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A discourse analysis on how service providers in non-medical primary health and social care services understand their roles in mental health care☆

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ABSTRACT

Enhancing collaboration between specialist mental health services, primary health care and social care services has been a key priority in mental health policy reform in many countries for about 20 years and remains so. Yet progress in terms of widespread implementation of demonstrably effective models of collaborative care has been slow. The views that different providers hold regarding the parameters of their roles, and the values that guide their approach to service delivery, are likely to exert profound effects on engagement with collaborative initiatives. Little research has explored these issues.

In this study, discourse analysis from a structurational perspective was used to explore the views of providers in a diverse purposive sample of non-medical primary health and social care services in the state of Victoria, Australia regarding their mental health care roles. Four interconnected discourses were revealed as supporting role positions constructed in opposition to the putative role positions of specialist mental health services: an informal as opposed to a formal approach; a normalising as opposed to a pathologising approach; holistic social and emotional health and wellbeing, and an individualised or client-focused model of care as opposed to an illness-focused model. These oppositional role constructions may contribute to reluctance among providers in these sectors to engage with some agendas being promoted by specialist mental health services, through either reduced self-efficacy or active resistance to innovations that conflict with strongly held values. Greater awareness of, and critical reflection upon, contrasting role constructions, and the implications of these for practice may facilitate the design of more appropriate collaborative models and stronger commitment to their implementation.

Introduction

Enhancing collaboration between specialist mental health services, primary health care and social care services has been a key priority in health policy reform in many developed countries for nearly 20 years, and is receiving increased attention in less developed countries. There is growing realisation that specialist mental health services can only ever serve a small proportion of the population affected, and a small proportion of their complex needs. Persistent high levels of unmet needs for mental health care, particularly for social and psychosocial interventions, demand continued effort to engage primary health and social care services in collaborative efforts (Herrman & Harvey, 2005; Hickie, Groom, McGorry, Davenport, & Luscombe, 2005; Townsend, Pirkis, Pham, Harris, & Whiteford, 2006).

Despite considerable policy attention, progress in terms of widespread implementation of demonstrably effective models of collaborative care has been slow. In the United States mental health 'systems of care' including agencies from a range of sectors have been widely implemented (Cook & Kilmer, 2004), and managed care organisations are increasingly involving administrative integration or establishment of networks across diverse providers (Yohanna & O'Mahony, 2001). Increased integration at an administrative level and changes in service configuration can be achieved, but do not necessarily translate into enhanced quality of care or clinical outcomes (Bickman, 1996; Lehman, Postrado, Roth, McNary, & Goldman, 1994). Similarly in the UK, various administrative measures have been implemented to support integration of health and social care services including joint purchasing, co-location and budget pooling, but these administrative measures have not necessarily led to providers from these sectors actually working more closely together at the level of service delivery, or to better outcomes for clients (Brown, Tucker, & Domokos, 2003; Hudson, Hardy, Henwood, & Wistow, 1997). In Australia, ongoing work

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under the National Mental Health Strategy and various state government strategies has established promising pilot programs in specific locations. Reform leaders are still struggling however to achieve effective collaboration on a wide scale between mental health services, primary medical care, and alcohol and other drug services (Hickie et al., 2005; Townsend et al., 2006), and expansion of these efforts to embrace other sectors such as housing and employment has barely begun (Waghorn, Still, Chant, & Whiteford, 2004; Whiteford & Buckingham, 2005).

Many factors operating at various levels of organisational systems interact to facilitate or inhibit collaboration across sectors in human service systems. Several writers have emphasised the benefits of potential partners sharing a set of values (Anderson, McIntyre, Rotto, & Robertson, 2002; Labonte & Laverack, 2001) that help guide decision-making about goals and strategies. Support for this hypothesis comes from related lines of organisational theory (Klein & Sorra, 1996) and empirical research (Foster-Fishman, Salem, Allen, & Fahrbach, 1999) indicating that employees' perceptions regarding consistency between the values represented by an innovation or a reform, and their own values, strongly influences the likelihood that a particular innovation or reform will be implemented. To the extent that intersectoral collaboration requires changes in practice or innovation, the perceptions that providers have regarding similarities and differences between their values and those of providers in other sectors will affect their likelihood to engage in collaborative initiatives. If change leaders and agents have more accurate insight into the values and attitudes of providers across different sectors, they may be better able to design interventions that are effective in facilitating intersectoral collaboration and any required changes in practice. While there is a substantial literature exploring the perceptions of primary medical care providers regarding their mental health care roles (Carr et al., 2004; Dew, Dowell, McLeod, Collings, & Bushnell, 2005; Smith, Walker, & Gilhooly, 2004), there is no equivalent body of work exploring the views of providers in non-medical primary health and social care services.

