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A B S T R A C T

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 and 2021) evaluating MHP efforts within a Danish 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 partnership and literature on MHP. We propose a taxonomy consisting of five roles: 1) decision-maker; 2) MHP specialist; 3) MHP co-ordinator; 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 interrelatedness 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.

1. 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 (Kalra et al., 2012; Barry, 2019a; IUHPE, 2021; Wahlbeck, 2015; Herrman and Jane-Llopis, 2012; Burns et al., 2022). 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 (Barry, 2007). Therefore, MHP is an intersectoral matter and should include sectors such as education, housing, health, employment, transport, arts, sports, and urban planning (Wahlbeck, 2015; Herrman and Jane-Llopis, 2012). The need for intersectoral approaches to MHP, such as partnership and community-based efforts, is recognised in national and international MHP-recommendations (Kalra et al., 2012; Barry, 2019a; IUHPE, 2021). The World Health Organization, for example, has set a global goal that 80% of countries should have at least two functioning national, multi-sectoral promotion and prevention programs targeting mental health by 2030 (WHO, 2021).

The body of literature regarding the implementation of MHP efforts is sparse but growing (Barry, 2019a; Herrman and Jane-Llopis, 2012). 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 (Enns et al., 2016). 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 (McCabe and Davis, 2012; Barry, 2009); practitioners perceiving mental health as an unfamiliar term which is often negatively loaded and seen as blurred and difficult to define and operationalise (Ekornes et al., 2012); and practitioners lacking knowledge and competences to work with MHP (Ekornes, 2015; Christiansen et al.,

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2015). 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 (Barry, 2019b).

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 (Kalra et al., 2012; IUHPE, 2021; Barry, 2007; Stansfield, 2015). Emerging research applying a capacity perspective is mapping competences related to MHP, for example, for practicing MHP within the health sector (Tamminen et al., 2018) and for engaging in intersectoral efforts such as partnerships (Tamminen et al., 2021). Furthermore, strategies for building MHP capacity have been tested and investigated, for example, in a Canadian hospital setting (Horn et al., 2014) and in a Danish community setting (Hinrichsen et al., 2022). 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 (Stansfield, 2015).

Based on the knowledge base of public health and health promotion (Stansfield, 2015; Davies, 2013), 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 (Barry, 2019c). 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.

2. Conceptual clarifications

2.1. 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 (Barry, 2019d). 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 (Tamminen et al., 2016). 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 (Barry, 2019d). Effective MHP should address the determinants of mental health at all levels – from the individual to societal level. These determinants include, for example, mental health literacy, sense of belonging at school/work, engagement in mentally healthy activities, family functioning, access to recreational activities and areas, and policies influencing housing conditions (Barry, 2019d; CLEMCPH, 2020). Moreover, MHP works across intervention levels, from macro policy to local practices embedded in day-to-day practices (Barry, 2007). In line with the Ottawa Charter for Health Promotion, MHP 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 (Barry, 2019d). Also, to address the multiple and varied determinants of mental health, MHP needs to be viewed as an intersectoral matter.

2.2. Roles within MHP

Given the intersectoral nature of MHP, the responsibility to implement MHP practices cannot be placed on specific professions or sectors alone (Wahlbeck, 2015; Barry, 2019d). Implementation recommendations for MHP outline which groups of workforce and what sectors should be involved in implementing MHP efforts (Barry, 2007; Stansfield, 2015). For example, Barry (2019c) 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 workforce needed within public mental health (Stansfield, 2015). This categorization includes *leaders*, *public health specialists and senior staff*, *public health practitioners*, and *wider workforce* (Stansfield, 2015), 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 (Skeen et al., 2010). 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 interrelatedness of such functions. Therefore, in this study, we aim to develop a taxonomy of roles on an individual level which is applicable across sectors and levels of interventions and, also, encompasses the interrelatedness of the roles.

Inspired by functional role theory (Biddle, 1986), 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, organizational 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).

3. Methods

To investigate key roles within intersectoral MHP efforts and their interrelatedness, we conducted an iterative, staged analysis of MHP efforts found within the Danish ABCs of mental health (ABCs) partnership (Koushede and Donovan, 2022). We particularly investigated the case of a pilot implementation of an action learning program (ALP). The ALP aimed at developing and promoting practices, knowledge, skills, and competences related to MHP within and across organizations. 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 (Hinrichsen et al., 2022). 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 (Timmermans and Tavory, 2012) 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 transsituationally, 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 (Timmermans and Tavory, 2012).

3.1. Setting – the partnership

The ABCs 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 (ABCs, 2022)). 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 seeks to bridge the gap between international recommendations, research, policy, and practice related to MHP (Hinrichsen et al., 2020). 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 (Hinrichsen et al., 2020). 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)" (Hinrichsen et al., 2020). A smaller group of partner organizations' main contribution lies in supporting other organizations developing and implementing MHP practices. The background, development, and organization of the ABCs and the ABC-framework are described in more detail elsewhere (Hinrichsen et al., 2022).

