus, MHP is relevant to the whole population regardless of age or physical and mental states of health [6,11].

Key determinants of mental health are found in the settings of everyday life [11]. This implies that MHP is not only a concern for professionals within the healthcare sector (e.g., hospitals and general practice) but is relevant for a wide range of professions. MHP initiatives cover activities operating at the individual, organisational and community level, and they can be categorised as universal (addressing the whole population), selected (targeting subgroups) or indicated (targeting individuals) [6,11]. Universal initiatives drawing on intersectoral and interprofessional approaches are highlighted as promising to achieve effective and sustainable MHP initiatives [8,11–13]. Intersectoral and interprofessional collaborations should aim for synergistic impacts and outcomes by mobilising, utilising and sustaining resources contributing positively to MHP [12]. In terms of the determinants that should be targeted within MHP, there is general agreement for the need to improve mental health knowledge and awareness in the general population, public sector and private sector and to provide and promote opportunities for individuals to engage in mentally healthy behaviours [6,10,11].

In Denmark, municipalities are accountable by law to initiate health promoting efforts for their citizens [14]. According to the Danish Ministry of Health, this also includes MHP efforts and these should be designed and implemented within local settings in everyday contexts, such as family settings, day care centres, schools and workplaces [15]. However, two national studies on MHP activities in the Danish municipalities, from 2013 and 2015, indicate a lack of MHP capacity, e.g., knowledge and competencies among service-providers, resulting in little action [16,17].

In 2014, the Danish intersectoral partnership of the ABCs of mental health was founded [9]. The overall aim of the partnership is to promote public mental health in Denmark by bridging the gap between international recommendations, research, policy and practice related to MHP. The partner organisations develop and initiate MHP initiatives within their local settings based on a research-based framework for understanding and working with MHP: the ABC-framework. The ABC-framework was designed to not only reduce the complexity surrounding the concept of mental health for the population at large but also to provide service-providers, health professionals and volunteers with a practical framework for practicing MHP.

The aim of this paper is two-fold. First, we outline the overall characteristics of the MHP initiatives that are based on the ABC-framework and developed and implemented by partner organisations of the ABCs partnership. Secondly, we explore local coordinator and stakeholder perceptions of the implementation processes and the impact of these MHP initiatives. The findings of this paper add to the scarce practice-oriented and research-based literature on translating widely advocated recommendations of applying universal, intersectoral and interprofessional strategies for MHP.

1.1. *The ABCs of Mental Health*

1.1.1. Origin of the ABCs of Mental Health

The ABCs in Denmark is inspired by the Australian MHP campaign Act–Belong–Commit which was adapted to a Danish context by researchers at the National Institute of Public Health (NIPH), University of Southern Denmark [9]. The ABCs is based on the idea of promoting mental health through guidance on what makes people mentally healthy, similar to health promotion and prevention

efforts related to other health topics, e.g., alcohol, tobacco and physical activity [10]. This information is compiled and communicated as a feasible and actionable framework for MHP practice: the ABC-framework. The framework is centred around three domains Act, Belong and Commit:

> *"'Act' means that individuals should strive to keep themselves physically, socially and cognitively active. [...]*
>
> *'Belong' refers to being a member of a group or organisation (whether face-to-face or not), such that an individual's connectedness with the community and sense of identity are strengthened. [...]*
>
> *'Commit' refers to the extent to which an individual becomes involved with (or commits to) some activity or organisation. Commitment provides a sense of purpose and meaning in people's lives."* [10]

The three domains are derived from primary research on lay peoples understandings of mental health promoting behaviour and reviewing the scientific literature [10]. Recent longitudinal population-based studies have demonstrated the mental health promoting effects of the factors pertaining to these domains have [18–20].

The ABC-framework builds on a salutogenic rather than a pathogenic orientation and is therefore in line with the aforementioned definition of MHP. In short, the focus is on factors that support human health and well-being rather than on factors that cause disease (for more on salutogenisis, see [21]). In the process of adapting the campaign to the Danish context, the three domains were transformed into a slogan of three action-oriented messages: *do something active, do something with someone, do something meaningful* (in Danish: "*Gør noget aktivt, gør noget sammen, gør noget meningsfuldt*") [22].

1.1.2. Organisation of the ABCs of Mental Health

Starting with five partner organisations in 2014, the ABCs partnership has continuously expanded and currently counts more than 46 partner organisations. Further details on partnership expansion are shown in Figure 1. Partner organisations are both public and private organisations; at the time of the latest data collection, there are 25 municipalities, 11 NGOs, 4 unions and 6 other types of organisations.

Based on a bottom-up, community development approach, most partner organisations develop and implement MHP initiatives aiming "*to influence individual behaviour and create supportive environments for fostering and maintaining mental health*" [9]. The bottom-up approach implies that the partner organisations are not provided with exact implementation protocols or standardised manuals. To support this work, some partner organisations receive funding from the ABCs partnership to contribute with specific services to the partnership [22]. Researchers at the NIPH lead and coordinate the partnership and conduct research relevant to the work with MHP in the partnership including a formative process evaluation. The Danish Mental Health Foundation (DMHF) (*Psykiatrifonden*) is responsible for developing and coordinating campaign activities. In addition, the DMHF provides support for adapting campaign materials to local settings and offers communication workshops. The Centre of Prevention in Praxis (CPP) (*Center for Forebyggelse i Praksis*), under KL-Local Government Denmark, provides implementation support and counselling to all municipalities in the partnership. The Healthy Cities Network (*Sund By Netværket*) ensures dissemination of knowledge to municipalities in their network. Together, the Danish Sports Association (DGI) (*Danske Gymnastik-og Idrætsforeninger*), the Danish Scouts Association (*Det Danske Spejderkorps*), the NIPH and the CPP provide training for frontline personnel and volunteers in MHP and the translation of the ABC-framework into local MHP initiatives.

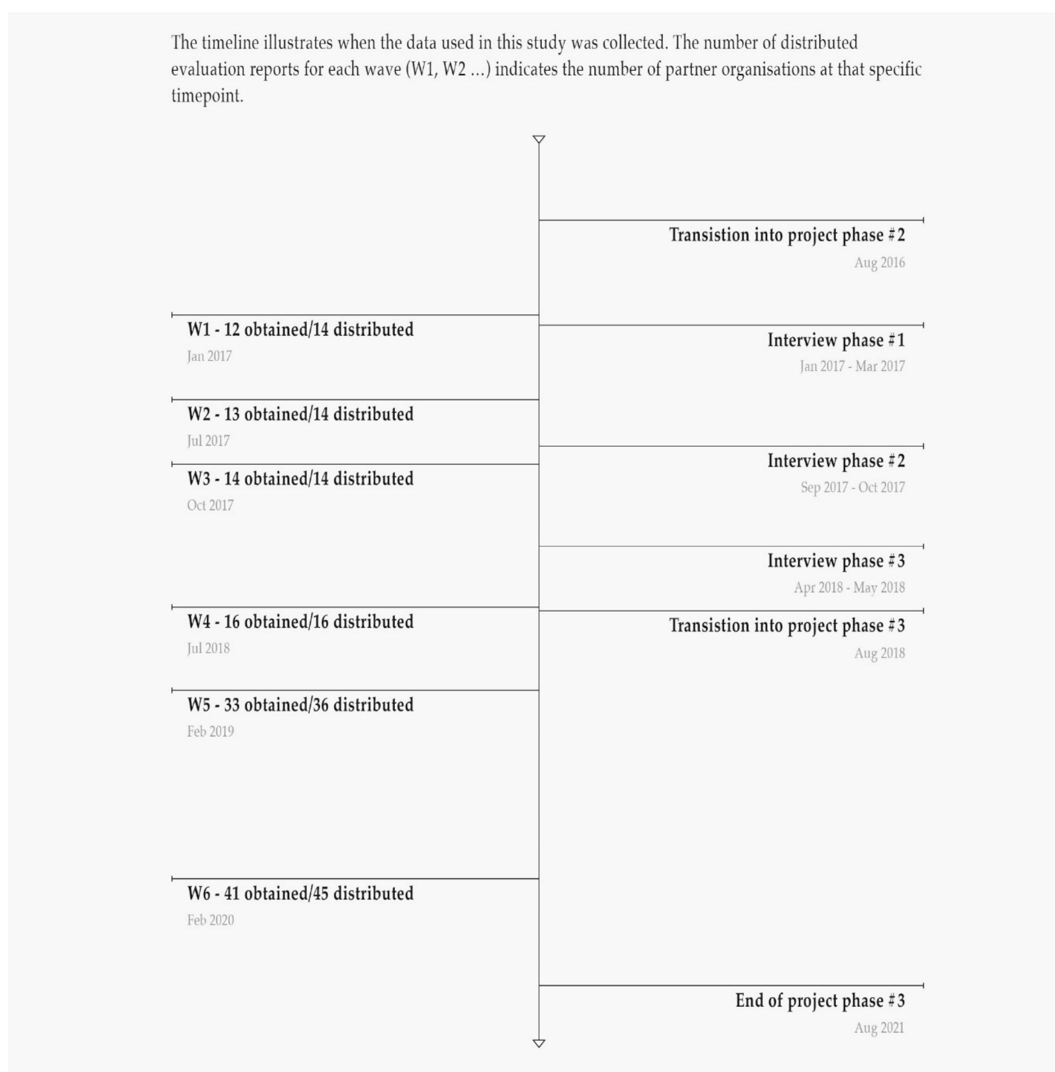

Figure 1. Date collection timeline.

Each partner organisation has at least one local coordinator (ABC-coordinator). Besides coordinating the development and implementation of ABC-initiatives at a local level, the ABC-coordinators also act as links between the partnership and their own organisations. For the purpose of networking and knowledge exchange, the ABC-coordinators are invited to partnership network meetings four times a year and to use an online platform for internal file sharing, accessible to all ABC partners. Coordinated by the NIPH, the form and content of the network meetings are based on the needs and requests expressed by the ABC-coordinators. The network meetings are also used for presenting and discussing findings of the process evaluation to stimulate and facilitate further development of the partnership and MHP initiatives initiated by the partner organisations.

The ABCs partnership has been granted funding for three project phases: 2014–2016, 2016–2018 and 2018–2021. Further information on the background and organisation of the ABCs can be found elsewhere [9,10,18–20,22,23].

2. Methods

2.1. Study Design

This paper draws on mixed method data from the formative process evaluation of the ABCs. The aim of the process evaluation is to document and guide the implementation of local MHP

initiatives among partner organisations. The process evaluation was initiated in 2016 and is ongoing. Study participants are ABC-coordinators and their superiors from the partner organisations. Data were collected through evaluation questionnaires consisting of a qualitative and quantitative part, semi-structured individual interviews and semi-structured group interviews. Data were collected at multiple time points from January 2017 to February 2020. A data collection timeline is presented in Figure 1.

2.2. Ethics

All participants were informed orally and in writing about the purpose of the process evaluation, that participation was voluntary and that they had the possibility to withdraw their statements at any time before the publication of the results. Written consent was obtained from all interviewees. The formative process evaluation received institutional ethical approval from the University of Southern Denmark (The formative process evaluation received institutional ethical approval from the University of Southern Denmark, No. 10.621, date of approval Dec 1st 2015 (renewed Aug 15th 2019)) and conducted in compliance with The General Data Protection Regulation and the principles of the Helsinki Declaration [24].

2.3. Evaluation Questionnaires

Over six waves (W1–W6), 141 questionnaires were sent out and 128 returned (response rate = 91%) (see details in Figure 1). At each wave, the local ABC-coordinators were asked to complete one questionnaire, possibly in collaboration with key stakeholders (e.g., from higher management levels). The questionnaires covered the following topics: motivation for joining the network and history of participation; local organisation and dissemination; collaboration with other partners and local collaborations; development of new materials and activities; facilitators and positive experiences using the ABC-framework; obstacles and barriers; and recommendations to other partners.

The latest questionnaire, W6, consisted of additional items measuring the perceived impact of working with the ABCs. These items, 14 in total, were developed and tested by researchers at the NIPH for the purpose of evaluating the ABCs (Table 1). Of all items, 13 were statements which the respondents were asked to rate on a five-point Likert scale. Five of these items pertained to the individual level and eight items to the organisational level. Further, a categorical item was used to assess perceived impact at the individual level.

Table 1. Survey items to measure perceived impact used at W6.

Item	Variable	Questionnaire Item	Response Category
Individual level			
1.1	Overall benefit	Participation in the ABC partnership has been beneficial for me as an employee.	1 = Fully disagree, 2 = Partly disagree, 3 = Neither agree nor disagree, 4 = Partly agree, 5 = Fully agree, 0 = Not relevant
1.2	Knowledge about MHP	Through the ABCs of mental health, I have gained knowledge about what to focus on if I want to work with mental health and mental health promotion.	
1.3	Awareness of relationship between MHP and professional tasks	My knowledge about the ABCs of mental health has made me reflect on how mental health and mental health promotion is related to my work.	
1.4	Increased awareness, personal mental health (mind-set)	My knowledge about the ABCs of mental health has made me think more about my own mental health.	
1.5	Behaviour change, personal mental health	My knowledge about the ABCs of mental health has made me actively do something for my personal mental health.	
1.6	Behaviour change, talking about the ABCs	I have talked about the ABCs of mental health with . . . (multiple answers allowed)	a) Colleagues, b) Collaborators from other organisations, c) Friends, d) Family, e) Others, f) None

Table 1. *Cont.*

Item	Variable	Questionnaire Item	Response Category
Organisational level			
2.1	Overall benefit	It has been beneficial for my organisation to be a partner in the ABC partnership.	1 = Fully disagree, 2 = Partly disagree, 3 = Neither agree nor disagree, 4 = Partly agree, 5 = Fully agree, 0 = Not relevant
2.2	Relevant framework for MHP	The ABCs of mental health offers a relevant framework for understanding and working with mental health promotion in my organisation.	
2.3	Mutual language for external collaboration	Through the ABCs of mental health, we have obtained a mutual language for mental health which makes it easier to collaborate on mental health promotion initiatives with external collaborators.	
2.4	Mutual language for internal collaboration	Through the ABCs of mental health, we have obtained a mutual language for mental health which makes it easier to collaborate on mental health promotion initiatives within my organisation.	
2.5	Usage of ABC-framework by employees/volunteers	The ABCs of mental health is being used by employees/volunteers in my organisation.	
2.6	Increased focus on MHP	The work with the ABCs of mental health has sharpened our focus on protective factors and positive aspects of mental health.	
2.7	Initiation of new initiatives	In my organisation, we have initiated new activities or initiatives which would not have been developed without being involved in or knowing about the ABCs of mental health.	
2.8	Modifications and changes in existing initiatives	Knowing about the ABCs of mental health has resulted in changes in the focus or aim of existing activities in my organisation.	

2.4. Interviews

Five semi-structured individual interviews and 12 semi-structured group interviews were conducted. Interviewees were local ABC-coordinators (consultants and one student assistant) and their superiors (municipal heads of department, secretariat director and secretary-general) from two municipalities, one NGO and one union. These four organisations were purposefully chosen [25] with the aim of including organisations working with the ABC-framework in diverse ways. Interviews were

conducted at the participants' workplaces at three time points (see Figure 1). In total, 15 individuals were interviewed. Most of the interviewees were re-interviewed once or twice. However, due to staff turnover, some interviewees were only interviewed once. Through the interviews, we gathered in depth information on participants' perceptions on the following topics: the organisation's role in the partnership; motivation and history of participation; local organisation and dissemination; experiences with local ABC-initiatives; planned ABC-initiatives; campaign congruence with existing objectives and activities; satisfaction with being part of the partnership; and creating sustainable MHP initiatives. The interview data supplemented the questionnaires by generating more in-depth information on participants' experiences and perceptions.

The interviews were audio recorded. A summary of each interview was written using a literary style [26] with the purpose of condensing the data material but holding on to the overall meaning of the interview content. Based on preliminary findings of the analyses, some passages were transcribed verbatim allowing extraction of passages and citations used for further analyses and reporting the findings. The transcripts and this paper were de-identified, i.e., names of people and places were changed, to prevent participants identity to be revealed.

2.5. Analyses

To describe the overall characteristics of the MHP initiatives among partners, data from the questionnaires were thematically analysed [27]. First, MHP initiatives were identified in the data. Secondly, to illustrate and provide an overview of the characteristics of the MHP initiatives under investigation, clusters of MHP initiatives were discussed among co-authors and underwent several iterations. The initiatives were grouped according to three strategies for MHP: (1) building capacity to work with MHP; (2) campaign activities to promote mental health awareness and knowledge; and (3) establishing and promoting opportunities to engage in mentally healthy activities.

To describe local coordinator and stakeholder perceptions of the implementation processes and the impact of the MHP initiatives, a thematic analysis was conducted on the qualitative data. For this purpose, the six steps of conducting template analysis described by Brooks et al. were followed [28]. The Consolidated Framework For Implementation Research (CFIR) [29] was used as a theoretical framework to guide this analysis. The CFIR is a pragmatic meta-theoretical framework, presenting key factors and mechanisms that are of potential importance to implementation processes [29]. The framework can be used to guide formative evaluations and guide post-implementation explorations of implementation processes [29]. The five major themes of the CFIR were applied as a priori themes: characteristics of individuals, characteristics of the intervention, process, inner setting and outer setting [29]. In the analytical process, the authors experimented with clusters of subthemes within each theme to compare, contrast and link the content of each theme. To increase the validity of the qualitative findings, respondent validation [30] was performed by discussing preliminary findings with ABC-coordinators at network meetings. The software NVivo 12 (QSR International) was used for managing the qualitative data and assisting analytical processes.

The coordinator and stakeholder perception of the impact of the ABCs was also analysed through descriptive statistics of the quantitative data from W6. In total, 45 questionnaires were sent out and 41 were returned. One respondent only completed the qualitative part of the questionnaire. Thus, the quantitative results are based on data from 40 respondents (response rate = 89%). Frequencies are reported in Section 3.3. Microsoft Excel was used for the quantitative analysis.

3. Findings

The findings are presented in three parts. First, we outline the overall characteristics of the MHP initiatives that are based on the ABC-framework and developed and implemented by ABC partners. Next, we use the five themes of the CFIR to structure the presentation of local coordinator and stakeholder perceptions of the implementation processes and the impact of these MHP initiatives. Finally, we present the findings of the quantitative analyses of the perceived impact.