The research reported here sought to address this gap in the knowledge base, by systematically identifying and describing the understandings of service providers working in non-medical primary health and social care services about their roles in mental health care. The data used in the analysis are drawn from a larger study that examined issues affecting intersectoral collaboration around mental health care in Australia. A novel method of surveying providers was employed whereby respondents worked in groups to complete a structured survey that collected quantitative and qualitative data simultaneously. The current discourse analysis arose out of a primary content analysis examining qualitative responses accompanying quantitative ratings given to items describing different mental health care related activities. Over time it became apparent that certain "systematic ways of talking" (Harper, 1995) were emerging that were highly consistent across the respondent groups, role items and ratings categories, and that respondents were using these ways of talking to perform social functions that have been described by discourse analysts such as making excuses and justifications (McKinlay et al., 2005), and demarcating boundaries (Sanders & Harrison, 2008). Discourse analysis aimed at clarifying the 'positions' of different subjects in a field of social interaction (Breheny & Stephens, 2007; Potter & Wetherell, 1995) appeared well suited to the current task of understanding how role constructions may affect engagement in intersectoral collaboration. This method has been used previously to explore the perceptions of health professionals about their roles in contested territories such as health promotion (McKinlay et al., 2005), heart failure care (Sanders & Harrison, 2008) and mental health care (Dew et al., 2005).

The approach taken to discourse in the current study is a structurational one, that seeks to bridge the gap between action-focused and structure-focused accounts of social phenomena (Giddens, 1984; Heracleous & Hendry, 2000). The language used in discourse is viewed as both descriptive or representative of underlying social structures that exist in the world outside of language, as well as being constructive of social reality through its effects on actors' thoughts, interpretations, intentions and actions (Heracleous & Hendry, 2000). Aspects of organisational or professional culture such as normative roles, shared values and attitudes, shared knowledge and interpretive schemes can be understood as underlying social structures, or 'rules and resources' (Giddens, 1984) that actors draw on in the production of discourse, and which are in turn reproduced, and potentially transformed through discourse (Heracleous & Hendry, 2000).

In the current study, the action orientation of the discourse is most clearly discernable in the raw language used, and this action orientation is elaborated in the analysis of language use presented in Results section. The deeper structural features of the discourse become clearer when the various discourses or themes are considered together, as elaborated in Discussion.

Methods

Setting and participants

Participants were staff of non-medical primary health and social care services, although the unit of analysis was the service or organisation. These were defined as 'community-based health and welfare services, excluding general practitioners (GPs), that are accessible to clients without a referral from another service provider'. In most cases, these comprised service units or teams within larger organisations such as community health services, non-government organisations or local government. Occasionally more than one team or service unit represented a particular organisation (e.g. a counselling team, a housing team and a drug and alcohol team within a community health service). These multiple units were treated as one 'service' or one 'organisation' for the purposes of this study. A total of 172 service providers participated across 41 service organisations, yielding a mean of 4.2 participants in each.

Selection and recruitment of participants

A purposive sampling strategy was employed, aimed at achieving a diverse sample of organisations that enabled assessment of the generalisability of the findings across service types and geographic areas (Shadish, 1995). A three stage recruitment process was used focusing on communities, services and staff members.