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 (Hinrichsen et al., 2022). 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 (Pedler and Burgoyne, 2015). Action learning works through processes of trial and error, critical reflection, group discussions, and receiving specialist input (Hinrichsen et al., 2022; Zuber - Skerritt, 2002). 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.

The ALP was developed and piloted as a sub-project in collaboration between multiple partners of the ABCs (Sept. 2019 to June 2020). This included the National Institute of Public Health (NIPH), University of Southern Denmark, and a large national umbrella organisation within sports, which both were central partner organizations in leading and developing the ABCs (Hinrichsen et al., 2020). Furthermore, the health promotion department of a municipality was the host of the ALP, i.e., inviting local organizations to participate and the facilitation of the ALP. Two researchers from the NIPH (CH and VK) 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 organizations that participated in the ALP (to strengthen their MHP practices and capacity) 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.

3.2. Data

Data used in this study was originally generated for the purpose of evaluating the ALP (Hinrichsen et al., 2022). 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 (Hinrichsen et al., 2022).

3.3. Analytical approach

Our analysis was iterative, conducted in three stages, and operating in an interplay between individual and collaborative analytical processes. The first author conducted the individual analytical processes. The collaborative analysis refers to analytical processes involving co-authors of this paper where different disciplinary perspectives were brought to bear on the analysis and interpretation of the data (Cornish et al., 2014). The first two stages of the analysis concerned the development of the taxonomy of roles and applied an analytical approach inspired by King's Template Analysis (King et al., 2012). 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.

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 Partnership (Hinrichsen et al., 2020, Kusier and Nelausen, 2021; Koushede, 2018) and literature on MHP. Inspired by the key workforce categories described by Barry (2019c) and Public Health England (Stansfield, 2015) 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 (Brooks and King, 2014) 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 (Hinrichsen et al., 2022). Also, this stage entailed a collaborative analytical process (Cornish et al., 2014) (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 (Kusier and Nelausen, 2021) 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

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	1) Leader 2) MHP specialist 3) MHP practitioner 4) Wider workforce	Prior evaluations of the ABCs (Hinrichsen et al., 2020, Kusier and Nelausen, 2021; Koushede, 2018) and literature on MHP (Stansfield, 2015; Barry, 2019c)
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 (Kusier and Nelausen, 2021)
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)

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.

4. 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.

4.1. 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. Altogether, 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 organizations/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 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 depends 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 through 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. Referring to the promotion of a "friendly culture" as a MHP initiative, this fucntion 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.

4.2. 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 of the ALP. The presentation of illustrative scenarios from the ALP-case is structured in a chronological order: before, during, and after the implementation of the ALP. Fig. 1 summarizes the results of this study. It illustrates main areas of tasks that 1) are related to the key functions of each role (first part of the results) and 2) represent key areas of interactions between roles (second part of the results).

4.2.1. Before implementation of the ALP

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, organizations, and sectors. Based on the results of studying and evaluating MHP-initiatives within the ABCs (specialist/technical knowledge), researchers from the NIPH (CH and VK) 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. The quote refers to his function of identifying and recruiting organizations/departments interested in participating in ALP, which we consider intersectoral advocacy for MHP and strategy work. This was done by reaching out to management employees, i.e., decision-makers, from several departments within the municipality and other organizations, such as a 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, which we consider strategy work.

4.2.2. During implementation of the ALP

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 NIPH 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-

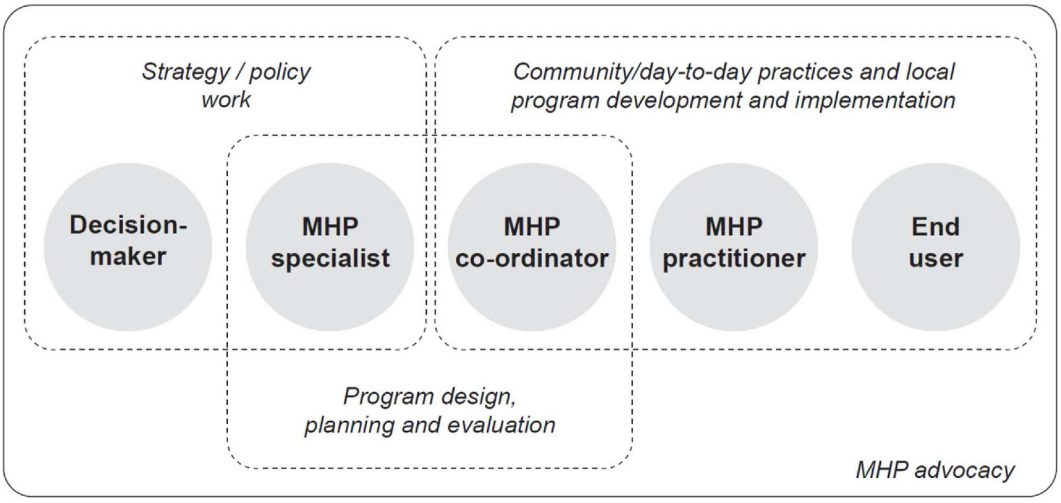

Fig. 1. Roles, functions, and key areas of interactions. The figure illustrates the five roles of the taxonomy for intersectoral MHP in relation to overall tasks that 1) are related to the key functions of each role and 2) represent key areas of interaction between roles. The function MHP-advocacy is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