3.1. Overall Characteristics of the MHP Initiatives—Three Strategies

The MHP initiatives developed and implemented by the partners in the ABCs partnership all shared the same overall goal of promoting mental health. They differed on other aspects such as short term aims, i.e., targeted determinants of mental health and the level of intervention (e.g., on an individual, organisational and community level) and the target population (e.g., end-users, i.e., the persons who's mental health is targeted and service providers). The initiatives were grouped according to three different strategies:

1. building capacity to work with MHP (e.g., by providing staff training and promoting intersectoral and interprofessional collaboration);
2. campaign activities to promote mental health awareness and knowledge (e.g., online advertisements and campaign events); and
3. establishing and promoting opportunities to engage in mentally healthy activities (e.g., volunteer led walking groups and community kitchens).

The division between the three strategies is not clear-cut and they sometimes overlap because the initiatives build upon each other. For example, capacity building efforts at an organisational level were often followed by campaign activities and establishing and promoting opportunities for end-users to engage in mentally healthy activities. However, the categorisation into three strategies is a means of illustrating and providing an overview of the characteristics of the MHP initiatives under investigation.

3.1.1. Building MHP Capacity

Building MHP capacity constituted a major part of the partners' activities. The capacity building efforts generally aimed to increase knowledge about MHP and to improve relevant organisational structures, e.g., through the training of employees and volunteers and creating local and national intersectoral and interprofessional collaborations. Participants viewed building MHP capacity as a step towards improving and promoting MHP practices, e.g., by enabling and encouraging service providers and volunteers to create and promote mentally healthy activities and environments. Training programs targeting different groups (e.g., employees in municipalities and volunteers in NGOs) were developed, tested and refined by single partner organisations or in collaboration between several partner organisations including the NIPH. The training programs were primarily designed as one-day workshops focusing on how mental health and MHP is conceptualised within the ABC-framework; how the framework can be translated into locally adapted MHP practices and activities; and health communication skills. Figure 2 presents an example of a workshop focusing on capacity building. The partnership network meetings and an online platform for internal file sharing, accessible for all ABC partners, were used for sharing knowledge, e.g., materials and exercises for training purposes and experiences working with the ABC-framework.

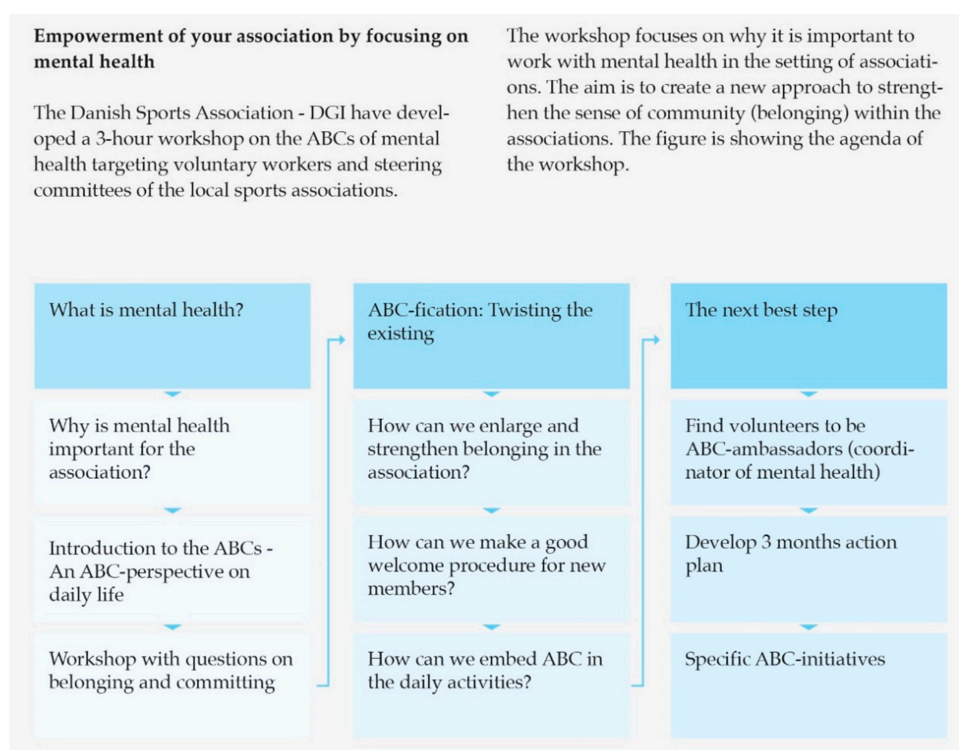

Figure 2. Example of capacity building activity.

3.1.2. Campaign Activities

The second group of MHP initiatives represent various forms of campaign activities developed and/or adopted and executed by the partner organisations. These aimed at increasing mental health awareness and knowledge about how to sustain and promote the mental health of oneself and others. The three domains of the ABC-framework were used as a foundation for developing the campaign activities. In line with the salutogenic approach of the ABC-framework, the campaign activities applied positive appeals, e.g., highlighting the benefits of specific behaviours such as taking up an old hobby using a humoristic approach. Campaign materials were developed by individual partner organisations or in collaboration within the partnership and supported by the DMHF. Figure 3 presents an example of a campaign activity. Campaign materials included print and video advertisements, information leaflets, games and merchandise such as T-shirts, paper fortunes, conversation guides and umbrellas. The channels and settings of communication used for the campaign varied, e.g., social media, newspapers, webpages of the partner organisations, educational institutions and externally initialised events such as music festivals and fitness events. The campaign activities varied in terms of whether they targeted the general population or specific groups, e.g., children in primary schools or adolescents at university colleges.

A for Australian football, B for baby swimming, C for camping etc. The vision of the campaign "ABC's ABC" is to give inspiration and examples of how to act, belong and commit. In the end, the campaign reads: "What makes you happy? Get inspired with ABC's ABC". The campaign consists of a movie and a graphic for each letter of the alphabet. There is also a poster (detail of poster shown below), a leaflet and a postcard with all the letters together and the text "What makes you happy?" in addition to more information about the ABC's for mental health.

ABC's ABC was used on the communication channels of the ABC's partnership, such as Facebook, Instagram, website and in newsletters. In addition, the campaign was made available for use for partner organisations. They used both digital and print materials. Several of the materials were also adapted and versioned with local activities where letters and graphics point directly to specific, local activities.

The campaign is still used by partner organisations. It serves as a framework for communicating about activities and communities in a broad way that can be translated into many different contexts.

Figure 3. Example of campaign activity: ABC's ABC.

3.1.3. Mentally Healthy Activities

The MHP initiatives pertaining to the third strategy aimed at establishing and promoting opportunities for end-users to engage in mentally healthy activities. These initiatives were often outcomes of capacity building efforts, as described above. Activities were characterised as being mentally healthy if they were in line with the ABC-messages. For example, several partner organisations arranged community kitchens aimed at engaging and fostering a sense of belonging among community members. In addition, partner organisations used the ABC-framework as a theoretical lens to examine existing activities and services and adjust or refine practices where relevant. This method was labelled "*ABC-fication*" among some partners and was used to boost aspects related to one or more of the three domains within an existing activity or service. For example, several partner organisations increased their efforts in promoting inclusive environments and a sense of belonging among their target groups within existing community activities (for an example, see Figure 4).

Walking for happiness

"Walking for happiness" originates from The Danish Ramblers' Association who had a desire to create walks focusing on the positive sense of belonging. In collaboration with another ABC-partner, the Danish Sports Association – DGI, they planned a training program for ABC ambassadors that could guide these walks. The training program consisted of nine-hours ABC training including theory as well as practice. Ten volunteers joined the program and were trained to be ABC ambassadors over three weeks. The ambassadors meet every Tuesday to go for a walk. In just six months, about 60-80 new members joined the walks called "Walking for happiness". The volunteers of the ABC ambassador group were so pleased with the initiative that they became an independent group in The Danish Ramblers' Association. This mentally healthy activity now continues, with ABC ambassadors and other participants walking 5 km together in Copenhagen every Tuesday. It's free to join and they report new entrants every time they meet.

Figure 4. Example of mentally healthy activity.

An important aspect of several initiatives within this strategy was to promote activities and services by branding or rebranding them as mentally healthy. By highlighting the mental health promoting effects of these activities and services, the branding and rebranding specifically aimed at encouraging target groups to proactively engage in mentally healthy activities. These efforts were similar to the campaign activities but differed in the sense that their primary aim was to increase participation in specific activities and utilisation of specific services, whereas increasing mental health awareness and knowledge was a secondary aim.

3.2. Qualitative Findings of the Perceptions of the Implementation Process and the Impact

3.2.1. Characteristics of Individuals

Individuals involved in implementation processes are not passive recipients or mediators; they experiment with, evaluate, seek meaning in and develop feelings (positive or negative) for the innovation or intervention at hand [29]. The first theme from our analysis is concerned with the participants' (of this study) perception of and beliefs about the ABC-framework.

Attitudes toward the ABCs

Overall, the aim and underlying assumptions of the ABCs (i.e., to promote mental health by applying a salutogenic approach and collaborating across sectors, professions and organisations) generally invoked positive reactions from ABC-coordinators, decision makers and potential implementers from various sectors and organisations. They described the ABC-framework as useful in terms of facilitating simple, accessible and tangible communication about MHP with decision makers, service providers and volunteers. Some participants substantiated this by stressing that the plain and simple wording of the ABC-messages made the framework relatable to various groups of people and helped to break down the otherwise complex concepts of mental health, MHP and health promotion. Participants also praised the broad applicability and adaptability of the ABC-framework as this was considered to promote MHP practice across organisational levels.

> *"So thanks to your three messages [ABC-messages] one is actually enabled in working with the entire health promotion methodology. That is without having to complicate things or talk a lot about it."* (Interview, coordinator, municipality 1)

> *"The broad frame of understanding encompassed by the ABCs enables working with mental health at all levels; from political decision makers and cross disciplinary management areas down to the local citizen. Furthermore, we can see a great potential in translating the ABC-framework to locally based methods, initiatives and tools to support activities in promoting mental health."* (Questionnaire W2, municipality 3)

In line with the above quotation, the ABC-framework proved to be applicable and suitable in various settings such as kindergartens, elementary schools, nursing homes, sports clubs, evening

schools, etc. On the one hand, some participants found these broad possibilities of application inhibiting to the process of developing and initiating MHP initiatives, either because they could not decide where to begin or because their efforts were too extensive related to the resources available. On the other hand, these relatively broad possibilities of application of the ABC-framework were appreciated by participants as they viewed the framework as a conceptual basis for linking ongoing and new initiatives across different departments, sectors and/or organisations. According to some participants, the implementation of ABC-initiatives and a subsequent increased attention on MHP resulted in increased staff motivation to collaborate across professional and organisational boundaries. In a questionnaire from a municipality, for example, working with MHP and the ABC-framework is described as having highlighted that several departments within the municipality work with tasks that reach across internal organisational boundaries, have health promoting effects and would benefit from input from other departments. Therefore, the dissemination of the ABC-framework and the implementation of ABC-initiatives were perceived as promoting synergistic effects through integrated, intersectoral and interprofessional MHP efforts.

3.2.2. Characteristics of the Intervention

Implementation effectiveness is largely influenced by stakeholders' and implementers' perception of the intervention characteristics [29]. In our analysis, participants' perceptions of the appeal forms of the ABCs were particularly prominent.

Credibility and Campaign Appeal Forms

The ABC-framework is research based and the partnership is coordinated by a research institute. This was highlighted by several participants as a strength and as creating credibility and legitimacy. In addition, this was seen as supporting the belief that ABC-initiatives and behaviours in line with the ABC-messages will produce the intended outcomes.

> *"The fact that the ABCs of mental health is research-based has created credibility from the beginning—albeit that the three domains [act, belong and commit] are obvious for many, it is still meaningful for people to be confirmed that what they are doing is in the right direction."* (Questionnaire W4, NGO 1)

Several participants described the positive appeal forms used in, for example, the campaign materials, as desirable, a new way of thinking about health promotion, and, especially, in non-health-oriented settings, making the campaign materials more attractive and appropriate than if they drew on appeals such as risk and fear.

> *"Rather than being completely submerged in risk, treatment, shouldn't and must, then try looking at the fact that there is something that may benefit you in other areas. To me that is exactly what the ABCs enables. As you say, patient associations entail a sort of community with mutual interests and so on, so to me it (the ABC's) makes sense in several areas."* (Group interview, coordinator, municipality 2)

> *"But no one wants to join the scouts because they're overweight. That's also not why you take up football or something else. So this 'hey, you need to find out what makes you happy' and 'what it is that gives you the energy to smile at the other cyclists' and stuff like that, that is the focus that decides if you join the scouts . . . "* (Interview, coordinator, NGO 2)

Participants had mixed opinions about the appeal of the Danish name ABC for mental sundhed (the ABCs of mental health) and in which situations it was appropriate to use when communicating to end-users. Some participants preferred not to use the name as they saw it as a disruptive element that might complicate the interaction with specific groups, e.g., older adults and children. Therefore, in some situations, the name was not used explicitly; instead, mental health was talked about in broader terms.

3.2.3. Process

The implementation of new practices, ideas and initiatives may be seen as series of interrelated sub-processes that affect the implementation effectiveness [29]. Our analysis showed that the processes of engaging others, e.g., health promotion planners, service providers and volunteers, were substantial in the process of developing and implementing ABC-initiatives.

Engaging Others as an Essential and Challenging Aspect of the Implementation Process

Engaging health and non-health-oriented professionals as implementers and mediators of campaign messages was an essential and relatively time-consuming aspect of the local implementation process. Participants reported that local implementers of the ABC-framework, such as health promotion planners, service providers and volunteers, generally deemed the ABC-framework a relevant and useful tool. The implementers found the framework to be in line with existing health promotion initiatives and with general organisational goals of promoting mental health.

> *"Overall, the ABCs of mental health have contributed with a method to talk about mental health and wellbeing as well as incorporating mental health in the health promoting work, because all groups of employees understand the ABC messages because they are simple and relevant for most people."* (Questionnaire W4, municipality 1)

> *"There is a great interest in and accept of the ABC's as a method. Most employees with contact to citizens think the ABC's is meaningful as a framework to talk about being active and sense of community."* (Questionnaire W5, Municipality 4)

> *"We have been able to concretise and put some simple words on how we can help promote population mental health. Something we probably already did sporadically and in a more complicated manner but that we can now clearly formulate."* (Questionnaire W4, NGO3)

However, according to the participants, some practitioners (e.g., pedagogues and health care providers) who were introduced to the ABC-framework deemed it as irrelevant and not contributing with anything new. A common initial attitude and response among practitioners was "*we're already doing it?*". Some participants reported it as challenging to attract, involve and/or create commitment among colleagues and external collaborators. This challenge was in some cases linked to the difficulty and complexity of conveying the novelty and relevance of the ABC-framework or how it could be applied in practice, precisely because it was in line with already on-going efforts. In an evaluation report, for example, it is reported: *"There is a little 'The Emperor's New Clothes" about it—we're already doing that [...]"(Questionnaire W1, municipality 1).* The challenge of engaging others was also linked to the bottom-up approach and the lack of an exact implementation protocol or standardised manual, i.e., not having a clear picture of what the final MHP initiative should encompass or look like.

> *"That is the difficult aspect of this, trying to communicate it (the ABC-framework), concretize it, and make it manageable and actionable. That is those next steps."* (Interview, coordinator, NGO 3)

> *" ... how can we as a municipality motivate and concretize "what's in it for me" for the local collaborative partners?".* (Interview, coordinator, municipality 2)

As a result, a recurring recommendation, from the participants in the initial questionnaires and interviews, was to provide practice-oriented examples of ABC-initiatives and manuals or guides on how to translate the theoretical framework into practice, thereby making the ABC-framework less "*fluffy*". The challenges related to engaging others left some participants with a feeling of progressing more slowly than expected. However, over time, participants developed several strategies to increase the success of engaging relevant stakeholders. Participants found it effective to present the ABC-framework and potential ABC-initiatives as a means of reaching the goals embedded in

the core tasks of the audience. This was viewed as particularly relevant in the context of engaging non-health-oriented professionals and volunteers (e.g., pedagogues, teachers and NGO volunteers). In these cases, participants found it effective to shift the main focus from a MHP perspective, with explicit health related goals, to the audiences' specific core tasks e.g., learning outcomes for teachers.

> *"The ABCs is in many ways a simple tool, but nevertheless a tool that needs to be contextualized and adapted depending on the audience. Many local stakeholders, service providers, and municipal partners don't consider themselves "mental health ambassadors" although they know that their activities promote wellbeing. Also, they don't use the words "mental health" in their everyday activities. As an ABC-coordinator you therefore need to be able to relate to the context of various local stakeholders and use words that in their setting can be translated and equal mental health such as "feeling good" and "being happy". Sometimes that means letting go of the words "mental health" and "the ABCs of mental health" because when it comes down to it, the local stakeholders decide for themselves how the ABCs are to be used and highlighted in their activities. That doesn't mean that they don't do ABC-activities—just that they have adapted the messages, so they work and live in their organisation."* (Questionnaire W4, municipality 3)

> *"It isn't something extra (you need to do), it is just something that can help support you in reaching the goals you are meant to. That is what I find resonates with people. It isn't rocket-science. It is a way of communicating so practitioners can see, that this is a method that can help them achieve their goals. . . . You find resources in working with health promotion that makes their job easier."* (Interview, coordinator, municipality 1)

Using participatory methods instead of one-way dissemination of information and providing specific examples of ABC-initiatives was also described as a good strategy to increase the success of engaging individuals. Further, when adapting communication and materials to different target groups or settings, participants highlighted the need to balance the theoretical and practice-oriented elements according to the audience. For example, one participant stated: *"We need positive stories and knowledge that isn't too heavy." (Interview, coordinator, NGO 2),* whilst others wanted a thorough introduction to the research and theory base. In addition, presenting a selection of concrete ABC-initiatives and campaign materials was described as a way of increasing the chances of decision makers, implementers and collaborators deeming local ABC-initiatives as feasible, suitable and relevant. Again, participants highlighted the need for the training and intervention materials to be balanced in terms of, on the one hand, allowing participants themselves to identify how the ABC-framework might be applied in their context and, on the other hand, receiving concrete examples and guidelines.