First, four distinct geographical communities or service networks were selected from 32 Primary Care Partnerships (PCPs) operating throughout the state of Victoria, each of which was invited to submit an expression of interest (EOI). PCPs are voluntary alliances or networks of primary health and social care agencies from two or three local government areas formed in order to enhance service planning and coordination. Eleven submitted EOIs, and four eventually committed to the project after a series of meetings assessing the level of readiness and commitment. Two of these were located in the city of Melbourne and two were located in regional/rural communities. Second, key stakeholders in these four communities were asked their views about the relevant and important primary health and social care organisations to include in the study. A total of 41 services eventually agreed to participate (9–13 per PCP). They ranged in size from very small (1–10 EFT) to large (over 100 EFT), with most employing between 11 and 40 equivalent full time (EFT) staff. The most common service types

were drug and alcohol services, varied combinations of child and/or youth and/or family services, allied health teams, aged and disability, maternal and child health, and generalist social welfare services. Participating services covered the full range of client age groups. Third, key contact persons within each agency were advised that three to five respondents should be selected to participate in the group interview, and that these should be individuals with good knowledge of the organisation as a whole, who capable of speaking beyond their own perspective in order to represent a range of views. It was recommended that participants be selected at a staff meeting.

Exploring mental health care roles

The design of the group interview schedule was informed by literature review, the results of five focus groups from a previous study (Mitchell, 2004), consultation with stakeholders on early drafts, and a piloting exercise. The final schedule had four sections, the first three of which are relevant here. Sections One and Two collected basic information about the respondents (e.g. gender; main roles performed in their service) and data about the service and the clients served, respectively. Section Three, examining mental health care roles, was designed to enable simultaneous collection of quantitative and qualitative data, so it involved a mix of quantitative and qualitative features. While the quantitative data are not the focus of this article and are reported elsewhere (Mitchell, 2008) their simultaneous collection shaped the way in which the qualitative data were generated. On the quantitative side, the interview schedule was highly structured with a standard set of questions requiring respondents to make quantitative ratings using a four-point Likert-type scale indicating perceptions of the extent to which their service was currently performing each of 30 different roles, and the extent to which their service should ideally be performing each role. On the qualitative side, the questions were phrased in an open-ended manner, respondents discussed each question freely, exploring a range of interpretations, perceptions, and opinions before making a collective rating, and the group process actively shaped the course of discussion of each question.

Mental health care roles were broadly defined as 'activities that contribute to the mental health care of individuals or the advancement of the mental health of populations'. Consistent with this broad definition, the 30 role items were designed to capture a wide range of potential role domains as outlined in Table 1. Further details of how these role domains were selected are provided elsewhere (Mitchell, 2008).

Table 1
Initial set of mental health care role domains and example items.

Role domain name	Example items
Mental health promotion	Working with communities to enhance protective factors such as social connectedness (e.g. community development)
Primary prevention and early intervention	Providing social and/or psychosocial interventions that may help prevent the development of a mental disorder
Identification and assessment	Identifying/recognising clients who may have depression, anxiety or other mental disorders
Referral and advocacy	Helping clients with depression, anxiety and other mental disorders get access to effective mental health care treatment services (i.e. advocacy)
Social and psychosocial interventions and support	Providing social and/or psychosocial support services for people who have mental disorders
Treatment	Working with other services (e.g. specialists) to provide treatment or psychological therapies
Rehabilitation and continuing care	Working with other services to provide relapse prevention, rehabilitation or integrated/chronic disease management programs

Procedure

Data were collected over a 6 month period in 2004. The study was approved by The University of Melbourne's Human Research Ethics Committee. Participants provided signed confirmation of their voluntary consent to participate prior to the interview beginning.

The group interview method, as opposed to individual interview, was selected as the most 'natural' method for gathering information about the ways in which social phenomena are perceived and understood in organisational contexts (Steyaert & Bouwen, 1994). Interviews usually involved between three and five members from each service, were facilitated by the researcher, and took approximately 3 h including a short break. Each participant was given a printed copy of the interview schedule. Groups worked through the schedule one item at a time, but occasionally several related items were considered simultaneously. The procedure involved simply reading the item as stated in the interview schedule and allowing respondents to reflect. Respondents sometimes requested definition of terms or other types of clarification. These were provided only as reference points for discussion. Respondents were encouraged to question and challenge proffered definitions in terms of their own professional backgrounds and understandings, and explain if and how these concepts had relevance to their work.

All 41 interviews were tape-recorded and audio-tapes were professionally transcribed. Because the intended analyses focused only on the content of what was said, the transcription protocol specified full transcription of all words spoken and corrections in speech, but finer details such as brief hesitations, changes in intonation, and overlaps between different speakers were omitted. In the extracts used to illustrate findings, a slash (/) is used to indicate interruption by another speaker, and a series of full stops (…) is used to identify omission of sections of text.