facilitating the workshops. Through the facilitation of the workshops and supporting participants in their work with developing and implementing local MHP practices, 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 MHP-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 … being aware of wellbeing. For instance, within the education system. […] That means, if they, the staff of the educational institutions 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 design and planning of MHP practices in other sectors and organizations 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 local 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 provided a forum for MHP-specialists to discuss matters related to designing, 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. 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 and implementation of local MHP initiatives. The 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)

4.2.3. *After implementation of the ALP*

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 local development 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 MHP-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 can I engage them in this? And how can I 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 and implement sustainable MHP initiatives that are perceived as relevant and meaningful by local actors, in the roles of, for example, MHP practitioners and end users.

5. 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 – i.e., essential functions for the specific roles. Regarding these functions, it should be noted that the functions pertinent to each role should not be seen as clear-cut and some functions are shared between roles. 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 are not defining for their 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; 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 organizations and sectors sharing and exchanging MHP specific knowledge and experiences within the ABCs. 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 development and implementation (Fig. 1). 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 ABCs partnership 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 (Kalra et al., 2012; WHO, 2021; Stansfield, 2015) 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 (Stansfield, 2015; Barry, 2019c), 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 (Barry, 2019c; Corbin, 2017; Dubois et al., 2015). 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 practices. In contrast to the framework provided by Public Health England (Stansfield, 2015), 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 (Barry, 2019c; O'Mara-Eves et al., 2013).

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 (Ekornes, 2015; Hinrichsen et al., 2020). The potential of embedding MHP practices into existing workflows is the focal point of MHP initiatives such as the capacity building programme *Health Compass* (Horn et al., 2014) and the initiative Making every contact count (NICE, n/a). Regarding planning and implementation of successful intersectoral MHP efforts, current evidence highlights the importance of establishing clear roles and responsibilities (Barry, 2019a; Corbin et al., 2016). 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 (Davies, 2013; Barry, 2019c; Batras et al., 2014). Similar to the workforce categories *public health specialists* and *public health practitioners* proposed by Public Health England (Stansfield, 2015), 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 organizations/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* (Batras et al., 2014) and *health brokers* (Harting et al., 2010). 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 (Barry, 2019a; IUHPE, 2021; Jane-Llopis and Barry, 2005). Building on, for example, the competencies for MHP and intersectoral collaboration identified in two recent studies (Tamminen et al., 2018, 2021), 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 (Barry, 2019d). Secondly, this highlights the importance of creating awareness and understanding of MHP practices across practice-policy divides and organisational hierarchies. Also, in this regard, we want to highlight the cross-cutting function of MHP-advocacy taking place on different levels and in different settings depending on the role that performs this function. In our analysis, MHP-advocacy was seen performed by all roles but was not a key area for collaboration/interaction between roles. Other notable aspects of the case study are the dynamics of knowledge exchange between the local setting of the ALP and the ABCs. 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 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 (Corbin et al., 2016).

5.1. Design limitations and strengths

The results should be interpreted considering the following limitations and strengths. Firstly, the empirical data is limited to the Danish 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 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 study includes only a limited number and one type of "end users" (i.e. students) and 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 a broader variety of end users and sectors 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. (Stansfield, 2015)) 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 is to some extent simplified. For example, decisions about participating in the ALP are influenced by several factors that are not included in our 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 (Biddle, 1986), 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.

6. Conclusion

In this study, we propose a taxonomy of roles involved in intersectoral MHP practices that can be used as a 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. 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 outlined. 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.

CRediT authorship contribution statement

Carsten Hinrichsen: Conceptualization, Methodology, Formal analysis, Investigation, Data curation, Writing – original draft. **Line Nielsen:** Formal analysis, Investigation, Writing – review & editing, Project administration. **Nina Tamminen:** Conceptualization, Writing – review & editing. **Malene Kubstrup Nelausen:** Formal analysis, Investigation, Writing – review & editing, Project administration. **Amalie Oxholm Kusier:** Formal analysis, Investigation, Writing – review & editing. **Ziggi Ivan Santini:** Formal analysis, Writing – review & editing. **Frederik Schou-Juul:** Writing – review & editing. **Charlotte Meilstrup:** Formal analysis, Investigation, Writing – review & editing, Project administration. **Morten Hulvej Rod:** Conceptualization, Methodology, Writing – review & editing, Supervision. **Vibeke Koushede:** Conceptualization, Methodology, Writing – review & editing, Supervision, Funding acquisition. **Sigurd Lauridsen:** Conceptualization, Methodology, Writing – review & editing, Supervision.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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