> *"The ABC-framework has provided a clear message but has given loose boundaries in relation to developing and letting the ABCs take shape according to the context and resources. To some degree this has been liberating as it has provided the ABC-coordinator with the freedom to act on and to form the project locally. On the other hand, at times, as an ABC-coordinator, you needed an indicator that allowed you to set the standards for your work and guide you in terms of being on the right track."* (Questionnaire W4, municipality 3)

Several participants highlighted the importance of feeling well prepared for the task of disseminating and promoting the implementation of the ABCs within their organisations. Therefore, the partnership became a valuable platform where the ABC-coordinators could: (1) exchange experiences with other coordinators; and (2) obtain communication training (e.g., communication workshops), educational and training resources (e.g., slides, exercises and relevant literature) and guidance on how to trigger reflections on how the ABC-framework can be translated into practice by different target groups (e.g., through implementation workshops).

Throughout the project period, a decrease in the reported difficulties with engaging, for example, decision makers and local implementers was evident.

3.2.4. Inner Setting

Implementation processes are affected by several aspects relating to the inner setting of an organisation including formal and informal organisational structures and implementation climate [29]. Our analysis showed that the implementation of MHP initiatives was challenged in certain organisations due to existing organisational structures and requirements.

Challenges Related to Producing an Economic Case for MHP Initiatives

Some participants indicated that the requirements found within public organisations in some respects challenged the initiation of MHP initiatives, such as the ABCs. Specifically, they experienced that management and decision makers such as politicians requested an economic case, e.g., cost benefit analyses, before initiating or continuing the implementation of MHP initiatives. This was described as challenging the implementation process of ABC-initiatives because producing this type of economic case was seen as almost impossible due to several aspects: applying a bottom up approach and not having a standardised implementation protocol or intervention; lack of resources to predict changes in population mental health or the potential economic gains (as a result of initiatives); and the relative short time frame of the project combined with aiming at long-term outcomes and effects. For example, a manager from a municipality stated:

> *"So it depends a lot on the economy of it all. And I also think that it is really really difficult to prove that we might save money. Because it is in the future. It is difficult to calculate how much money we might save, and this is always required, when we do these types of things. How much will we save in the future, because we are doing this now?"* (Interview, stakeholder, municipality 2)

3.2.5. Outer Setting

Similar to the inner setting, several elements of the outer setting of an organisation can influence implementation processes within an organisation [29]. These elements include target groups (e.g., service users and patients) and the degree to which an organisation is networked and collaborates with external organisations. In our analysis of the outer setting, three subthemes related to the target groups, interorganisational collaborations and the ABCs partnership were evident (partnership functioning will be described in another paper).

Positive Feedback from End-Users on ABC-Initiatives and ABC-Messages

Several participants reported that end-users adopted a positive attitude towards ABC-initiatives and the ABC-messages, e.g., when communicated through the interactive campaign materials such as paper fortune tellers and conversation guides. The framing of the initiatives was highlighted as being essential for how they were received by end users. According to a number of participants, some end-users felt that the term "mental health" had negative and stigmatising connotations and was deemed unappealing or unintelligible because it could be construed as something theoretical, academic or disease oriented. As implied in the following quotation, some participants overcame this issue by using the ABC-messages or related terms to conceptualise mental health when interacting with end users.

> *"I find it a challenge that it is called mental health. It creates a barrier in our world. If it was "happy" or "thriving". I mean if you could find other words to describe it, because it becomes somewhat clinical. When I say something with mental health I hurry up and add 'active' or 'belonging'."* (Interview, coordinator, NGO 2)

Promoting Interorganisational Collaborations through MHP

Most participants reported that the topic of mental health and the promotion of holistic, intersectoral and interprofessional approaches were already agendas within their organisations when joining the

ABCs. Several participants described the development and implementation of ABC-initiatives as a welcoming opportunity, and the ABC-framework as a resource to operationalise these agendas. In addition, participants voiced a great interest in collaborating with external organisations on the development and implementation of ABC-initiatives. According to the participants, several collaborative initiatives based on the ABC-framework were established successfully. Even though the collaborations were often described as successful, they were also subject to challenges. The use of dissimilar terminology related to the local implementation of ABC-initiatives across the partnership was by some reported as an obstacle in the process of developing and implementing ABC-initiatives in collaboration with others. A discussion of the terminology within the partnership was suggested as a means of preventing misunderstandings by several participants. This was discussed at several network meetings in the partnership, the conclusion being that the term "the ABCs of mental health" first and foremost covers a research-based framework for mental health promotion as well as the organisational partnership.

The Partnership as a Source of Resources

The participants described the partnership as a source of valuable resources for the process of developing and implementing ABC-initiatives. The resources referred to were: staff training, educational and campaign materials (e.g., flyers, posters, PowerPoint slides and exercise descriptions); professional network; and knowledge and consultations from experts and practitioners (e.g., practice experiences with working with MHP in various settings from other partner organisations, scientific knowledge from the involved researchers or advice on planning and executing campaign activities). Some of these resources were brought into the partnership by specific partners and others were created within the partnership by a single partner or in collaboration between multiple partners. The partner organisations that received funding from the partnership played an essential role in developing and distributing these resources.

> *"At the same time, we can learn something from the other partners. That is the balance that makes a partnership interesting. That we can influence and contribute with something we are particularly good at. But it is also interesting that we can mirror ourselves in other organisations and the way they do things. Or learn something from how others receive this type of project and how they work with it. I find that is the balance that makes it rewarding."* (Interview, stakeholder, NGO 2)

Specifically, the educational and campaign materials produced in the partnership were highlighted in several evaluation reports as essential resources for disseminating the ABC-framework and establishing it as an applied resource and, thus, aiding the process of implementing ABC-initiatives locally. In an evaluation questionnaire, it is stated that these materials tap into a lack of organisational and individual resources for initiating and developing MHP initiatives:

> *"In the ABCs we inform people that even small adjustments and reprioritizing in your everyday life can help promote your mental health. However, not all citizens, organisations or workplaces have the creativity or energy to devise what these changes might be."* (Questionnaire W3, municipality 3)

Furthermore; the free counselling and services related to communication activities offered to all partners (e.g., developing and planning campaign activities) proved to be particularly valuable to partners as they were perceived to facilitate the development and implementation process of local ABC-initiatives. Most partner organisations used these opportunities, and numerous partners praised these services in the evaluation questionnaires. For example, one participant described how this made it possible for them to develop and try out new concepts which they otherwise would not have had the resources to develop. The centrally coordinated campaign, based on a social marketing strategy and executed by the partner organisations, in connection with local ABC-initiatives was described as creating positive synergy effects. A participant, for example, mentioned that it was meaningful to promote specific campaign messages when the same messages were echoed in the media.

3.3. Perceived Impact–Quantitatively Assessed

3.3.1. Characteristics of Respondents

The characteristics of the respondents at W6 are presented in Table 2. Of the respondents, 23 were from municipalities, 10 from NGOs, 3 from unions and 5 from other types of organisations. Twenty-nine respondents (70%) had been involved with the implementation of the ABCs in their organisations for two years or less. The remaining respondents had been involved since 2015 (2%), 2016 (20%) or 2017 (7%). The majority of the respondents stated *health* (71%) as their primary field of professional interest; around one third stated *volunteer work* (34%); and around one fifth stated, respectively, *culture* (22%), *social services* (22%) and *physical activity* (20%) (multiple answers were allowed).

Table 2. Characteristics of the respondents of the questionnaire at W6 collected in February 2020.

Characteristic	Category	N (%)
N		41
Type of organisation	Municipality	23 (56)
	NGO	10 (24)
	Unions	3 (7)
	Other	5 (12)
Year of involvement with the implementation of the ABCs	2015	1 (2)
	2016	8 (20)
	2017	3 (7)
	2018	12 (29)
	2019	17 (41)
Primary field of professional interest [a]	Health	29 (71)
	Culture	9 (22)
	Senior	7 (17)
	Social service	9 (22)
	Non-profit	3 (7)
	Physical activity	8 (20)
	Volunteer work	14 (34)
	Other	6 (15)

[a] Several answers allowed pr. respondent.

3.3.2. Response Frequencies for Items on Perceived Impact

Response frequencies for items assessing perceived impact using a Likert-scale are presented in Figure 5. Respondents generally agreed that working with the ABCs had an impact on an individual level. For example, when asked whether the participation in the ABCs partnership was beneficial for them as an employee (Item 1.1), 75% of the respondents fully agreed, 15% partly agreed and 2.5% answered neither agreed nor disagreed (7.5% stated not relevant). Further, respondents generally agreed that their knowledge of the ABCs had motivated them do something for their own personal mental health (Item 1.5): 40% fully agreed, 32.5% partly agreed, 17.5% neither agreed nor disagreed and 5% partly disagreed (5% stated not relevant). Overall, between 72.5% and 95% of the respondents partly agreed or fully agreed on the items on the individual level (Items 1.1–1.5).

The diagram is based on data from 40 respondents. Respondents were asked to rate each item. Items 1.1–1.5 pertain to the individual level and Items 2.1–2.9 to the organisational level.

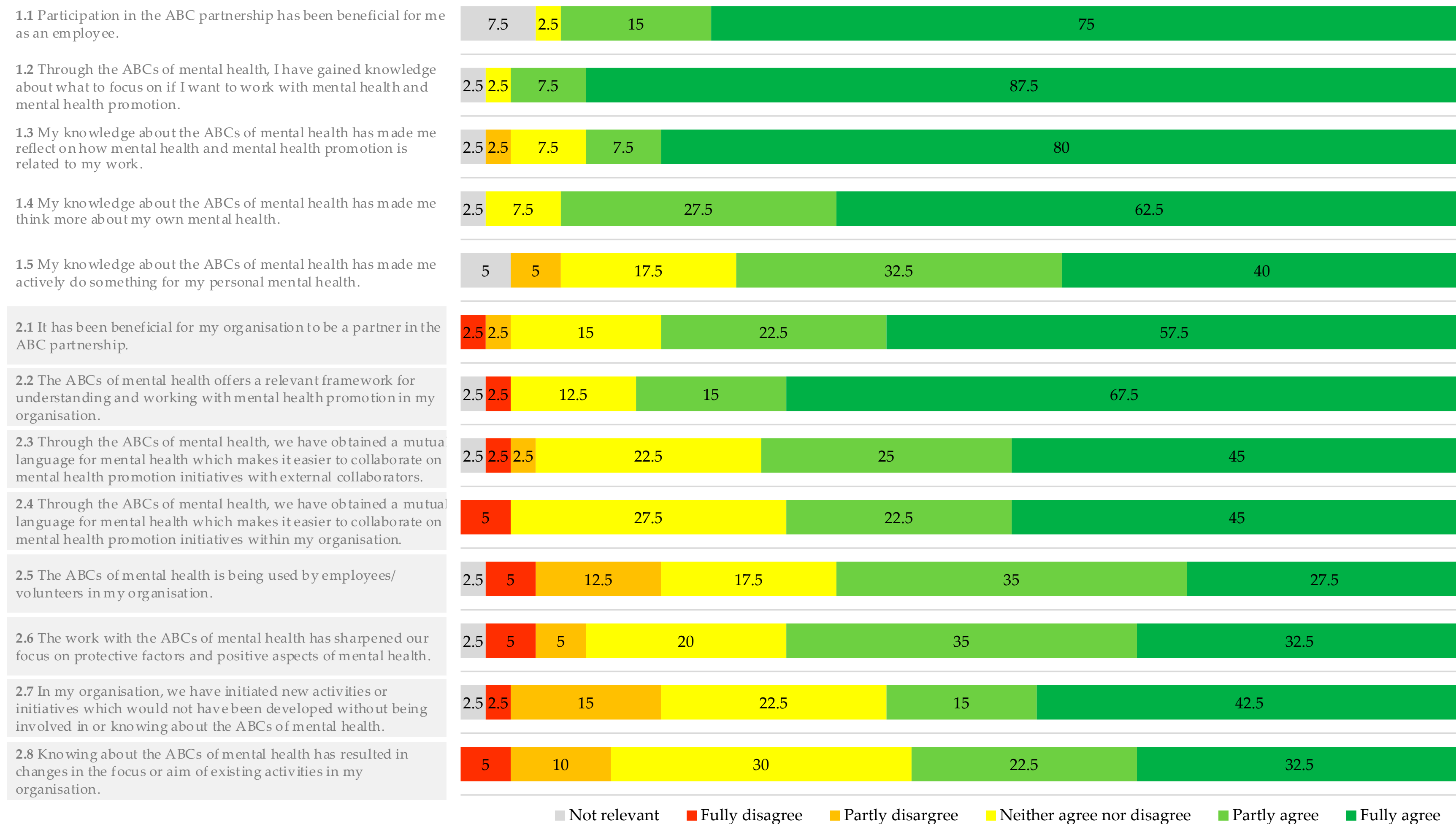

Figure 5. Response frequencies in per cent for survey items on perceived impact.

All respondents (i.e., 100%) reported to have talked with colleagues about the ABCs; 82.5% with partners from other organisations; 70% with friends; 77.5% with family; and 12.5% with others (results not shown).

Most of the respondents agreed that working with the ABCs had a positive impact on an organisational level. Overall, between 55% and 82.5% partly or fully agreed on Items 2.1–2.8 pertaining to the organisational level. For example, when asked whether new initiatives or activities had started up as a result of their involvement in or knowledge about the ABCs (Item 2.7), 42.5% of the respondents fully agreed, 15% partly agreed, 22.5% neither agreed nor disagreed, 15% partly disagreed and 2.5% fully disagreed (2.5% stated not relevant). In addition, 67.5% fully agreed and 15% partly agreed that the ABC-framework was relevant for understanding and working with MHP in their organisation (Item 2.2.), while 12.5% neither agreed nor disagreed and 2.5% partly disagreed to this (2.5% stated not relevant).

4. Discussion

In this study, we first investigated and described the overall characteristics of the ABC-initiatives that are developed and implemented by the partner organisations of the ABCs. These initiatives were grouped according to three strategies: (1) building MHP capacity; (2) campaign activities to promote mental health awareness and knowledge; and (3) establishing and promoting opportunities to engage in mentally healthy activities. Secondly, we analysed and described local ABC-coordinator and stakeholder perceptions of the implementation processes and the impact of the MHP initiatives. ABC-coordinators and stakeholders deemed the ABC-framework as useful in a range of strategies for MHP and feasible in various settings. Overall, the ABC-initiatives were positively received. However, our results also indicate several challenges to the implementation processes. Participants, particularly from the public sector, reported challenges related to meeting organisational requirements of providing economic cases for investing in MHP initiatives. Other challenges were related to balancing local adaptability and concrete guidance and engaging others in the implementation. The study participants viewed the ABC-framework as providing relevant knowledge for working with MHP and as a means by which to foster intersectoral and interprofessional collaboration on MHP. Overall, these results are in line with evaluation studies on the Act–Belong–Commit campaign in Australia, which, among others, found that the campaign provided a useful framework for teachers to talk about mental health with students [31] and assisting local stakeholders in creating sustainable local collaborations across organisational boundaries [32].

4.1. A Novel Approach to MHP?

As our results indicate, the work with the ABC-framework is in some respects similar to strategies and approaches already used across different organisations in Denmark. For example, existing practices in various settings (e.g., schools, libraries and sports clubs) were deemed as being in line with the ABC-framework, and in some cases the ABC-framework was even dismissed by practitioners with the statement "*we're already doing that*". This may be explained by the fact that the ABC-framework and the underlying approach builds on existing knowledge from several disciplines [9,10] and, therefore, isolated elements of it may be similar to existing practices. However, the ABC-framework and its underlying approach was conceived as a new approach to practising MHP that complies with the recommendations for MHP [6,8,11,13]. The intended novelty lies in providing a salutogenic oriented conceptual framework for working with MHP based on concrete and actionable guidance as well as linking MHP strategies across different departments, sectors and/or organisations, thus aiming for synergistic effects. The ABC-framework can aid practitioners from various professions and settings to employ a health promoting practice that is based on deliberate decisions regarding which elements of their practice are health promoting—not to be mistaken for more preventive-oriented measures. For most participating organisations, this re-orientation of practice was a desired goal. Through staff training, this goal was pursued by enabling practitioners: (1) to identify these mental health promoting

elements fitting their daily practice; and (2) to adjust, if already existing, or to apply them if deemed necessary. Our findings support that the ABC-framework is a relevant contribution for advancing mental health promoting practices, with participants predominantly agreeing that the ABC-framework was relevant for understanding and working with MHP in their organisation. Overall, the findings indicate that developing and implementing MHP initiatives based on the ABC-framework can be characterised as a new approach that builds on existing knowledge.

4.2. Balancing Adaptability and Guidance

Initially, a main focus was to provide partner organisations of the ABCs with a research-based tangible framework for developing and implementing MHP initiatives. Applying this type of bottom-up approach which allows for local adaptation is recommended for MHP and is important as a means to create empowerment and sustainability [6,33]. As anticipated, the bottom-up approach was considered a strength by participants in this study as this allowed for tailoring initiatives to local settings and various professions and, thus, facilitated coherent MHP efforts across organisational boundaries. These findings are in line with previous studies on the implementation of the Act–Belong–Commit campaign [31]. It soon became clear, however, that some implementers and ABC-coordinators needed more guidance and concrete examples of how to use the framework in practice. As time has passed, good examples from practice have become more readily available (e.g., in evaluation reports and training materials) and have been shared across the partnership on a regular basis. Hence, challenges pertaining to this have been markedly reduced. The partnership still aims to facilitate room for creative thinking on how the ABC-framework can be translated into practice locally, before giving too many concrete examples and guidelines. In addition, our results showed that applying a bottom-up approach when planning and implementing MHP initiatives can be time-consuming and resource demanding for local organisations and implementers. Based on these findings, we encourage health promotion planners and practitioners to carefully consider the balance between local adaptability and concrete guidance as a means of facilitating an effective process of developing and implementing MHP initiatives based on local needs and resources. In addition, the potentially time and resource demanding processes pertaining to a bottom-up approach should be planned for.

4.3. Responsibility for Ensuring MHP Initiatives

The Danish Ministry of Health advocates that MHP initiatives should be designed and implemented within local settings where people live their daily lives such as family settings, day care centres, schools and workplaces [15]. To achieve this focus on MHP in these settings, there is a need for re-orienting policies and practices through a broad engagement across sectors and professions [11]. The emphasis on including non-health-oriented settings might be construed as a placement of responsibility for ensuring the provision of MHP initiatives on the staff working in these settings. However, our findings show that some non-health-oriented professionals and volunteers do not consider themselves as *mental health ambassadors*. This might indicate that they view issues related to MHP as outside their sphere of interest, responsibility and/or expertise, which has been shown in other studies, for example, among teachers and health professionals [34–36]. These potentially diverging perspectives between policies and staff and a lack of interest and motivation among implementers may challenge the implementation of MHP initiatives [33] and, overall, the re-orientation of public services towards a practice with a greater awareness of mental health. Such challenges may be amplified when MHP is conceptualised and approached differently across professions and sectors [37,38], which can leave frontline staff with a feeling of mental health as difficult to define and operationalise [34]. This relates to the importance of bringing attention to the process of engaging relevant individuals in implementation, among others, by promoting a mutual understanding of MHP. This is also highlighted by the participants of this study as well as in the literature on implementation and MHP [29,39]. In the case of promoting the implementation of MHP initiatives, this study shows that it can be particularly effective to present MHP

initiatives as a means of supporting non-health-oriented professionals and volunteers in conducting their core tasks.