Data analysis

Consistent with the meso-discourse approach described by Alvesson and Karreman (2000) the analysis involved detailed examination of language use in specific contexts as well as identification of systematic ways of talking that were consistent across a range of contexts, in this case the different primary health and social care organisations, the different mental health care roles, and the ratings categories. An earlier content analysis of qualitative data structured around particular items and quantitative response categories provided source material that was subjected to further analysis within a discourse analytic framework. There were three main stages to the analysis in technical terms.

The first stage involved the development of familiarity with the data. Based on the intimate knowledge of the interview material developed through many months of coding for the content analysis, the possible presence of several distinct but overlapping discourses was recognised. This intimate knowledge of the material included a sense that 'systematic ways of talking about topics' (Harper, 1995) were evident across a wide range of organisations, items, and ratings categories, and that respondents were using these systematic ways of talking for specific purposes.

The second stage involved thematic coding in the manner described by Potter and Wetherell (1995) to "make the analytic task simpler by focusing on relevant material" (p87). Comprehensive coding tables developed for the content analysis were read through and items of text relevant to hypothesised discourses were cut and pasted into a separate file. Headings and sub-headings relevant to emergent discourses were developed as coding proceeded using cycling (Potter & Wetherell, 1995) or the constant comparative

method (Madill, Jordan, & Shirley, 2000). In addition to providing a more manageable data set for the final stage of the analysis, the way the material was organised at this stage gave an indication of the relative volume of material relevant to the different discourses, and the extent to which each was present across different services, items and ratings categories.

The third stage, the discourse analysis proper, involved delineating and describing in coherent prose, the four main discourses identified. This process included describing the various systematic ways of talking that represented each discourse, identifying and analysing the discursive content and devices that appeared to be operating, describing variations in expression of the discourses across ratings categories where applicable, and assembling these components into a coherent account.

Results

It was possible to identify several discourses that appeared repeatedly throughout the interviews across a wide range of role items and across the different types of services included in the sample. There were some differences in the ways these discourses were used across the rating categories, but these differences were subtle. Four main discourses will now be discussed.

Informal as opposed to formal approach

The discourse of informality in the approach to mental health care activities was almost pervasive in its breadth across items in the interview and across categories of ratings given in response to those items. The informal approach was generally constructed in opposition to the formal approach and this construction had two main dimensions: structure (or lack of it) in the design of strategies or programs, and intentionality (or lack of it) in the targeting of mental health issues or clients with mental disorders.

> I think we do but not necessarily in a structured or targeted way if you know what I mean. We provide a whole range of interventions which are largely targeted around people's substance use needs but which clearly provide advantage in a range of other areas in their lives. … but I don't know that our workers think about it in quite that structured way … [Youth drug and alcohol service, stand alone non-government organisation]

The informal approach was frequently presented or positioned as contrasting with a formal targeted approach perceived as the domain of specialist mental health services.

> Not as a specialist service but we do same as any other client./… See I would think we would not run a group for kids that have depression./No./… We would incorporate them in any social programs we ran./… We're not saying we're providing social service for someone with a mental health disorder but we're providing social services for kids that are in RESI and some of them happen to have./Which is quite a lot. [Child, youth and family service based in a non-government organisation]

Descriptions of the informal approach tended to replace the more formal terminology such as 'education' used in the interview schedule with 'softer' less formal language such as 'awareness' and 'acknowledgement'.

> But the part that I'm getting a bit confused about is 'educating our clients about depression'. I see that, I don't see that as our role./… But we certainly do awareness, community awareness and find awareness around mental health but we wouldn't be educating people./… but acknowledging that they are stressed or anxious and what they can do to look after themselves in that …/Yes. [Carer respite service based in a community health service]

Evident in each of these pieces of text is an apparent ambivalence or inconsistency marking the action orientation that is a hallmark of discourse (Potter & Wetherell, 1995). These respondents seem to be constantly shifting around in their answer to any question: first they say they do, but they don't (e.g. "I think we do but not necessarily in a structured or targeted way …"); next time they think they don't, but they do (e.g. "Not as a specialist service but we do same as any other client …"). Potter and Wetherell argue that this kind of variability is to be expected as people perform different actions with their talk and try to reconcile potentially conflicting accounts. The informality discourse performs the function of affirming the position that 'yes we do have a role in mental health care' while at the same time constructing or reconstructing the role as 'different from how it's framed in the question'. The informality discourse observed here provides a clear illustration of the discursive device of oppositions (Harper, 1995). By constructing their involvement as informal as opposed to formal, these providers are distinguishing and demarcating their roles from those of specialist providers.

Normalising as opposed to pathologising approach

The lack of focused targeting of mental health issues inherent in the discussion about the informality of their approach to mental health care was frequently connected with language related to the concept of normalisation and the avoidance of pathologising terminology.

> I guess I'm making the distinction there between a more pathologised, 'come to our CBT group because you're depressed', or we wouldn't perhaps quite be selling it like that, we'd be saying, 'you've got these identified needs and we think this program might be really helpful for you in stabilising things or improving your life circumstances'. [Youth drug and alcohol service, stand alone non-government organisation]

Respondents often framed their work in terms of addressing challenges confronted by all people moving through particular phases of life, and steered away from talking in terms of 'mental health care' interventions or even 'mental health issues'.

> And in terms of providing rehabilitation I guess my premise is part of that management program is helping those parents who are still parents and who are probably struggling with their parenthood that's where our expertise comes in …/But that is part of our role identifying needs and gaps in parents' capacity to parent./But that's not dealing with their mental health issue, that's their parenting. And that's the critical… That's the conceptualisation. [Maternal and child health service based in local government]

The use of oppositions to demarcate roles is evident here too. By framing their work as 'not focused on mental health issues', the speaker positions the role of his or her organisation as not specialist mental health. Occasionally respondents explicitly labelled their approach in terms of normalisation and argued strongly for the value or importance of this approach.

> and the mother's groups provide a very important preventative role in terms of social isolation, normalising, reducing anxiety, understanding, sharing ideas about parenting, very normalising process, now that can be really important in terms of helping particularly those that are at risk of high anxiety and so on to get more realistic expectations. [Maternal and child health service based in local government]

The language used here demonstrates a clear preference for a normalising as opposed to a pathologising approach to providing mental health care. In other words the discourse appears to reflect the presence of a social value that is widely shared across this group of health and social care providers.

Holistic social and emotional health and wellbeing

A third distinct discourse evident throughout the responses across all ratings categories can be labelled the 'holistic social and emotional health and wellbeing approach'. This perspective is holistic in the sense of paying attention to multiple aspects of life and a range of systems that affect health and wellbeing. The term 'social and emotional wellbeing' is preferred to that of 'mental health', and is viewed as just one aspect of a wider domain of health and wellbeing. Discourse on this theme was closely interwoven with discourse around normalisation, and these links were sometimes explicitly recognised, even emphasised by respondents.

> I like that notion of social and emotional wellbeing because I think it captures, it doesn't pathologise in any way shape or form, which is something we talked about at the start. [Youth drug and alcohol service, stand alone non-government organisation]

A central concern or value evident in this approach is to understand and address the needs of the individual within the context of their relationships or social networks, or the community to which they belong. The focus is shifted away from illness, defined as pathology located within the individual, towards facilitation of life processes and transitions that are, or should be, universal.

> you do it through working with different elements of the community…Yeah our overall service vision is just that, to provide young people with a safe healthy transition into adulthood in a community that respects them and acknowledges that. [Youth service based in local government]

The holistic health and wellbeing approach was frequently viewed or positioned in opposition to an approach focused on mental health or mental illness. A sharp focus on this opposition was sometimes evident in the responses associated with relatively low ratings, and was explicitly used to assert and justify a lack of involvement in particular categories of activity.

> We don't do it. No we work on a holistic health care model, if you argued that it was more than [general health promotion] I'd say that's not true. … realistically even though you've divided it into mental health, you don't really differentiate that. [Youth health service based in a division of general practice]

Individual- or client-focused versus illness-focused model of care

A fourth discourse, again closely interwoven with the other themes, revolved around an individual- or client-focused model of care. Consistent with the holistic health and wellbeing approach, attending to mental health needs was viewed as part and parcel of attending to the range of needs that may be presented by an individual client or family.