4.4. Methodological Considerations

In this paper, we present findings of a process evaluation of a large national partnership outlining how 45 organisations approached the development and implementation of MHP initiatives. We also explore the implementation processes and the impact of the MHP initiatives. These findings add knowledge to the existing research on MHP in practice and are relevant for planning and implementing such initiatives. Findings are derived at using a mixed methods design with data regarding more than three and a half years of partnership work collected at multiple time points (six waves of evaluation questionnaires and three interview phases). This allowed for an iterative exploration over time of development and implementation processes and the impact of MHP initiatives. The analysis was guided by the CFIR [29], which allowed for an exploration of essential factors on multiple levels.

Interviews were only conducted with coordinators and stakeholders from four of 45 organisations, and their perspectives might not be representative for coordinators and stakeholders from other partner organisations. However, the questionnaire data allowed for investigating the prevalence of certain perspectives and preliminary findings among coordinators and stakeholders from a wider segment of partner organisations. Further, preliminary findings were discussed at network meetings within the ABCs partnership, providing the authors with valuable insights for interpreting the data in this study and, thus, strengthening the credibility of the findings. The methodology used in this study was limited, as it is not clear who were involved in the completion of the evaluation questionnaires, as the local coordinators could do so in collaboration with key stakeholders from their organisation. In addition, frontline staff and end-user perspectives are relevant to study in order to better understand implementation processes and impacts [29].

This process evaluation can be characterised as internal, or not independently conducted, as it was conducted by researchers from the NIPH who also lead and coordinate the partnership. Internal evaluations are subject to advantages and disadvantages [40,41]. In this case, the evaluators' central role in the partnership due to their managerial tasks might have led to participants holding back criticism, overreporting the number of implementation activities and overrating the impact in order to please or avoid conflict with the evaluators [41]. To minimise this type of information bias, study participants were explicitly urged to share their thoughts and experiences without filter during data collection. The choice of conducting internal evaluation was based on the formative purpose of the evaluation by creating "organisational learning" within the ABCs partnership. According to Volkov, this requires informed evaluators with a thorough knowledge of organisational functioning and dynamics [42], which may also lead to more accurate and context sensitive interpretations [41].

Evaluation studies on the long-term effects applying mental health and economic outcomes are needed to fully understand the potential of approaching MHP as in the Danish ABCs partnership. These types of studies were not deemed relevant at the time of initiating the partnership. This was due to the developmental state of the ABCs partnership and the underlying bottom-up approach which, among others, entailed an uncertainty about which specific outcome measures would be relevant to apply. Based on the findings of this study and other evaluation activities, evaluation studies using measures on mental health outcomes are planned.

4.5. Implications for Practice

There is consensus that mental health is more than merely the absence of mental illness [43]. However, to date, the focus in mental health—politically as well as scientifically—has primarily been on treatment or prevention of mental illness [8]. As a result, people may perceive the term mental health to be related to mental illness, or even use the terms interchangeably, and to have stigmatising connotations [34,44], which our findings also indicate. Whilst treatment and prevention of mental illness are very important to ensure, strategies solely focused on mental illness cannot stand alone

if the aim is to reduce the amount of people in the population that are affected by mental health problems [6–8]. WHO, the EU-commission and experts have stated the need to supplement treatment and preventive strategies with mental health promotion and a focus on the positive aspects of mental health and well-being [6,11,43,45]. Being able to join and engage in various leisure- or work-related activities, having a sense of belonging and commitment to something and someone are vital aspects of mental health for everyone regardless of age, gender, income, physical or mental health problems or disabilities [6,11]. Building on and integrating MHP components in existing programmes and practices in local communities should be prioritised from a MHP point of view [13]. It is therefore important that the public and private sector understand how they may be able to promote mental health and wellbeing through contributing to supporting surroundings and empowering various target groups to engage in mentally healthy activities. Our findings offer not only an outline of three relevant strategies for MHP, including examples of MHP initiatives from practice, but also describes insights from implementation processes that are valuable when developing and implementing MHP components in practice. In addition, our results indicate that using the ABC-framework holds promising potential for promoting MHP efforts and collaborations across sectors and professions. The framework may also be a valuable tool for raising awareness regarding opportunities to act, belong and commit in local communities, verbalising mental health as something more than just the absence of disease and as something that is valuable in itself and should be prioritised.

5. Conclusions

The MHP initiatives investigated in this study were grouped according to three strategies: building MHP capacity, campaign activities to promote mental health awareness and knowledge and establishing and promoting opportunities to engage in mentally healthy activities. The ABC-framework has proved useful in various types of MHP initiatives and feasible in various settings. However, using a bottom-up approach to develop and implement MHP initiatives can be time-consuming and resource demanding, and it requires a deliberate balancing of local adaptability and concrete guidance when engaging stakeholders and implementers. We found that it can be particularly effective to engage non-health-oriented implementers by presenting MHP and the ABC-framework as means of supporting them in conducting their core-tasks, which might not be explicitly linked to mental health. The findings presented in this paper offer valuable practice-oriented insights relevant to consider planning and practicing MHP. Overall, the ABC-framework has been positively received by local implementers and stakeholders and viewed as a means by which to foster intersectoral and interprofessional collaboration. Overall, using the ABC-framework to develop and implement MHP initiatives holds great promise for advancing and promoting MHP practice. Rigorous effectiveness studies are needed to determine the long-term effects of these MHP initiatives.

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The workings of an action learning program for building mental health promotion capacity – A realist evaluation

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ABSTRACT

Action learning is a promising approach for building mental health promotion (MHP) capacity. The aim of this study is to explore how action learning processes can strengthen MHP capacity within and across organizations in a community setting. We applied an embedded case study design and a realist evaluation framework to explore key combinations of mechanisms and contextual factors that generated the emergent MHP capacity outcomes of an action learning program, i.e. context-mechanism-outcome-configurations (CMO-configurations). Data consisted of 18 semi-structured face-to-face interviews, 10 telephone interviews, two group interviews, observations, and documents. Interviewees (n = 21) were participants and management employees. Our analytical provision of CMO-configurations provides insights into how contextual factors, such as participant motivation, organizational support, and existing task descriptions, in combination with certain program mechanisms, such as legitimization of specific agendas, learning-by-doing, and collaborations across organizational boundaries, explain the identified outcomes. Outcomes ranged across implementation of MHP initiatives, personal development among participants, and relational and collaborative development. Taken together, our results strengthen the notion that mechanisms of action learning hold the potential to build MHP capacity on an individual, organizational, and community level. This study, also, illustrates that realist evaluation offers a relevant methodology for investigating the underlying workings of capacity building programs.

1. Background

Developing and enabling mental health promotion (MHP) practices across sectors, professions and disciplines is essential to reduce the burden of poor mental health and mental illness (Forsman et al., 2015; IUHPE, 2021; Kalra et al., 2012; WHO, 2013). MHP is "any action taken to maximize mental health and well-being among populations and individuals that focuses on improving social, physical and economic environments that affect mental health, and enhancing the coping capacity of communities as well as individuals" (Donovan, James, Jalleh, & Sidebottom, 2006, p. 34). To strengthen MHP efforts, scholars have called for a re-orientation of practices and organizational cultures and norms. This re-orientation should support the notion that mental health and well-being is an integral part of overall health and that frontline personnel throughout society has a role in promoting the mental health and well-being of the population (Barry, 2019; Jane-Llopis & Barry, 2005; Van den Broucke (2017)). Also, provision of effective MHP efforts requires MHP capacity in organizations not only inside but also outside the health sector because the responsibility to ensure MHP efforts lies within the whole society (Barry, 2019; WHO-Europe, 2012). In agreement with this perspective, Van den Broucke has proposed that working with "capacity building shifts the focus from directly trying to influence the health of the population towards enabling systems and networks to promote health in a self-determined and sustainable manner, thus enhancing, prolonging and multiplying the health effects of actions undertaken" (Van den Broucke (2017), p. 764). Based on conceptualizations of public health capacity (van Herwerden, Palermo, & Reidlinger, 2018) and health promotion capacity (McLean, Feather, & Butler-Jones, 2004; Smith, Tang, & Nutbeam, 2006), we conceptualise MHP capacity as the ability and potential of individuals, organizations, and systems to deliberately conduct effective MHP. Accordingly, building capacity for MHP refers to the process of developing

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knowledge, skills, commitment, structures, systems, and leadership to enable effective MHP practices (Smith *et al.* 2006). In accord with these recommendations and perspectives on MHP, the Danish partnership ABCs of mental health (ABCs) developed and piloted an action learning program (ALP) aiming to build MHP capacity. Action learning refers to a collaborative, action-based approach to learning where groups of people work on solving particular issues, and in that way build problem-solving capacity (Pedler & Burgoyne, 2015). Several scholars describe action learning as a working philosophy or a mindset rather than a standardized practice (Hale, 2014; Pedler & Burgoyne, 2015). The ALP under examination in this study aimed at developing and promoting practices, knowledge, skills and competences related to MHP within and across organizations through processes of trial and error, critical reflection, group discussions, and receiving specialist input (Zuber-Skerritt, 2002). The introduction of the ABC-framework, which was used for conceptualizing and working with MHP in practice, was a core component the ALP (the ABC-framework is elaborated elsewhere (e.g. Hinrichsen et al., 2020; Koushede, Nielsen, Meilstrup, & Donovan, 2015)). The ALP was piloted in a Danish community setting with participants from the local municipality, four departments of a university college, and a community volunteer center.

Action learning is recommended for capacity building in multi organizational networks for health improvement (Learmonth, 2007) and an evaluation study of the ABCs shows that participatory methods, similar to action learning, hold promising potential to facilitate the process of building MHP capacity (Hinrichsen et al., 2020). Furthermore, based on a literature review on capacity assessment in public health, van Herwerden *et al.* (2018) recommend that capacity building interventions should build on and embrace local knowledge, experiences, and resources, which are core elements in action learning (Zuber-Skerritt, 2002). However, in a recent systematic review assessing the literature on interventions targeting public health capacity, the authors highlight that evaluations available in the current literature are surprisingly sparse (DeCorby-Watson *et al.* 2018). Moreover, scholars argue that there is a need for a thorough understanding of the underlying workings of such capacity building programs (DeCorby-Watson et al., 2018; Sobeck & Agius, 2007; van Herwerden et al., 2018). Therefore, the aim of this study is to explore how processes of action learning can strengthen MHP capacity. By conducting a realist evaluation of the pilot implementation of the ALP, including all participating organizations in this study, we, particularly, seek to explore key combinations of mechanisms and contextual factors that explain the emergent outcomes. Knowledge about mechanisms for efficiently building capacity can be used to better inform the design and evaluation of MHP capacity building efforts (Astbury & Leeuw, 2010; Jolley, 2014).

2. Methods

2.1. Realist evaluation

Methodologically, we applied Pawson and Tilley's realist evaluation framework which has at its core the question of which programs work for whom, in what circumstances, and in what respects (Pawson & Tilley, 1997). We answered this question by investigating context-mechanism-outcome-configurations (CMO-configurations), which are causal explanations about how outcomes (O) in observed data are interrelated with combinations of mechanisms (M) and contextual factors (C) (Jagosh et al., 2015). This heuristic is central to realist evaluation and is often presented as C+M=O. We use the definition of context given by Pawson and Tilley (1997); features of the conditions in which programs are introduced that are relevant to the operation of the program mechanisms. These conditions may change over time and changes may be program induced (Jagosh et al., 2015). Within a realist evaluation, program mechanisms describe what it is about programs that bring about any outcome and are conceptualized as the resources (knowledge, materials, opportunities etc.) created or introduced by a program and how subjects interpret and act upon these resources (Jagosh et al., 2015; Pawson & Tilley, 1997). According to Astbury and Leeuw (2010), mechanisms, in a realist understanding, hold three essential characteristics: (1) they are often hidden; (2) they are sensitive to context variation; and (3) they are generative, i.e. they generate outcomes. This implies that there is more to programs than what we observe, namely the interactions between context and mechanisms, which explain the observed outcomes. Outcomes comprise the intended and unintended consequences of programs resulting from the activation of program mechanisms. In this study, we particularly investigated outcomes related to MHP capacity.

2.2. Study design

Drawing on observational, individual face-to-face interview, group interview, and telephone interview data and documents, our analytical approach builds on an embedded case study design (Yin, 2014). The pilot implementation of the ALP comprises the empirical case and the participating organizations are grouped into three units of analysis (elaborated below).

The study holds similarities with an internal evaluation as several co-authors were involved in developing and implementing the ALP being investigated. This position allowed us to follow the processes related to the ALP closely, those happening at the end of the participating organizations and those at the end of the facilitators. Our poisition as "internal evaluators" is subject to several advantages and disadvantages (Bachrach & Newcomer, 2002; Conley-Tyler, 2005), which are elaborated in the discussion section.

2.3. Ethics

Institutional ethical approval was received from the University of Southern Denmark, Faculty of Health Sciences (No. 10-600; 02–08–2019). The study was conducted in compliance with The General Data Protection Regulation and the principles of the Helsinki Declaration (World Medical (2001)). Verbal and written informed consent were obtained from all participants.

2.4. Development and piloting of the action learning program

The ALP was developed and piloted in collaboration between the National Institute of Public Health, University of Southern Denmark (NIPH); the Danish Sports Association (DGI) (Danske Gymnastik-og Idrætsforeninger); and the health promotion department of the participating municipality. The latter being the host, i.e. inviting local organizations to participate and supporting the facilitation of the ALP. The NIPH (including two authors of this paper: CH and VK) and DGI were responsible for planning and facilitating the ALP. The participating organizations were: a local community volunteer center, the health promotion department of the hosting municipality[1] and four departments of a university college (nursing, social work, teacher training and social education).

[1] The department for Culture and Leisure of the hosting municipality, and a local department of DGI (with representatives from 3 sports associations) participated at the first workshop but continued in a parallel ALP due to issues regarding the timing of the workshops. The parallel ALP and organizations participating in it, are not included in this study.

The recruitment of individual participants was handled by the management of the participating organizations/department. From each organization/department, one or two sets (i.e. working groups) of one[2] to five participants (i.e. employees, volunteers, and students) partook in the ALP. Three sets included participants from two organizations/departments and two sets included participants from a single department.

The design of the ALP was based on the action learning process described by Folker & Lauridsen, 2017, recommendations for action learning (Stewart, 2009; Zuber-Skerritt, 2002), and evaluation results from working with MHP capacity within the ABCs (Hinrichsen et al., 2020; Koushede, 2018). The ALP ran over a nine-month time-period (Sept. 2019 to June 2020) and involved four workshops with a frequency of two to three months in between. The ALP sought to improve practice and stimulate organizational and individual learning (Pedler & Burgoyne, 2015), i.e. to build MHP capacity, through facilitating participants' work on developing and implementing solutions targeted specific local issues. Each set identified and worked with one or several issues pertinent to their organization/department. Throughout the ALP, the facilitators encouraged participants to reflect on and develop their MHP practice involving the processes of reflecting, acting, observing, and interpreting the consequences of actions. The workshops applied a mix of learning activities (e.g. presentations, reflection, and group exercises), covered themes related to developing MHP efforts (e.g. determinants of mental health and program implementation), and introduced several project management and implementation tools and frameworks (e.g. the ABC-framework).

2.5. Data generation

This study drew on multiple data sources which all together were used to capture the processes of the ALP and how they related to the local context and to MHP capacity, i.e., relevant contextual factors, mechanisms, and outcomes. Data generation ran from the initiation of the ALP until six months after the last workshop of the ALP (September 2019-December 2020). Further, the data generation was informed by the first author's involvement in the ABCs and informal conversations with the local coordinator in the hosting municipality, participants, and the facilitators. The first author and a trainee conducted observations at the workshops of the ALP. Observation guides (Tjørnhøj-Thomsen & Whyte, 2008) covering the themes of participants' reactions to ALP resources and participants' approaches to developing and implementing new practices guided the observations. Project-documents produced by participants during the ALP (e.g. action plans) were collected to gain insight into the details of the MHP initiatives being developed. Insights from the observations and project-documents enabled us to trace developmental and implementation processes and informed the preparation of narrative descriptions (elaborated under data analysis) and the subsequent data generation.

All participants were invited for an interview within one month after the last workshop (June 2020). All accepted, except for two students who declined due to lack of time. The first author conducted 17 individual face-to-face interviews with participants of the ALP (employees (n = 9); volunteer (n = 1)), non-participating management employees (n = 6), and the local municipal coordinator (n = 1), and two group interviews, each with two participating students (n = 4). Individual and group interviews were semi structured and conducted face-to-face, except three that were conducted via Skype due to COVID-19 restrictions. Based on interview guides, the interviews explored the interviewees' perspectives on the processes related to and resources introduced within the ALP and MHP capacity outcomes of the ALP, including implementation of new initiatives and practices. Inspired by the literature on health promotion capacity (McLean et al., 2004; van Herwerden et al., 2018) and implementation capacity (KL, 2015), the exploration of MHP capacity outcomes was structured around 6 themes: organizational behavior, staff, management, organizational focus, organizational resources, and external factors. All individual and group interviews were audio recorded and transcribed verbatim. Transcripts were de-identified, i.e. names of people and places were changed. Additionally, a total of 10 telephone interviews were conducted in two rounds. In each round, one representative from each set was interviewed. The telephone interviews at the first round (April 2020), two months before the last workshop, explored the impact of Covid-19 restrictions on participants' work related to the ALP. In round two (December 2020), six months after the last workshop, we used the telephone interviews to assess the outcomes of the ALP in terms of the implementation of initiatives and practices resulting from the ALP. Telephone interviews were audio recorded and used to inform narrative descriptions. Table 1 provides an overview of the total number of interviews conducted in this study.

2.6. Data analysis – context-mechanism-outcome configurations

This study presents the analysis of key CMO-configurations of the ALP. Our analysis was iterative and retroductive (referring to the identification of underlying causal mechanisms generating program outcomes (Gilmore, McAuliffe, Power, & Vallières, 2019)). The analytical procedures were inspired by Herens, Wagemakers, Vaandrager, van Ophem, and Koelen (2017) and Gilmore et al. (2019). The software NVivo 12 (QSR International) was used to assist the analysis.

Data organization and narrative descriptions. The raw data was organized according to three units of analysis allowing a context sensitive reading of the data (Mason, 2018). Each unit consisted of two organizations/departments:

- local community volunteer center and the health promotion department of the hosting municipality (unit 1)
- two departments of a university college – location a (unit 2)
- two departments of a university college – location b (unit 3)

The organizations/departments were grouped together if they collaborated on initiatives developed during the ALP. Further, drawing on the data from observations, telephone interviews, and project documents, we drafted narrative descriptions (Yin, 2014) for each unit covering the overall processes related to the ALP (not included in this paper). This enabled us to attain an overview over and link relevant processes and contextual factors within each unit.

Coding of CMO-concepts. The first author coded all interview data and the narrative descriptions in terms of *context*, *mechanism,* and

Table 1
Number of interviews.

	TI 1	I & GI	TI 2
Participants			
Employees	3	8	3
Students/volunteers	1	4	1
Management	1	1	1
Non-participants			
Management	0	6	0
Total (interviewees)	5 (n = 5)	19(n = 21)	5 (n = 5)

TI 1 =Telephone interviews round one (April 2020).
I & GI= Individual interviews and group interviews (June 2020).
TI 2 =Telephone interviews round two (December 2020).

[2] Participating organizations were recommended to participate with sets of three to seven people. However, due to lack of resources, two sets consisted of less participants with respectively one and two participants. Also, participating organizations were encouraged to choose participants with an interest in working with MHP. Interviews with participants and management showed that most participants were asked to participate based on their interest in MHP. Further, two participants stated that they were not motivated to participate and did not see an opportunity to decline participating in the ALP.

outcome – theoretical definitions and operational descriptions are presented in Table 2. Subsequently, all coded data was further thematized (identified themes are presented in Table 3 in the results section). This involved both inductive and deductive techniques (Gilmore et al., 2019), that is, an iterative movement between data and literature on action learning and capacity building. Throughout this analytical process, themes were regularly discussed with co-authors.

CMO-configuration elicitation. The elicitation of CMO-configurations started with assessing outcome-patterns (Pawson & Tilley, 2004) for each unit, and, thus, was of a more data driven nature as opposed to testing CMO-configurations defined a priori. To do this, we compiled, examined, and summarized unit specific data coded as outcome for each unit. This resulted in the identification of six outcome types across units. Next, using single outcome types as a starting point, we applied a retroductive analyses to trace back interactions between key mechanisms and context factors that explained these outcomes (Gilmore et al., 2019). This enabled us to identify context-mechanism-dyads relevant in the generation of each specific outcome type and, thus, to answer how the identified outcomes were generated. The CMO-configurations were discussed among co-authors. It must be noted that CMO-configurations were sometimes embedded in each other or configured in a series (i.e. the outcome of one CMO-configurations being the context of another CMO-configuration). For clarity, CMO-configurations are presented separately in this study.

CMO-configuration refinement. In an analysis across units, inspired by the analytical process presented by Gilmore et al. (2019), we further refined the CMO-configurations. Within this phase, we first collated CMO-configurations from all units according to outcome types. This enabled us to compare and contrast preliminary CMO-configurations across units, hereby taking context, mechanism, and outcome variations into account in the refinement process. In the results, key CMO-configurations are presented according to outcome themes (implementation of MHP initiatives, personal development among participants, and relational and collaborative development). Mechanisms and context factors were labeled as *generic* if they related to all outcome types within one outcome theme. For example, the context factor *Support within participants' organizations* related to both outcome types within the outcome theme *Implementation of MHP initiatives*.

3. Results

In the following, organized according to the three outcome themes, we elaborate key CMO-configurations identified in this study. Interview

Table 2
Definition and operationalization of CMO-concepts.

Concept	Theoretical definition[a]	Operational description[b]
Context	Refers to features of the conditions in which programs are introduced that are relevant to the operation of the program mechanisms.	Situation, condition, or factor relevant to the operation of the ALP, that may change over time.
Mechanism	Refers to the resources created or introduced by a program and how subjects interpret and act upon these resources.	Activities, processes, and elements related to the ALP and responses (e.g. cognitive, emotional, motivational) of involved actors (participants, management, staff).
Outcome	Comprises the intended and unintended consequences of programs, resulting from the activation of program mechanisms.	Result or consequence of the ALP that is related to MHP capacity (i.e. the ability and potential of individual people, organizations, and systems to plan and conduct effective MHP).

[a] Based on Pawson and Tilley (1997) and Jagosh et al. (2015).
[b] Based on Pawson and Tilley (1997), Herens et al. (2017), and Jagosh et al. (2015).

Table 3
Themes identified in the analysis, including outcome types (O1-O6).

Context	Mechanism	Outcome
• Participant-related factors • Organizational factors • External factors	• Learning activities (incl. reflection processes and learning-by-doing) • Legitimizing the MHP agenda and collaborative approaches • Allocating time and effort for ALP processes • Relational work (incl. face-to-face meetings and experiencing fruitful collaborations) • Collaborating across organizational boundaries • Perceiving ALP content as relevant • Reinforcing/creating motivation	• Implementation of MHP initiatives o Practice development (O1) o Knowledge dissemination (O2) • Personal development (participants) o Knowledge, skills, and competences (O3) o Awareness (O4) • Relational and collaborative development o Collaborations (O5) o Relationships (O6)

quotations illustrate participants' views underpinning our analytical propositions about the generation of the identified outcomes. CMO-configurations are also summarized in Figs. 1–3 depicting the CMO-configurations in form of the realist evaluation heuristic C+M=O. To present a thematic overview of the findings, themes identified in our analysis are summarized in Table 3, including all outcome types (O1-O6).

3.1. CMO-configurations explaining the implementation of MHP initiatives

Implementation of MHP initiatives was identified as an outcome theme within all units, including practice development (O1) and knowledge dissemination targeting staff and/or end users (e.g. students) (O2). Practice development included, for example, a volunteer led walking group for elders and a peer-to-peer buddy system and social activities for students. Knowledge dissemination activities entailed disseminating knowledge, skills, and competences within participants' organizations. For example, workshops and presentations about MHP targeted staff and workshops about wellbeing and MHP as a part of the routine program for all first-year students. Contextual factors and mechanisms related to these outcomes are elaborated in the following sections and summarized in Fig. 1 (depicting the interrelations between context-mechanism elements and outcome types O1 and O2). Subscript numbers indicate which outcome contextual factors and mechanisms relate to.

Participants and management employees described that the participation in the ALP increased the legitimacy of MHP as an organizational agenda. We considered this a generic mechanism (GM_{1-2}) in developing and implementing MHP Initiatives. An interviewees' account of this mechanism is illustrated in the following interview quote:

> Well, if you're working with something, then things start to come to light. Therefore, it [participating in the ALP] is also a lever for our work with mental health. (Management employee, unit 1)

Also, we considered the process of participants allocating time and effort to engage in developmental and implementation processes a generic mechanism (GM_{1-2}). This was triggered through activities related to the ALP (e.g. receiving a reminder about an upcoming workshop) and, also, included participants adapting content of the ALP workshops (e.g. information materials and exercises) to their own initiatives.

For most participants the motivation to engage in the ALP activities was reinforced or created through engaging in group discussions about MHP and an appealing facilitation style applied in the ALP (GM_{1-2}). This

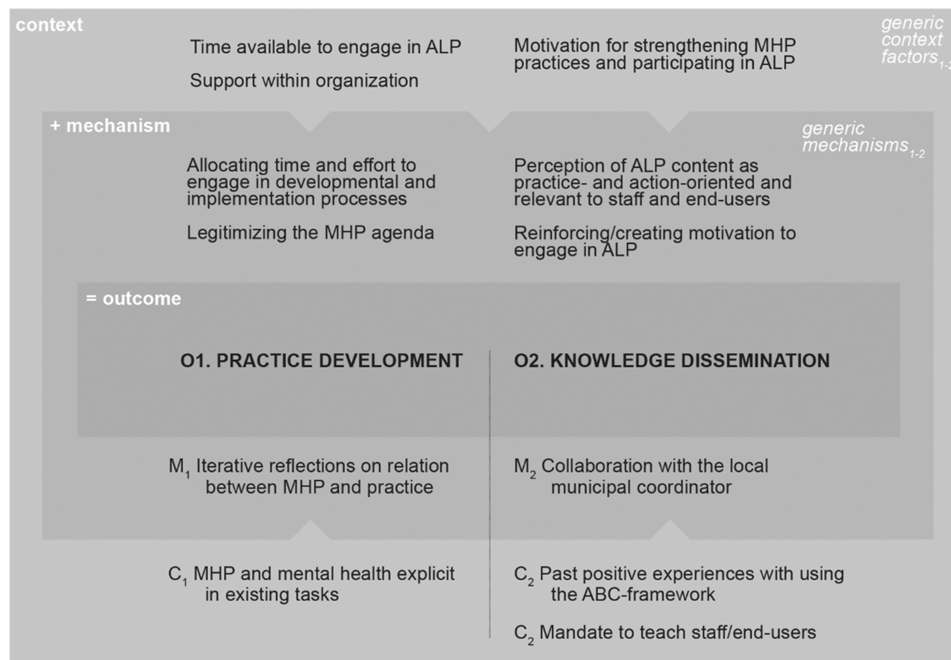

Fig. 1. Summary of context-mechanism-outcome-configurations (C+M=O) on implementation of MHP initiatives (O1 and O2).

was also identified as a generic mechanism. However, one participant deemed the facilitation style as a control measure creating a feeling of being called to account for her efforts which decreased her motivation to engage actively in the ALP. This participant clearly stated not to have been motivated to participate in the ALP at any time and, therefore, did not prioritize the allocation of time and effort to engage in the ALP.

Another generic mechanism was linked to the introduction of materials and exercises at the ALP workshops that participants regarded as relevant and offered inspiration for their own practice and knowledge dissemination activities (GM_{1-2}). A participant explained:

> Practically, we choose to apply a lot of the materials and exercises almost one-to-one in our teaching. (Participant, unit 3)

Also, several participants applied the ABC-framework as a conceptual basis in their knowledge dissemination activities, because the framework was perceived as a plain practice- and action-oriented framework relevant to staff and students. This is illustrated in the following interview quote:

> I think the ABC-framework is a good framework. Because it is simple. And to sell something new, it shouldn't be too difficult. Not even to colleagues… Even though they could easily read 20 research papers. But, after all, that takes time, you know. (Participant, unit 2)

Generic contextual factors supporting the mechanisms of implementing MHP initiatives related to participants' and managements' motivation for strengthening MHP practices and to participate in the ALP (GCF_{1-2}). Participants were likely to be less motivated to engage in the ALP activities if participation was involuntary, as illustrated in the following interview quote:

> You know, we have been assigned this task along with 45 other tasks. So, to us perhaps it has been like… yet another thing that needs to be fixed. (Participant, unit 3)

Competing agendas and restructuring of organizational tasks were identified as generic contextual factors influencing participants' available time to engage in the ALP (GCF_{1-2}). For example, the Covid-19 pandemic prompted major changes in organizational tasks and, thus, reduced participants' available time to engage in the ALP. Another generic contextual factor supporting the implementation of MHP initiatives was support within participants' organizations (GCF_{1-2}). For example, support from employees and volunteers regarding planning and implementation processes and from management in terms of allocation of working hours earmarked for the implementation of new practices.

Practice development (O1). Besides the generic mechanisms, we identified iterative reflections on the relation between MHP and participants' and organizational practices (M_1) as a mechanism for developing practices. These reflections were initiated and facilitated within the ALP, e.g. through group discussions and program development exercises. Working groups including representatives from different groups of actors, such as students and staff or participants from different organizations or departments, gave room for multiple perspectives which in turn allowed for more nuanced discussions of issues and potential solutions. For example, participants from the university college praised the collaboration between students and staff for bringing together a diverse range of complementary knowledge and skills. Furthermore, several participants highlighted the time frame of the ALP of nine months and the continuous external facilitation of the developmental and implementation processes as essential program resources. These resources, for example, triggered and allowed for iterative reflections and, also, secured participants engagement over time without making the ALP a time-consuming project. As a participant described:

> That somebody external comes in, to make sure we keep our noses to the grindstone, actually has a really good effect… And when receiving an email from you… "Oh Yeah! [giggles] We need to do something." And that's actually fine, really. (Participant, unit 2)

A contextual factor in support of implementing practice developments related to participants' existing tasks, namely, if mental health and MHP were already explicit in their job descriptions, e.g. in the curriculum of the lecturers at the university college (C_1).

Knowledge dissemination activities targeted staff and end-users (O2). We considered the collaboration with the local municipal coordinator, initiated because of participating in the ALP, a mechanism in implementing knowledge dissemination activities (M_2). Participants described the collaboration as bringing together complementary resources and skills. Participants' prior positive experiences of using the

content of the ALP were considered a supportive contextual factor (C_2), for example, for allocating time and effort to develop knowledge dissemination activities. A restraining contextual factor was if participants did not feel they had the mandate to teach staff or end-users about MHP (C_2). This is, for example, expressed in the following excerpt from an interview with a participant regarding knowledge dissemination activities targeted staff:

> Potentially, it would have fit perfectly on a staff-level. But [...] I cannot do that as an employee. Because I would go in and point out some things about my colleagues, which… "So, who are you to tell me that?" And [interviewees name] cannot do that. A manager or person working on a specific project can do that, but we cannot. I mean… We cannot put each other in such a situation, as colleagues, in my opinion. (Participant, unit 3)

3.2. CMO-configurations that matter in personal development among participants

Personal development among participants was identified as a prevalent outcome. Most participants stated to have gained knowledge, skills, and competences related to practicing MHP, project management, and co-creation processes between public sector organizations and NGOs (O3). Moreover, participants across all units reported an increased awareness about mental health promoting practices and behaviors in their daily work routines (O4). The increased awareness related to, for example, bringing a MHP mindset into practice, also, when conducting tasks not explicitly related to health:

> It's always good to be reminded about stuff, I think. Because then I'll bring it with me when teaching other classes as well. Also the ones that are not necessarily about health or health professions. (Participant, unit 3)

Contextual factors and mechanisms related to outcomes of personal development are elaborated in the following sections and summarized in Fig. 2 (depicting the interrelations between context-mechanism elements and outcome types O3 and O4). Subscript numbers on contextual factors and mechanisms indicate which outcome they relate to.

Participants allocating time and resources to engage in a mix of passive and participatory learning activities ($GM_{3–4}$) was identified as a generic mechanism for shaping participants awareness, knowledge, skills, and competences. Passive learning activities, were, for example, presentation of mental health promoting determinants. Participatory learning activities were, for example, group exercises and discussions related to MHP. Participants with a positive attitude towards program resources were more likely to allocate time and resources for these learning activities. Several participants described the educational materials, exercises and information provided at the ALP workshops as appealing, relevant, and adaptable to their work with MHP. For example, participants perceived the ABC-framework as relevant and useful for promoting MHP efforts and for working with MHP across organizational boundaries. We deemed ambiguous perceptions of the relevance and tangibility of the content of the ALP as a restraining factor for the mechanisms that generated personal development. The following excerpt, where a participant appreciates the underlying ideas and intentions of the ALP but finds the program trivial and inadequate, illustrates the relation between this ambiguity and the allocation of time and effort put into the ALP:

> And these are relevant thoughts, that are important to hold on to. But frankly, there's nothing new about it. And I think that's what you've been sensing about me. In cases where I just thought to myself: "Ahhh… come one. This is money down the drain (Participant, unit 3)

Individual and collective reflection processes were often embedded in or resulting from the learning activities applied in the ALP. We considered these reflection processes, for example, on MHP in relation to own practices as a generic mechanism for personal development ($GM_{3–4}$). The nine-month timeframe of the ALP, creation of room for reflection processes at the workshops, and facilitation skills of program facilitators for motivating and engaging participants were identified as program resources facilitating and enabling the generic mechanisms for personal development.

Generic contextual factors supporting the mechanisms of implementing MHP initiatives related to participants' and managements' motivation and available time to participate in the ALP and in co-creation processes ($GCF_{3–4}$).

Strengthened knowledge, skills, and competences related to MHP, project management, and/or co-creation (O3). We identified learning-by-doing as a mechanism for developing participants' knowledge, skills, and competences (M_3). The type of learning-by-doing-activity, initiated within the framework of the ALP, determined the

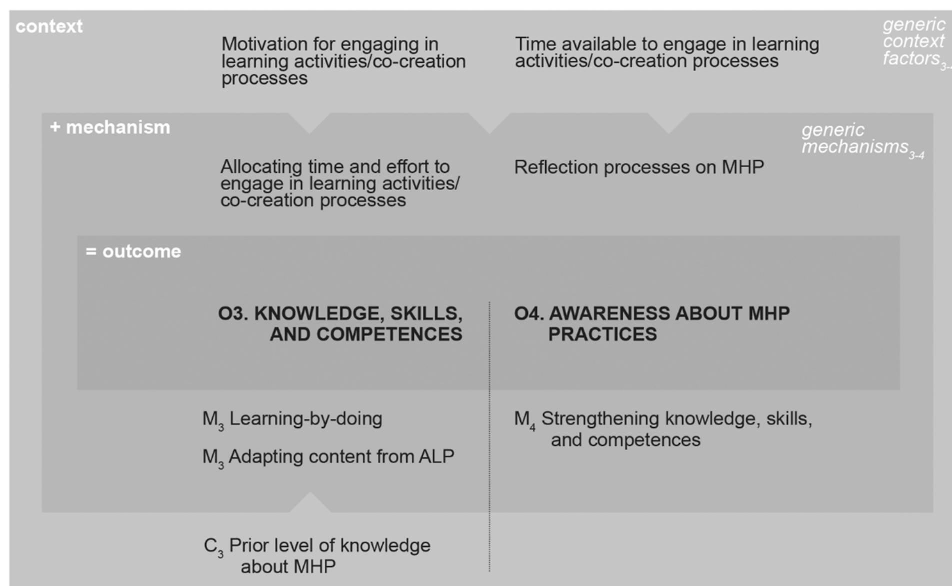

Fig. 2. Summary of context-mechanism-outcome-configurations (C+M=O) on personal development among participants (O3 and O4).

nature of the acquired knowledge, skills, and competences. For example, developing and implementing MHP initiatives strengthened skills and competences related to MHP and project management, and engaging in collaborations across public sector organization and NGOs strengthened participants' skills and competences related to co-creation. An interviewee explained:

> Well, at any rate, I think I've gained some experience related to collaborating with volunteers and [name of participating community volunteer center] […] And because the ABCs of mental health and the action learning program have created this opportunity, which has produced some interesting and good experiences of entering this space [for collaboration] together. (Participant, unit 1)

Also, we considered the process of adapting exercises and educational materials introduced during the ALP to the participants' own practice a mechanism for developing skills and competences (M_3).