> I mean like we see a client, we look at this, this and this. I think it's just in part of our assessment of where that family is at, at the moment and what's happening in the family. [Child, youth and family service based in a non-government organisation]

> like people I'm working with will get physio, they come in and tap into physio, they get some legal stuff … and might get a mental health assessment./So I reckon we do that./… we design it on an individual basis, we do. [Community and family team based in a district health service]

According to the client-focused discourse people with mental disorders are treated the same as any other client. Having mental health care needs does not make someone special or different from any other client.

> … we don't discriminate … those that come in who already do have a mental disorder it's just exactly the same./We do the same thing./… Because the agency says that we don't discriminate so therefore we don't label, and every individual that walks through the door we see it as an individual case, that's why. [Housing support service based in a non-government organisation]

While still invoking the discursive device of oppositions, the client-focused and holistic health and wellbeing discourses move on to a different type of stance, that positions mental health or mental illness-focused care as just one element or strand of a more comprehensive and overarching approach. In this sense the holistic, client-focused approach is positioned as structurally superior to the illness-focused approach, and the discourse serves to affirm and legitimise the role position of these providers in relation to providers who focus on illness-care. Again the operation of value-based preferences is clearly evident.

Discussion

Discourse is comprised of both action-oriented discursive devices and elemental content or discursive structures that persist beyond immediate language use (Heracleous & Hendry, 2000). Discursive structures, like other social structures, are rules and resources that actors draw on to guide action in their daily practice (Giddens, 1984). They do not exist in isolation from other social structures, rather, they sourced from broader societal and cultural contexts and patterns such as bodies of knowledge, cognitive or interpretive schemes, norms, and values (Heracleous, 2006; Heracleous & Hendry, 2000). Structurational analysis of the interplay between stable, 'deep structures' and flexible, 'surface communicative actions' as developed by Heracleous (2006) provides a particularly helpful framework for understanding how values and attitudes may play a part in discursive action.

The present discussion builds on structurational analysis (Heracleous, 2006; Heracleous & Hendry, 2000) to examine how bodies of professional knowledge and values, understood as deep structures, interact with action-oriented discursive devices to shape the construction of role positions relevant to intersectoral collaboration around mental health care. The concept of deep structures from structuration theory is elaborated with reference to the concepts of social representations and framing from social and cognitive psychology which have been used directly in studies of attitudes and attitude change (Sibley, Liu, & Kirkwood, 2006). Understood as clusters of rules that provide a means of making sense of social practices (Giddens, 1984), frames are an example of the interpretive schemes that Heracleous (2006) proposes as the primary modality through which action and structure reproduce and transform each other.

The four discourses of informality, normalisation, holistic social and emotional wellbeing, and the individual/client-focused model are highly consistent across a diverse sample of primary health and social care organisations and across the wide variety of specific mental health care roles. They are also closely interwoven with each other. This consistency across speakers and contexts suggests the operation of relatively deep discursive structures (Heracleous, 2006; Heracleous & Hendry, 2000). The interwoven nature of the

discourses further suggests that they are part of an integrated frame in the manner of Grand Discourse (Alvesson & Karreman, 2000) or well elaborated social representations, described by Sibley et al. (2006) as "widely communicated bodies of knowledge that are shared to a greater or lesser extent among various sub-groups in society" (p3).

Key bodies of knowledge that are likely sources for the discourses found here include the long-standing comprehensive primary health care approach of the World Health Organization (Petersen, 2000) and Engel's widely known biopsychosocial model (Engel, 1977). Social representations theory is additionally relevant and useful for the interpretation of the current results because it has been used to inform research on attitudes and attitude change and because social representations are understood as composed of, and anchored in, varied types of information. These include the relatively malleable publicly elaborated concepts and arguments commonly understood as comprising discourse, as well as more stable social values (Sibley et al., 2006).

Deep structures such as social representations and values can be viewed as sources of discursive content that is available to most players in a discursive field. It is well known, for example, that a wide variety of health and social care providers endorse values consistent with holistic client-focused care. Recent research has also shown that this values-based discursive content is used to perform functions like professional boundary making and role legitimation (Sanders & Harrison, 2008). However, the ways in which these discourses and associated values may influence intersectoral collaboration at the organisational level has not been subjected to systematic investigation. The results of the current study provide new insights into mechanisms by which such discourses and underlying values may affect intersectoral collaboration in mental health care.