Participants prior level of knowledge about MHP (C_3) was deemed a relevant contextual factor playing a pivotal role for the generation of outcome patterns reported by the individual participants. For example, participants who indicated to have only little theoretical knowledge on MHP prior to the ALP voiced to have gained knowledge about mental health promoting determinants through the ALP. Other participants reported not to have gained knowledge through the ALP, alluding to several years of experience with practicing and teaching MHP. However, they reported strengthened skills and competences, as the adaptation of educational materials, exercises, and the ABC-framework helped them to translate their existing knowledge into MHP efforts.

Increasing awareness about MHP practices within daily routines (O4). A mechanism for increasing participant's awareness about MHP practices was the strengthening of knowledge, skills, and competences for working with MHP[3] through participating in the ALP (M_4). For example, several participants praised the ABC-framework for providing them with three simple principles of orientation for practicing MHP which heightened their awareness about MHP in their daily routines. Other mechanisms and contextual factors related to the strengthened awareness are described above as generic.

3.3. CMO-configurations that matter in relational and collaborative development

The initiation of recurring collaborations across organizational boundaries, strengthening MHP capacity, was identified as an outcome of the ALP across all units (O5). These interorganizational and intra-organizational collaborations related to, for example, the above-mentioned practice developments, such as the biannual workshops for first-year students. Strengthened relationships between actors from across organizations or departments was also identified as an outcome of the ALP (O6). This, for example, manifested itself as some participants experienced greater motivation for collaborating with other organizations/departments and that "psychological boundaries" for reaching out to other organizations/departments regarding work-related issues were lowered. Contextual factors and mechanisms related to these outcomes are elaborated in the following sections and summarized in Fig. 3 (depicting the interrelations between context-mechanism elements and outcome types O5 and O6). Subscript numbers indicate which outcome contextual factors and mechanisms relate to.

Generic contextual factors in support of the mechanisms for relational and collaborative development related to the involved actors' motivation for strengthening existing relationships and collaborations ($GCF_{5–6}$). Several participants viewed the ALP as an opportunity to act on this motivation which was stated as a reason to participate in the ALP to begin with. Another supportive contextual factor was a shared interest across organizations/departments in community-oriented and co-creational approaches to MHP ($GCF_{5–6}$). Here, expressed by a participant from the university college and a management employee from the hosting municipality:

> Of course, we are always happy here at [name of university college] when someone external is coming. Because, obviously, they can bring other things into play than we can do as lecturers. (Participant, unit 3)

> We must get out there and facilitate the civil society. […] You cannot sit and wait for a citizen to get sick. You must get out and […] prevent that another citizen becomes a case, right? (Management employee, unit 3)

This interest was particularly strong among actors from the hosting municipality. On several occasions (interviews and ALP workshops) they expressed an organizational agenda of supporting local organizations in strengthening their MHP efforts. Furthermore, convergent goals across organizational boundaries were identified as a supportive generic contextual factor ($GCF_{5–6}$).

Strengthened collaborations across organizational boundaries (O5). A mechanism for initiating and developing these collaborations was that the participation in the ALP increased the legitimacy of participants' engagement in collaborative practices across departments/organizations (M_5). Specifically, the ALP created room and provided tools and frameworks for collaborating on MHP efforts. An interviewee explained:

> I really think that the framework [referring to the action learning program and the ABC-framework] has provided a good foundation for a good co-creation process around: "if we want to make a difference for the citizens in this area here, what are our initiatives then?" (Participant, unit 1)

Furthermore, we considered the process of initiating collaborative practices (M_5), which was particularly evident among employees from the hosting municipality, a mechanism for strengthening collaborations. Support within participants' organization to engage in collaborative practices, e.g. through provision of resources from management or assistance from colleagues (C_5) was identified as a supportive contextual factor for initiating collaborations.

Strengthened relationships across organizational boundaries (O6). Mechanisms for strengthening relationships across organizational boundaries were: face-to-face meetings at the workshops allowing participants to get acquainted; participants' experiences of bringing together relevant and complementary resources and skills for solving organizational tasks through collaborations across organizational boundaries[4]; and experiencing fruitful collaborations that draw on resources and skills from several of the involved organizations/departments (M_6). The relation between these mechanisms and strengthening relationships is illustrated in the following interview quotes:

> I think it's always good to be able to put a face to someone in this way. Because then its way easier to call [that someone], right? […] So, it's really about this that you have met people, and that you have collaborated with people. Well, that really just makes it way easier [to reach out] if you get some sort of crazy idea or think "we really need to do something about this". (Participant, unit 1)

> It has been great to work on this initiative with [name of participant from the hosting municipality] and others where we just succeeded

[3] Acquisition of knowledge, skills, and competences is also considered an outcome (O3) and, thus, part of a series of interrelated CMO-configurations.

[4] Collaboration across organizational boundaries was considered both a time-related outcome (O5) and a mechanism and, thus, part of a series of interrelated CMO-configurations.

Fig. 3. Summary of context-mechanism-outcome-configurations (C+M=O) on relational and collaborative development (O5 and O6).

in implementing that sort of small activity within a really short timeframe and actually without making a big effort. And, I think, that has the potential to contribute to our collaboration [with the municipality] becoming even better. Because this sort of proofs that it doesn't have to be lengthy and complicated. Sometimes, you give up beforehand because these things need to go through so many layers. (Participant, unit 1)

Contextual factors supportive of these mechanisms are described above as generic contextual factors.

4. Discussion

Through an investigation of CMO-configurations, we explored the workings of action learning processes for building MHP capacity. The identified outcome themes range across implementation of MHP initiatives, personal development among participants, and relational and collaborative development across organizational boundaries. Our analytical provision of CMO-configurations adds to the literature with nuanced descriptions of the underlying workings of an action learning program. The account of CMO-configurations provides insights into how contextual factors (e.g. participant motivation and knowledge, organizational support, and existing task descriptions) in combination with certain mechanisms of the ALP (e.g. legitimizing MHP as an organizational agenda, learning-by-doing, and collaborations across organizational boundaries) explained the identified outcomes. Overall, our results regarding under which circumstances and for whom the ALP generated desirable outcomes are in line with the recommendations for and descriptions of pitfalls within action learning given in the literature (Folker & Lauridsen, 2017; Leonard & Marquardt, 2010; Zuber-Skerritt, 2002). Given the multitude of expert recommendations on the need to strengthen MHP capacity and for re-orienting practice towards integrating MHP practices (Barry, 2019; Forsman et al., 2015; IUHPE, 2021; Kalra et al., 2012), we find it worth noting that most participating organizations implemented knowledge dissemination activities targeting staff and end-users. These activities may support this movement called for by experts by promoting MHP knowledge, skills, and competences in their organizations.

In line with the recommendations for action learning (Zuber-Skerritt, 2002), our results suggest that providing (specialist) input, such as knowledge and tools, combined with group discussions and reflection processes guided by the ALP facilitators were central program resources for generating several of the observed outcomes. This finding is consistent with other studies on action learning (Folker & Lauridsen, 2017; Machin & Pearson, 2014). However, other mechanisms with less focus on external input may also be relevant to consider when planning, executing, and evaluating capacity building efforts. In this regard, some of the CMO-configurations presented lend support to the notion that action learning works through mobilizing and increasing the utilization of local resources (Hale, 2014; Zuber-Skerritt, 2002). These findings on the workings of the ALP are in line with the outline of action learning given by Reginald Revans, who is considered a pioneer of action learning (Pedler & Burgoyne, 2015). According to Revans, facilitators *do not* provide specialist input or teach participants. His approach to action learning gives a more prominent role to local (tacit) knowledge as opposed to specialist knowledge provided by facilitators and, thus, may draw on mechanisms allowing for relatively more room for peer-to-peer development. Furthermore, our findings show how participants' prior knowledge on MHP is an important factor regarding whether participants report to have gained knowledge or received help to translate existing knowledge into MHP competences. Overall, our findings indicate that developing MHP practices, and hereby increasing MHP capacity, benefits from facilitating translation of local knowledge and skills into concrete competences and practices – whether or not the facilitation strategy includes expert input.

Working with the three embedded units separately allowed for a context-sensitive analysis (Mason, 2018; Yin, 2014) which was an advantage when answering the questions *how, for whom,* and *in what circumstances* the ALP worked (Pawson & Tilley, 2004). This implies that the transferability of our findings to other contexts requires careful consideration and testing (Astbury & Leeuw, 2010). In this regard, our presentation of context factors related to program mechanisms offers an explicit warrant for under what circumstances and for whom the identified mechanisms may be considered feasible for strengthening MHP capacity.

Our position as "internal evaluators" entails several advantages and disadvantages (Bachrach & Newcomer, 2002; Conley-Tyler, 2005). For example, we cannot rule out that our position could have led to interviewees holding back criticism or overreporting outcomes. Also, our immersion in the project and the subsequent "lack of distance" may have resulted in blind spots in our reading of data. However, the position of "internal evaluators", on the other hand, allowed us to gain insights into reactions and interactions of the involved actors that were not captured in the data. Furthermore, our involvement in developing the ALP and

prior experience with planning and evaluating capacity building activities that include the ABC-framework and participatory methods (Hinrichsen et al., 2020; Koushede, Nielsen, Meilstrup, & Donovan, 2015) have provided us with valuable knowledge about the workings of programs like the ALP. We argue that these insights and prior experiences were considerable capacities for our analytical processes heightening the probability that we were able to tease out the most relevant CMO elements.

Put into a realist evaluation jargon, this study, in relation to prior evaluations of similar programs and efforts, can be seen as one of several turns of the *scientific wheel of realist evaluation* where programs are continuously developed, tested, and refined (Pawson & Tilley, 1997). Our study, presenting an analysis of CMO-configuration, contributes to this circular evaluation and research process with detailed knowledge on the interplay between capacity building mechanisms found within actions learning and contextual factors. In line with realist evaluation being theory driven (Jagosh et al., 2015), this knowledge can inform program development and should be tested in future evaluation and research (Jolley, 2014). Further research assessing the capacity building outcomes in the wider organization, e.g. resulting from participant driven knowledge dissemination, using quantitative outcome measures is warranted. This would allow for further exploring capacity building mechanisms of action learning that are not evident in this study (due to the limited scope of the outcome assessment of this study). Another remaining question is what the effect of building MHP capacity is, e.g., how the participant initiated MHP efforts impact the mental health of affected individuals. Attending to these questions requires further research, optimally, including longitudinal outcome data.

5. Lessons learned

Astbury and Leeuw (2010) suggest that evaluating social programs on the level of mechanisms (opposed to program components as such) widens the potential transferability of evaluation results. In line with this perspective, we believe that the detailed account of the workings of action learning provided in this study may be used to inform programs and implementation strategies targeting MHP capacity. When considering mechanisms for capacity building, it might be useful to take into consideration the discussion of whether mechanisms can be activated/not activated or can be activated to a greater or lesser extent (Ravn, 2019). For example, if the extent or duration of reflection processes affect the generated outcome. Furthermore, our evaluation results on the mechanism level might open up for the possibility to distinguish between "basic mechanisms" of action learning (e.g. learning-by-doing and reflection processes) and mechanisms related to specific resources introduced as part of the ALP evaluated in this study (e.g. the adaption of the ABC-framework). This would suggest that our presentation of CMO-configurations building on these basic mechanisms can be used to inform the design of capacity building and action learning efforts more broadly.

We found that realist evaluation offered a relevant and fruitful approach to evaluation by stimulating a comprehensive analysis of the workings of the ALP (leading to several valuable learnings that go beyond what is reported in this paper). However, it is our experience that engaging in a realist evaluation can be time-consuming and requires a thorough understanding of the philosophical and theoretical underpinnings. We received a great deal of advice and consultancy (e.g. regarding literature recommendations and concrete analytical challenges) in an online free-to-join network for researchers interested in realist evaluation.[5] Altogether, we consider realist evaluation a rewarding and helpful approach for gaining an in-depth understanding of social programs. Moreover, presuming time pressure is not an issue, we encourage evaluators to consider the potential of applying realist evaluation methodology in their work.

6. Conclusion

The purpose of this study was to learn about the underlying workings of action learning processes for building MHP capacity. This was done by exploring how combinations of mechanisms and contextual factors explained the observed outcomes of an ALP targeting MHP capacity. Presenting a detailed account of CMO-configurations, the findings of this study provide insights into the underlying workings and potential outcomes of action learning. For example, our results suggest that action learning works through not only expert input but also mobilizing and increasing the utilization of local resources that contribute to maintain and promote mental health. Taken together, our results strengthen the notion that the underlying mechanisms of action learning hold the potential to guide participants in addressing specific local issues and to build problem solving capacity, here MHP capacity, on an individual, organizational, and community level (Pedler & Burgoyne, 2015; Pounder, 2009). The insights provided in this study may be valuable for developing program theories and implementation strategies for programs targeting MHP capacity and/or applying action learning methods. This study, also, illustrates how realist evaluation offers a relevant methodology for investigating the underlying workings of capacity building programs.

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CRediT authorship contribution statement

Carsten Hinrichsen: Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft, Visualization. **Malene Kubstrup Nelausen**: Writing – review & editing, Formal analysis. **Line Nielsen**: Writing – review & editing. **Ziggi Ivan Santini**: Writing – review & editing. **Charlotte Meilstrup**: Writing – review & editing. **Morten Hulvej Rod**: Supervision, Writing – review & editing, Methodology. **Vibeke Koushede**: Supervision, Writing – review & editing, Funding acquisition, Project administration, Methodology. **Sigurd Lauridsen**: Supervision, Writing – review & editing, Methodology.

Declaration of Competing Interest

We declare no conflicts of interest.

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Artikel 3

Intersectoral mental health promotion – a practice-oriented taxonomy of roles and a study of intersectoral dynamics

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Intersectoral mental health promotion – a practice-oriented taxonomy of roles and a study of intersectoral dynamics

Abstract

The need for strengthening intersectoral mental health promotion (MHP), together with prevention and treatment, is widely acknowledged. However, what roles are involved in intersectoral MHP and the interrelatedness of these roles have received limited attention in the existing literature. Therefore, the aim of this study is, first, to develop a practice-oriented taxonomy of roles within intersectoral MHP practices and, secondly, to investigate interactions across roles within the implementation of MHP practices. We conducted secondary analyses on data from a study (conducted between 2019-2021) evaluating MHP efforts within the Danish ABCs of mental health partnership. Data included 17 interviews, 10 telephone interviews, two group interviews, observational data, and documents. Analytical processes were inspired by the approach of Template Analysis and drew on results of prior evaluations of the ABCs of mental health and literature on MHP. We propose a taxonomy consisting of five different roles: 1) decision-maker; 2) MHP specialist; 3) MHP coordinator; 4) MHP practitioner; and 5) end-user. Furthermore, applying these roles in a case study of the implementation of MHP practices in a Danish community setting, we elucidate and exemplify the interactions and interrelated across roles. The proposed taxonomy extends the current evidence-base for MHP by offering a language that can be used to clarify roles and functions within MHP practices across sectors and professions. It is, to our knowledge, the first of its kind specifically for MHP. Overall, our results add to the literature on MHP and facilitate a greater understanding of the intersectoral actions of MHP, which is relevant for strengthening practices and capacity building within MHP. Research on the transferability of the taxonomy and which competences are needed to successfully master the five identified roles is warranted.

Background

The need for strengthening mental health promotion (MHP) efforts is widely acknowledged not only to increase population mental wellbeing but also as a means to reduce the burden of mental health problems (1-6). A major part of the determinants for mental health and wellbeing are found in the context of peoples everyday life, making MHP everybody´s business (7). Therefore, MHP is an intersectoral matter and should include sectors such as education, housing, health, employment, transport, arts, sports, and urban planning (4, 5). The need for intersectoral approaches to MHP, such as partnership and community-based efforts, is recognised in national and international MHP-recommendations (1-3). The World Health Organization, for example, has set a global goal that 80% of countries should have at least two functioning national, multisectoral promotion and prevention programs targeting mental health by 2030 (8).

The body of literature regarding the implementation of MHP efforts is sparse but growing (2, 5). Within the past decade, several programs that apply intersectoral approaches have been developed and tested, but only limited evaluation and implementation results have been published (9). Several implementation challenges within MHP are related to the transdisciplinary and intersectoral nature of MHP and they include: practitioners voicing issues related to MHP being outside their sphere of interest or influence (10, 11); practitioners

perceiving mental health as an unfamiliar term which is often negatively loaded and seen as blurred and difficult to define and operationalise (12); and practitioners lacking knowledge and competences to work with MHP (13, 14). These issues seem to relate to the fact that MHP practices are often embedded in a broad array of practices and involve a wide variety of actors from fields not traditionally thought to be directly related to health. Also, the implementation challenges seem to constitute intersectoral and interprofessional differences regarding the conceptualization of MHP and varying perspectives on who is responsible for implementing and practicing MHP. In this regard, Margaret Barry has called for practice-based knowledge and theory that embraces the intersectoral nature of MHP (15).

International research-based guidance and recommendations for MHP highlight the need for building MHP capacity to meet implementation challenges and to strengthen MHP practices within and across sectors (1, 3, 7, 16). Emerging research applying a capacity perspective is mapping competences related to MHP, for example, for practicing MHP within the health sector (17) and for engaging in intersectoral efforts such as partnerships (18). Furthermore, strategies for building MHP capacity have been tested and investigated, for example, in a Canadian hospital setting (19) and in a Danish community setting (20). Public Health England published a framework for building workforce capacity for public mental health across sectors and, here, highlight the need for strengthening leadership for MHP, strengthening the expertise within the public health specialist workforce, and increasing the capabilities within the wider workforce (16).

The literature on MHP offers an overall indication of the roles within MHP but lacks comprehensive accounts of key functions and the interrelatedness of the individual actors that are involved. A shared language and conceptualization of the roles inherent to MHP that is applicable across sectors, professions, and disciplines would likely benefit capacity building efforts and the implementation of MHP practices (21). Therefore, this study aims to develop a practice-oriented taxonomy of roles within intersectoral MHP practices. A secondary aim is to investigate the interactions across roles within the implementation of MHP practices.

Conceptual clarifications

Mental health promotion

In this study, we conceptualize MHP as an approach to mental health improvement concerned with achieving positive mental health and well-being at an individual, community, and population level (22). Even though MHP shares some characteristics with preventive efforts targeting mental disorders, it should be seen as a distinct concept with a unique set of attributes and values (23). This includes a strong emphasis on promoting positive aspects of mental health (i.e., mental wellbeing, psychological flourishing, and life satisfaction) and applying a salutogenic approach (i.e., focusing primarily on strengthening resources for wellbeing rather than on risk reduction for mental health problems). Moreover, a core value within MHP is its relevance to all individuals because mental health is seen as an integral part of overall health (22). Effective MHP should work across intervention levels, from macro policy to local practices embedded in day-to-day practices (7). In line with the Ottawa Charter for Health Promotion, MHP therefore embraces both top-down policy and bottom-up community strategies and actions to achieve the goal of creating a society where MHP values and practices are embedded in all arenas and settings (22).

Roles within MHP

Given the intersectoral nature of MHP, the responsibility to implement MHP practices cannot be placed on specific professions or sectors alone (4, 22). Implementation recommendations for MHP outline which groups of workforce and what sectors should be involved in implementing MHP efforts (7, 16). For example, Barry (21) highlights that community members, health professionals, and governmental and non-governmental agencies are relevant to involve. Also, Public Health England presents an overall categorization of the work-force needed within public mental health (16). This categorization includes *leaders*, *public health specialists and senior staff*, *public health practitioners*, and *wider workforce* (16), the latter two being categorized as *front-line staff*. Others have focused on key tasks of MHP performed within specific sectors on a national level (24). These conceptualizations of which actors are involved in MHP are, however, relatively fragmented, i.e., they focus on one sector or one level of intervention only, and therefore, do not capture the intersectoral nature of MHP. Also, they generally do not or only partially account for functions on the level of individual actors. Taken together, there is a lack of a shared systematic and practice-oriented language about 1) key functions needed for developing, implementing, and sustaining intersectoral MHP practices, and 2) the in-terrelatedness of such functions. Therefore, in this study, we aim to develop a taxonomy of roles on an indi-vidual level which is applicable across sectors and levels of interventions and, also, encompasses the interre-latedness of the roles.

Inspired by functional role theory (25), in this study, roles are defined based on a portfolio of key functions, rather than for example which professions perform functions, in what sector functions are performed, or-ganizational hierarchies, or what work-related position individuals hold. The key functions may be closely related to or even depend on certain capacities inherent to individuals performing a certain role which in turn may be rooted in their professional background and experience (e.g., possession of specialized knowledge related to MHP) or qua their professional position (e.g., decision-making powers).

Methods

To investigate key roles within intersectoral MHP efforts and their interrelatedness, we conducted an itera-tive, staged analysis of MHP efforts found within the Danish ABCs of mental health (ABCs) partnership (26). We particularly investigated the case of a pilot implementation of an action learning program (ALP). Informed by emerging literature on MHP and results of prior evaluations of the ABCs, our analytical approach was based on an analysis of qualitative data from a previous evaluation study of the ALP (20). The analysis of the current study can be termed a secondary analysis because the data was collected for another purpose than the current study. Re-using the data to address the aims of this study allowed for a *defamiliarized* reading of the data (27) which have given room for new modes of thought and to problematise and crystalise aspects potentially glossed over in our initial examination of the data. Also, it allowed us to revisit data transsitua-tionally, and, hereby, potentially reexperiencing the data in a new way. According to Timmermans and Tavory, both defamiliarization and revisiting of data are methodological steps for empirically based theory construction drawing on abductive reasoning (27).

Setting – The partnership ABCs of mental health

The ABCs partnership is a nation-wide intersectoral partnership aimed at promoting mental health on a population level. The partnership is composed of mainly public and third sector organizations. The number of partner organizations has continuously increased since the partnership was established in 2014; from five to 65 partner organizations (at this writing, JAN 2022(28)). Partner organizations include public organizations such as municipalities, universities, and one of five Danish Regions (administrative health entities) and third sector organizations such as non-profit organizations from the fields of social housing, community development, sports and leisure activities, and education. The ABCs partnership seeks to bridge the gap between international recommendations, research, policy, and practice related to MHP (29). Most partner organizations develop and implement MHP initiatives within their local settings based on a research-based framework for understanding and working with MHP: the ABC-framework. The ABC-framework was designed to not only reduce the complexity surrounding the concept of mental health for the population at large but also to provide staff such as service-providers, health professionals, and volunteers with a practice-oriented framework for MHP (29). Overall, the initiatives developed within the partnership fit within the following strategies: 1) building capacity to work with MHP (e.g., by providing staff training); 2) campaign activities to promote mental health awareness and knowledge (e.g., online advertisement); and 3) establishing and promoting opportunities to engage in mentally healthy activities (e.g., volunteer led walking groups)" (29). A smaller part of partner organizations' main contribution lies in supporting other organizations developing and implementing MHP practices. The background, development, and organization of the partnership ABCs and the ABC-framework are described in more detail elsewhere (30).

The ALP was developed and piloted as a sub-project in collaboration between multiple partners of the ABCs partnership within the ABCs partnership (Sept. 2019 to June 2020). Further, the ALP aimed at developing and promoting practices, knowledge, skills, and competences related to MHP within and across organizations. We chose the ALP as a case in this study as we deemed it to be an exemplary case of intersectoral MHP because it was successful in facilitating the development of MHP practices and building MHP capacity in an interorganisational context (20). Action learning refers to a collaborative action-based approach to learning, where groups of people work on solving particular issues, and in that way, also, build problem-solving capacity (31). Action learning works through processes of trial and error, critical reflection, group discussions, and receiving specialist input (20, 32). The ALP ran over 9 months and entailed 4 workshops focusing on participant driven development and implementation of local MHP initiatives. A core component of the ALP was the introduction of the ABC-framework as a tool for conceptualizing and working with MHP in practice.

Data

Data used in this study was originally generated for the purpose of evaluating the ALP (20). Data was generated through 17 face-to-face interviews (n=17), 10 telephone interviews (n=5), two group interviews (n=4), observational data from workshops of the ALP, and project documents. The data generation sought to provide information regarding involved actors' perception of implementation processes including personal involvement, local project organization, local MHP practices, and impact of the ALP and local MHP initiatives. All interviewees were directly or indirectly involved in developing, planning, and/or implementing MHP initiatives and included: management employees and health promotion consultants from municipalities; management employees, lecturers, a student counsellor, and students from a university college; and a volunteer

engaged in a non-profit organization. Written informed consent was obtained from all participants. Details on data generation, participants, and ethical considerations are reported elsewhere (20).

Analytical approach

Our analysis was iterative, conducted in three stages, and operating in an interplay between individual and collaborative analytical processes. The first two stages concerned the development of the taxonomy of roles and applied an analytical approach inspired by King's Template Analysis (33). Template Analysis is a style of thematic analysis allowing for the use of *a priori* themes that are informed by theory and practice experiences. Further, inspired by the procedures of Template Analysis, our analysis involved the development of a template that acted as a structure for the taxonomy of roles. Our guiding questions for the development of the template were: What are the essential functions related to bringing MHP into practice and who is performing these functions? The analytical steps and development of the template (i.e., the set of roles) are summarized in Table 1.

Table 1. Description of purpose, procedure, roles in template, and data in the three stages of the analyses.

Stage	Purpose	Procedure	Roles in template	Data and key inspirational sources
1	Development of initial taxonomy of roles	Developing initial template analysis	1) Leader 2) MHP specialist 3) MHP practitioner 4) Wider workforce	Prior evaluations of the ABC's (34-36) and literature on MHP (16, 21)
2	Development of final taxonomy of roles	Further developing and refining the initial template in an iterative process of trying out successive versions of the template	1) Leader 2) MHP specialist 3) MHP practitioner 4) Wider workforce 5) End user	Data on the ALP, including interviews, group interviews, and narrative case-descriptions based on observational data and documents and telephone interviews + the reporting of a case study (35)
3	Eliciting interactions across roles	Mapping and linking interactions between roles to investigate their interrelatedness	1) Decision-maker 2) MHP specialist 3) MHP co-ordinator 4) MHP practitioner 5) End user	Data on the ALP, including interviews, group interviews, and narrative case-descriptions based on observational data and documents and telephone interviews

In the first stage, we created an initial template consisting of a set of a priori roles including broad descriptions of their functions. This process was informed by discussions of the findings and learnings of prior evaluations of the ABCs (34-36) and literature on MHP. Inspired by the key workforce categories described by Barry (21) and Public Health England (16) and after two rounds of discussions among co-authors, the initial template entailed four roles: *management*, *specialist*, *practitioner*, and *wider workforce*.

In the second stage, we applied this initial template on data with the purpose of further developing and refining the initial template. It was an iterative process of trying out successive versions of the template (37) and entailed an analysis of the case of the ALP (conducted by the first author), including data from face-to-

face interviews, group interviews, and narrative case-descriptions. The latter were based on observational data and 10 telephone interviews and produced in relation to the evaluation of the ALP (20). Also, this stage entailed a collaborative analytical process (38) (involving CH, AK, ZIS, FSJ, and CM) scrutinizing MHP practices that draw on the ABC-framework of a large national umbrella organisation working with sports. The object of analysis in this process was the reporting of the case study (35) produced as a part of a process evaluation of the ABCs (the case study drew on data from four interviews (n=4) and one group interview (n=4)). The second stage resulted in adding the role *end user* to the template. At this point, the template consisted of five roles, which constituted the final set of roles, i.e., the taxonomy. Based on discussions among co-authors, we renamed the roles to better reflect their functions, e.g., the role *practitioner* was coined *MHP co-ordinator* and *wider workforce* was renamed *MHP practitioner*.

The third stage of the analyses concerned the investigation of interactions across roles. For this purpose, we applied the taxonomy of roles to study the ALP-case. Drawing on data from the evaluation of the ALP, we mapped and linked interactions between roles to investigate their interrelatedness. A central analytical question at this stage was: How do the functions of the individual roles relate to and intersect with the functions of other roles? The multiple data sources provided deep insights into the multi-faceted and interwoven processes of MHP practices. This analysis is presented by means of a selection of illustrative scenarios from the ALP-case, which are reported in a chronological order (before, during, and after the ALP). In selecting scenarios, the main criterion was that they illustrated the interrelatedness of the roles and interactions reaching across sectors, professions, and organizational boundaries. This format allowed us, first, to explore how the five roles are manifested within the case and, then, to trace back the interrelatedness of these roles.

Results

The results are presented in two parts. First, we present the taxonomy of roles involved in intersectoral MHP practice. Secondly, we present the analysis of the ALP-case seeking to illuminate and exemplify interactions and interrelatedness across roles. Interview quotations illustrate participants' views underpinning our analytical propositions.

Roles and their functions

We identified five essential roles related to intersectoral MHP practice: 1) decision-maker; 2) MHP specialist; 3) MHP co-ordinator; 4) MHP practitioner; and 5) end-user which are described in the following.

A **decision-maker** has considerable influence on decision-making or makes executive decisions within an organization (e.g., jurisdiction, project, or department) that affect organizational MHP practices within the organization. In our empirical analysis, this role was identified among for example local level politicians, a head of a municipal department for health promotion and disease prevention, head of department and education managers at a university college, and the head of a community volunteer centre. The decision-maker's key functions include advocating and supporting the promotion of MHP initiatives and practices locally and to some extend in the wider community. Furthermore, decision-makers have influence on decision-making related to securing structures and systems that support MHP efforts. This includes allocation of resources; the initiation and promotion of collaborations and partnerships with local organizations; and securing relevant

expertise from internal/external MHP-specialists. All together, the functions of the decision-maker are centred around strategy and policy work. A head of a municipal department for health promotion and disease prevention described the strategic work related to strengthening organizational MHP practices as follows:

> "It [MHP] cannot be an additional… municipal task. But we work on massaging health promotion and disease prevention in as a means of reaching the end goals in […] municipal tasks or when being in contact with citizens/service users." (Decision-maker: head of health promotion department, municipality)

A **MHP specialist**'s main function is to support the development and implementation of MHP practices by providing guidance and/or advice to the other roles. This supporting function operates across boundaries of organisations/departments. The role of the MHP specialist requires specialized knowledge, skills, and competences related to MHP, for example, regarding intervention planning, implementation, evaluation and the determinants of wellbeing and mental health. In our analysis, this role was identified among for example a health consultant employed in municipal department for health promotion and disease prevention, a consultant employed in a non-profit organization, and MHP researchers employed at universities. The capacity of the MHP specialist is brought into play in various functions. This involves, for example, providing technical and research-based knowledge for policy and strategy processes and for supporting MHP co-ordinators to promote MHP practices, i.e., that are in line with MHP values and principles. The following quote, voiced by a health consultant acting as a MHP specialist, illustrates what lies at the core of the role of a MHP specialist:

> "… I prepare other professions to incorporate this wellbeing and mental health promotion. I think that […] we prepare actors to … in another organization… to be able to perform actions that promote mental health. And that needs to come from the bottom, but also from the top. That there will be… how do I put this? Allocated time to engage in this. (MHP specialist: health consultant, municipality)

A **MHP co-ordinator**'s key functions is concerned with strengthening local MHP practices. As opposed to the MHP specialist, this function is typically performed within the organisation/department of employment. This includes leading and carrying out the development, planning, implementation, and evaluation of local MHP initiatives (e.g., mental health and wellbeing literacy campaigns and activities promoting mentally healthy behaviours) and building MHP capacity locally (e.g., by disseminating MHP specific knowledge to MHP practitioner). These functions may be explicitly described in their job description but are not necessarily their main functions within an organization or system. In our analysis, this role was identified among for example lecturers and a student counsellor from a university college, a social counsellor employed at a community volunteer centre, and a health consultant employed in a municipal department for health promotion and disease prevention. The following interview quote provides an insight into the work of a MHP co-ordinator building local MHP capacity through disseminating knowledge to colleagues:

> " And, hopefully, this [presentation on MHP] will also make my colleagues become more aware of it [MHP]. And this is where [name of health consultant from municipality] and I need to set up a clever plan to make this happen." (MHP co-ordinator: lecturer, university college)

A **MHP practitioner** embeds a MHP values and principles in day-to-day practices and core tasks, and is not acting as a decision-maker, MHP specialist, or MHP co-ordinator. Other central functions are to engage in the implementation of local MHP initiatives. In our analysis, this role was identified among for example lecturers

from a university college, librarians, nurses, primary school teachers, residential social workers, and kindergarten teachers. Common for the work of these professions is the embedded opportunity or ability to positively impact wellbeing and mental health of other individuals, e.g., when teaching and practicing health and social care. The embeddedness of MHP practices of the MHP practitioner is voiced in the following quote by a lecturer:

> ”Both with myself and among my colleagues, I experience that we make an effort to… create wellbeing. But in reality, there isn’t really allocated any hours for it.” (MHP practitioner: lecturer, university college)

Through their practices, MHP practitioners are able to encourage and support end users to engage in mentally healthy activities and to reflect on determinants for mental wellbeing (e.g., by deliberately including topics of mental wellbeing in school curriculum and using simple conversation guides including topics related to wellbeing in social and health care activities). The type of MHP practices of the MHP practitioner depend on the extent and type of contact with end users such as citizens, patients, and service users. The MHP practitioner can also be involved in and contribute with practice-based knowledge to local MHP projects.

End users are individuals whose wellbeing and mental health is targeted and/or influenced trough MHP practices. In our analysis, we identified service users such as students at a university college, pupils at primary schools and residents of residential homes, members of sports and leisure activity clubs, and the wider population of municipalities as end users. End users’ degree of engagement in MHP initiatives varies. On the more passive side, they can act as recipients of campaign activities. On the more proactive/engaged side, end users can engage in co-creation processes, for example, by providing user perspectives. Moreover, end users can engage in promoting a MHP culture and MHP mindset in the local community, e.g., among peers and by engaging in bottom-up initiatives related to MHP. This function of promoting a friendly culture as a MHP initiative was explained as follows by a student from a university college:

> ”But it may also be that if you are met by a pleasant ‘good morning’, or a happy chat, that you will get a boost of energy, even though it’s been a busy and stressful morning.“ (End user: student, university college)

A cross cutting function, identified for all roles, was MHP-advocacy which denotes the act of promoting and supporting the case and practices of MHP. Decision-makers and MHP-specialist would do this both locally and in the wider community, and MHP co-ordinators, MHP practitioners, and the end users would do it primarily in the local community, e.g., within an organization or among peers.

The categorization of functions pertinent to each role should not be seen as clear-cut as some functions are shared and the functions across roles are interrelated (which is substantiated in the next part of the results). Also, it is important to note, that one individual may enact various roles depending on the specific context and situation. For example, a lecturer might take on the role as MHP co-ordinator when leading and implementing MHP initiatives in an educational organization. The same lecturer can engage in MHP as a MHP practitioner when lecturing. And the same person may be considered an end user, for example, when being exposed to MHP campaigns in the local community.

A case of MHP practices working across roles and sectors

With the five roles outlined above, we go on to apply the roles to analyse interactions and the interrelatedness of roles within the case if the ALP. The analysis is structured according to the following phases: Before, during, and after the implementation of the ALP. First, we briefly present the organisation of the ALP to provide some further context for the analysis. Figure 1 summarizes the results of this study. It illustrates main areas of tasks that 1) are related to the functions of each role (first part of the results) and 2) represent key areas of interactions between roles (second part of the results).

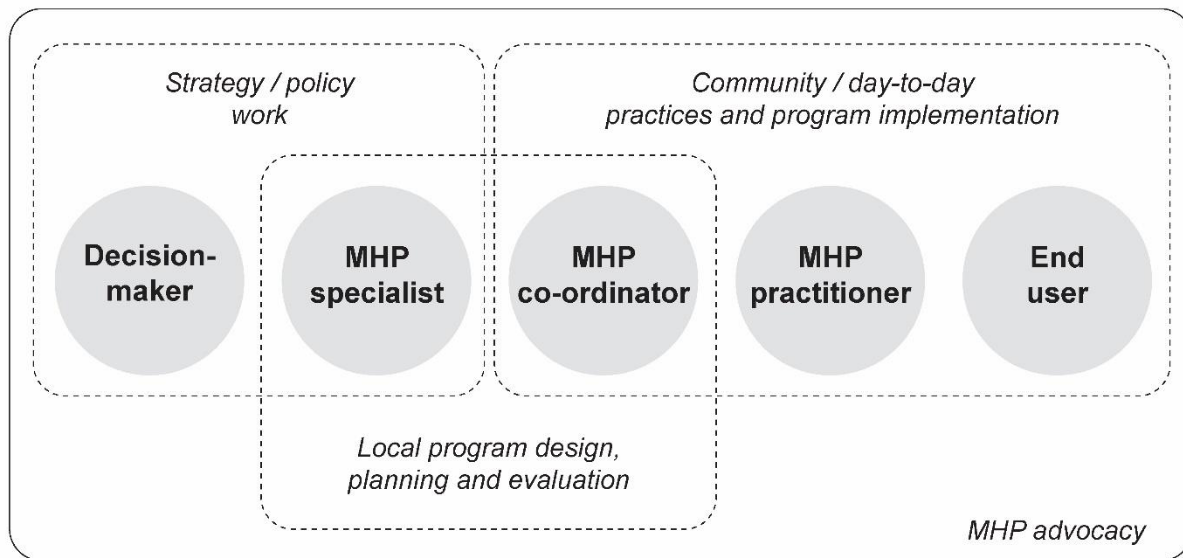

Figure 1. The five roles of the taxonomy for intersectoral MHP in relation to overall tasks that 1) are related to the key functions of each role and 2) represent key areas of interaction between roles. The function MHP-advocacy is mainly the former.

The organisation of the ALP

The involved organisations in the ALP were: A research institute; a large national umbrella organisation within sports; and the health promotion department of a municipality. The latter was the host of the ALP, i.e., inviting local organizations to participate and supporting the facilitation of the ALP. Two researchers from the research institute (CH and VJK) and a consultant of the umbrella organisation were responsible for planning and facilitating the ALP. This was done in close collaboration with a health promotion officer and the head of the department for health promotion and disease prevention of the hosting municipality. The participating organisations were a local community volunteer centre, the health promotion department of the hosting municipality and four departments of a university college (nursing, social work, teacher training and social education). Each participating organization was represented by a working group consisting of employees and in some cases included volunteers or students.

Before implementation

The development and planning of the ALP involved the roles MHP-specialist and decision-maker in program planning and recruitment activities. These activities involved negotiations across roles, organisations, and

sectors. Based on the results of studying and evaluating MHP-initiatives within the ABCs partnership (specialist/technical knowledge), researchers from the research institute (CH and VJK) outlined the basic ideas of the ALP. The design of the ALP was pitched to representatives of a municipality partnering in the ABCs, who agreed to collaborate on further developing and piloting the ALP. By engaging in these program design and planning activities, the researchers acted as MHP-specialists. Acting in the role of a decision-maker, the head of health promotion department from the hosting municipality described his functions related to the ALP as follows:

> "You know, before [the actual ALP started], I was probably a "midwife". Midwife assistant. Getting it [the ALP] up and running. And identifying all those arenas [organisations/departments potentially interested in participating]" (Decision-maker: head of health promotion department, municipality)

The position of a "midwife" refers to his work in supporting the development of the ALP, for example, by engaging in discussions and negotiations regarding the design of the ALP. Furthermore, the quote refers to his function of identifying and recruiting organisations/departments interested in participating in ALP, which we consider intersectoral advocacy for MHP. This was done by reaching out to management employees from several departments within the municipality and other organisations, such as the local university college. Some of the invited decision-makers accepted and some declined the invitation to participate in the ALP and, hereby, prioritised in terms of resource allocation for MHP in their own organisation/department.

During implementation

During the nine-month time-period of piloting the ALP, four workshops were conducted where participants developed, planned, and implemented MHP initiatives targeted specific local issues. The workshops set the scene for intersectoral collaboration where MHP-specialists could guide and support MHP-related work of the participants in the roles of MHP co-ordinators, MHP practitioner, and end users. Researchers from the research institute and the consultant from the umbrella organisation had the primary responsibility to facilitate the workshops, and a health promotion consultant from the hosting municipality was co-facilitating the workshops. Through the facilitation of the workshops and by providing guidance and support for the participants from the local community, the facilitators acted as MHP-specialists. Together, they contributed with a mix of specialist/technical competences, such as research-based knowledge on MHP and implementation processes (researchers), knowledge regarding the adaption of the ABC-framework and facilitation skills (consultant from the umbrella organisation), and knowledge about local resources relevant for MHP (consultant from the hosting municipality). The co-facilitator from the hosting municipality described her function and rationale for this work as follows:

> "We would call it something like playing on their side of the court and preparing them to do… being aware of wellbeing. For instance, within the education system. […] That means, if they, the staff of the educational institutions become… Become aware of well-being, mental health, and meaningful social relations, and if they embed it in their organization, well, then perhaps… is the hypothesis… dropout rates will decrease." (MHP-specialist: co-facilitator of the ALP, health consultant, municipality)

This quote illustrates how the MHP-specialist not only supports and guides the promotion of MHP practices in other sectors and organisations but also advocates for the MHP-agenda (by linking MHP with drop-out rates and hereby making the case for MHP in the specific local context). According to both participants and the facilitators, an important function of the facilitators was to continuously keep participants motivated and

engaged, e.g., through follow up e-mails and phone calls between workshops. Interviewees described this as an important factor for securing progress in the development and implementation processes. A participant explained:

> "That somebody external comes in, to make sure we keep our noses to the grindstone, actually has a really good effect… And when receiving an email from you… "Oh Yeah! [giggles] We need to do something." And that's actually fine, really." (MHP co-ordinator: participant in the ALP, lecturer, university college)

The ABCs partnership provided a forum for MHP-specialists to discuss matters related to planning and practicing MHP (e.g., at network meetings), which some of them would not have the opportunity to do in their own organisation. Thus, the partnership acted as a supporting structure that strengthened the MHP-related competences of the facilitators, which, in turn, enabled them to better support participants of the ALP. This supporting function of the partnership is voiced in the following quote by the co-facilitator:

> "I think it was really nice that I could draw on somebody who kind of possessed some perspectives to understand this. […] Well, discussing these overall consideration [regarding MHP] which I may not discuss with my colleagues […]" (MHP-specialist: co-facilitator of the ALP, health consultant, municipality)

The processes that are illuminated here provide insight into an ongoing exchange of practice-based knowledge between a community-based programme and a national partnership, namely, the ALP and the ABCs partnership. We read this as a mutually beneficial knowledge exchange. MHP specialists draw on the accumulated knowledge base found in the partnership, and the knowledge base of the partnership is expanded through the MHP specialists' experiences of engaging in local MHP initiatives.

During the ALP, collaborations between MHP co-ordinators, MHP practitioners, and end users within the working groups were essential in the development of local MHP initiatives. These developmental processes were led by local MHP co-ordinators, enacted by for example lecturers from the university college and a social counsellor from the volunteer centre. The MHP practitioners, enacted by lecturers and volunteers, and end users, e.g., students, contributed with knowledge on local issues and resources and ideas for MHP initiatives. They also engaged in testing and implementing the MHP initiatives. This collaboration between roles was appreciated and highlighted to be an asset in developing MHP initiatives that meet local needs. A lecturer explained:

> "If somebody is participating [in the ALP], then it needs to be both lecturers and students. […] You know, to understand how she [a student] thinks about this in the context of her year group. Because she was much better at explaining how I could, how she would catch the attention of those on her age." (MHP co-ordinator/MHP practitioner: participant in the ALP, lecturer, university college)

Commenting on the complementary input from students and lecturers, a student explained:

> "Well, I think it was really good, because, after all, we had… well, kind of very different perspectives in terms of 'well, where is it [MHP] relevant in [name of campus]?' And her: 'Well, if we do this', then I could say: 'No, but this is not optimal from the perspective of a student'. […] being able to have these discussions has been very helpful." (End user: participant in the ALP, student, university college)

After implementation

Based on learnings from the ALP, a lecturer from the participating university college took on the role as a MHP co-ordinator as she organized and implemented workshops for both staff and students aiming at strengthening knowledge about MHP within the organization. In other words, these workshops aimed at building MHP capacity among staff, i.e., MHP practitioners, and increasing mental health literacy among students, i.e., end users. The lecturer collaborated with the co-facilitator in the planning and implementation processes. Her intentions with these initiatives are voiced in the following interview quote:

> "On our first staff meeting after the holidays, I think we are going to do a presentation, [name of co-facilitator] and I. And you can say, hopefully, that will make this [MHP] more visible to some of my colleagues." (MHP co-ordinator: participant in the ALP, lecturer, university college)

Moreover, the following quote illustrates how this ongoing collaboration is viewed by the local co-facilitator acting as a MHP-specialist:

> "I am going to continue my work with the educational institutions. They have already asked me to conduct some ABC-workshops targeted their colleagues and their students. And in that regard, I am of course very aware of that I don't want to be that consultant who goes out there and throws something in their faces. But how I can engage them in this, and how I can incorporate this in a way that is meaningful." (MHP-specialist: co-facilitator of the ALP, health consultant, municipality)

We read this statement, particularly in connection with the previous quote, as an example of how a MHP specialist from one organization and MHP co-ordinators and MHP practitioner from another organization set out for a long-term intersectoral collaboration rooted in the local community. Together, the two latter quotes illustrate the mutually beneficial relationship between the MHP co-ordinator, leading the implementation of local MHP initiatives, and the MHP specialist, guiding and supporting the MHP co-ordinator. This dynamic of supporting others illustrates the key function of the MHP specialist. Further, the quotes indicate that the collaboration benefits from input from several roles. The MHP specialist is dependent on the collaboration with a local MHP co-ordinator to implement initiatives in the local community. As touched upon in the quote, input about the local setting from the MHP co-ordinator is essential to develop sustainable MHP initiatives that are perceived as relevant and meaningful by local actors, in the roles of for example MHP practitioners and end users.

Discussion

In this study, we first set out to develop a practice-oriented taxonomy of roles within intersectoral MHP practices. Based on our analysis of empirical data, we propose a taxonomy of roles consisting of the following five roles: 1) decision-maker; 2) MHP specialist; 3) MHP co-ordinator; 4) MHP practitioner; and 5) end-user. Each role is defined based on a portfolio of key functions. Factors such as the individual's job title, educational background, and if they are getting paid or not may influence the work with MHP, but they not defining for their role. A cross-cutting function for all roles was MHP-advocacy, taking place on different levels depending

on the role. Secondly, we applied this taxonomy to investigate the interactions across roles in the implementation of an ALP that sought to strengthen local MHP practices and capacity. This case study exemplifies various modes of interactions and interrelatedness between the identified roles. Examples of interactions and interrelatedness included negotiations about program design between decision-makers and MHP specialists; and MHP co-ordinators collaborating with MHP practitioners and end users to develop and implement local MHP initiatives targeting local needs; and MHP specialists from various organisations and sectors sharing and exchanging MHP specific knowledge and experiences within the ABC's partnership. Our results indicate the following overall patterns of interactions: 1) Decision-makers and MHP specialists interact regarding policy and strategic work; 2) MHP specialists and MHP co-ordinators interact regarding local program design, planning, and evaluation; and 3) MHP co-ordinators, MHP practitioners, and end users interact regarding community and day-to-day practices and program implementation. Our results illustrate the interrelatedness of all five roles by linking actions across levels of intervention and sectors. These actions range from activities in the national partnership ABCs to MHP practices within day-to-day teaching activities of a lecturer in a university college. These insights support that all roles are relevant to consider for understanding, planning, and researching MHP practices.

The taxonomy of roles extends the current evidence base and guidance for MHP (1, 8, 16) by proposing a practice-oriented language about the roles of individuals involved in MHP practices that is applicable across sectors, professions, and disciplines. The taxonomy builds on existing frameworks and conceptualizations of workforce involved in the field of public mental health (16, 21), but to our knowledge this is the first taxonomy or conceptualization of roles specifically for MHP. Within the field of health promotion, scholars have called for innovations that can assist the promotion of intersectoral thinking and actions that are truly embodied by the involved actors (21, 39, 40). The taxonomy presented in this study may offer guidance in doing so because it is not limited to sector specific tasks or professions. Outlining the key functions of the involved actors, the proposed taxonomy should be seen as a tool to organize, understand, and articulate the key actions and interrelatedness of intersectoral MHP practice. In contrast to the framework provided by Public Health England (16), our taxonomy includes the role of the end user as an essential role which allows for a more comprehensive understanding of the processes of MHP. This is in line with implementation guidance for MHP highlighting the potential of including the end-users in development, planning, and implementation efforts (21, 41)**.**

Outlining the function of the MHP practitioner illustrates that MHP practices are often embedded in existing practices. Acknowledging and better understanding the role of MHP practitioners in MHP is important and may help overcome the challenging task of engaging frontline staff such as teachers and health and social care personnel in MHP practices (13, 34). The potential of embedding MHP practices into existing workflows is also the focal point of MHP initiatives such as the capacity building programme *Health Compass* (19) and the initiative Making every contact count (42). Regarding planning and implementation of successful intersectoral MHP efforts, current evidence highlights the importance of establishing clear roles and responsibilities (2, 43). The proposed taxonomy offers a language that can be used to clarify roles and functions within MHP practices. Further, the proposed taxonomy, we believe, is relevant to consider for understanding MHP in general, also, if there is only limited or no intersectoral actions involved. However, the transferability of the taxonomy and the findings of the case study need careful consideration and should be explored in future studies.

In the fields of public health and health promotion, "expert roles" such as *public health specialists*, *public health practitioners* and *implementation champions* are acknowledged as key aspects of successful implementation processes and for sustaining initiatives over time (21, 44, 45). Similar to the workforce categories *public health specialists* and *public health practitioners* proposed by Public Health England (16), our analysis showed the need to distinguish between two types of expert roles, namely MHP co-ordinator and MHP specialist. The MHP specialist holds similarities to a consultant supporting other organisations/departments regarding policy and practice related issues. The MHP co-ordinator is more of a local expert operating mainly within an organisation/department, with a focus on leading and carrying out the adoption and adaption of evidence-based knowledge to local initiatives. This role holds similarities with roles coined as *implementation champions* (44) and *health brokers* (46). Barry (2007) highlights the importance of this local expert function and the need to secure implementation strategies and skilful practice, capable of contextualizing research/evidence/intervention strategies. The distinction between the roles of the MHP co-ordinator and MHP specialist allows for a nuanced understanding of the functions related to expert work and the skill sets needed to master these roles. In this light, the developed taxonomy can guide capacity building efforts by creating an overview of the roles involved in bringing MHP into practice and guiding an assessment of which workforce groups should be targeted. Therefore, the findings of this study can be linked to the call for strengthening MHP capacity (2, 3, 47). Building on for example the competencies for MHP and intersectoral collaboration identified in two recent studies (17, 18), future research should investigate which competences are needed to successfully master the five identified roles. This would provide highly valuable practice-relevant knowledge needed for building MHP capacity across sectors, e.g., through education and training of workforce.

The study reveals the interrelatedness of processes following a top-down policy logic, e.g., the decisions about participating in the ALP, and processes following a bottom-up logic, e.g., the implementation of MHP initiatives developed by participants of the ALP. Firstly, this illuminates how these two logics play together, as proposed in the Ottawa charter (22). Secondly, this highlights the importance of creating awareness and understanding of MHP practices across practice-policy divides and organisational hierarchies. Other notable aspects of the case study are the dynamics of knowledge exchange between the local setting of the ALP and the national ABCs partnership. This illustrates the potential benefits of knowledge dissemination, moving from a national partnership through MHP specialists and MHP co-ordinators and lastly influencing and informing local MHP practices, e.g., in a volunteer centre or university college. Parallel but with the opposite direction, practice-based knowledge based on experiences from the ALP disseminates through MHP specialists, who are involved in the ALP, to the partnership ABCs, thus, extending the cumulative knowledge base of the partnership. This dynamic of knowledge exchange could be a mechanism contributing to the generation of partnership synergy (43).

Design limitations and strengths

The results should be interpreted considering the following limitations and strengths. Firstly, the empirical data is limited to the Danish partnership ABCs, and we cannot rule out that investigating other MHP initiatives, e.g., taking place in different settings or countries, could have revealed other key functions and transverse dynamics. However, our data provides insights into MHP initiatives holding elements that could occur independent of the ABCs partnership or as a part of another MHP project. Also, our use of emerging literature

on MHP may strengthen the transferability of our results. Secondly, our data does not cover all sectors relevant to MHP and perspectives on MHP of, for example, regional and national politicians and actors from employment, justice, and transport. Including these voices could potentially have revealed other relevant processes, dynamics, and rationales. However, the role of for example politicians is illuminated through the interviews and literature (e.g. (16)) included in our study. We would therefore argue that the current results suggest some basic roles and dynamics of intersectoral MHP practices that are very likely to be similar for most sectors. Thirdly, our analysis of the processes within the ALP are to some extent simplified. For example, decisions about participating in the ALP are influenced by several factors that are not included in this analysis. However, it was not the scope of this study to analyse an exhaustive list of factors and actors influencing the processes, but rather to highlight the roles taken by key stakeholders. Fourthly, other branches of role theory, than functional role theory (25), would also be relevant and applicable to the field of MHP, e.g., investigating how actors understand and interpret their own and others' conduct and roles, and such studies may further expand the knowledge base relevant for advancing the field of MHP.

Conclusion

In this study, we propose a taxonomy of roles involved in intersectoral MHP practices that can be used as shared language to clarify roles and key functions across sectors and professions. It consists of the following five roles: 1) decision-maker; 2) MHP specialist; 3) MHP co-ordinator; 4) MHP practitioner; and 5) end-user. A cross-cutting function for all roles was MHP-advocacy. To our knowledge, this is the first taxonomy (conceptualization) of roles specifically for MHP. Furthermore, based on a case study applying these roles, we investigate the interactions and interrelatedness of the roles related to implementing MHP practices in a Danish community setting. The results offer practice-oriented insights into how different roles can contribute to the development, planning, implementation, and sustainability of MHP practices that originate from or draw on intersectoral actions. We identified three overall patterns of interaction, which are discussed. These insights strengthen the notion that all five roles are relevant to consider for understanding intersectoral MHP practices. The results add to the literature on MHP and facilitate gaining a greater understanding of the intersectoral actions of MHP, which is relevant for strengthening MHP practices and MHP capacity. Research on the transferability of the taxonomy and which competences are needed to successfully master the five identified roles is warranted.

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