In addition to widely available discursive content, the service providers in the current study employed discursive devices, specifically oppositions, to construct role positions that contrasted with the positions of others in the health and social care community. The position of non-medical primary health and social care providers is highlighted or defined through the drawing of a contrast with the position of specialist mental health services. This use of oppositions is apparent in each of the four discourses. The informal, holistic, normalising, individual/client-focused approach of primary health and social care services is contrasted with the putatively formal, narrowly targeted, pathologising, disease-focused approach of specialist mental health services.

This strongly oppositional construction has important implications for policy and practice in collaborative mental health care. Specifically, it may contribute to reluctance among providers in non-medical primary health and social care services to engage with some agendas being promoted by specialist mental health services. There are at least two ways in which this could occur. First, perceptions of role differences with mental health services might lead to lower assessment of the potential contribution that could be made to the mental health agenda due to reduced self-efficacy. Second, perceptions of value differences could lead to active resistance to the adoption of particular kinds of new roles and practices. The current analysis reveals both these processes, demonstrating how they may operate to suppress involvement in collaborative mental health care, and their relative openness to mitigation.

First, the four discourses were often invoked to perform the function of explaining or defending a perception of a lack of, or low levels of, involvement in particular mental health care roles. For example respondents would say something like 'no we don't do anything to do with mental illness because we just focus on social and emotional wellbeing' or 'we don't have programs like that because we only do it informally'. If an actor perceives that their contribution does not 'make the grade' of a legitimate contribution to a particular activity, in this case, formal mental health care, they may be much less likely to engage with collaborative initiatives around this activity.

The data suggest that such effects might be quite readily overcome. Subsequent to any initial rating of role involvement, the interview procedure required respondents to describe in their own words the kind of work that they actually did do which might be relevant to the item under discussion. This process of considering the actual work performed was frequently associated with critical reflection upon terminology, involving for example, comparison of the wording in the interview schedule with the language commonly used among respondents. This process frequently led to recognition that differences in language used to describe activities did not necessarily signify an absence of, or lesser, involvement in a particular role category. This recognition was often associated with upgrading of initially low ratings. In other words, critical reflection upon discourse in the light of relatively objective assessment of actual practice, enabled respondents to re-assess the initial construction of their role position and revise their construction. This process could be understood as a form of framing effect, whereby alternative features of an issue are made more cognitively available for use in the articulation of attitudes or positions and the making of judgements (Chong & Druckman, 2007; Sibley et al., 2006).

Second, role constructions based in oppositional discourse could additionally or alternatively support a process of active resistance to the adoption of particular kinds of new roles and practices. Perceptions like 'no we don't do anything to do with mental illness because we just focus on social and emotional wellbeing' or 'we don't do any targeting of people with mental illness' could be used to position speakers as upholding the moral obligations of the holistic social and emotional wellbeing discourse and the normalising discourse, and rejecting the biomedical and psychiatric discourses. This positioning could perform the social function of justifying the speakers' lack of involvement or low involvement in particular kinds of mental health care roles and defending the organisation, or particular staff members from expectations that they should be involved.

The results of the current study as a whole suggest that such active resistance is not widespread among the respondents in this sample. Respondents generally endorsed increased involvement in mental health care across the roles examined. However, support for increased involvement was relatively low for certain roles, particularly those that involved identifying clients with mental disorders and referring them to selective programs (Mitchell, 2008). This finding is consistent with the results of the current analysis which suggest that these providers prefer or value normalising and client-focused models of care. Collaborative programs that demand substantive changes in practice such as increased screening for mental disorders and more formal assessment of psychiatric symptoms by providers in non-medical primary health and social care services could be met with resistance because they are inconsistent with strongly held values.

These two proposed processes are consistent with the social representations theory of attitude change described by Sibley et al. (2006) who propose that framing effects are more likely to influence attitudes that relate to peripheral elements of a social representation, while core elements that are heavily anchored in strongly held values will be resistant to framing effects. In the first process involving reduced self-efficacy, the language or discourse used to construct role positions may rely on relatively peripheral or cosmetic aspects of the social representations that inform the discourse. In the second process involving active resistance, role

positions appear to be constructed from discourse that is anchored in core values and are not amenable to reframing. Recent research in the fields of social and political psychology provides empirical support for the contention that attitudes anchored to well elaborated social representations and associated with strongly held values are not readily amenable to framing effects (Chong & Druckman, 2007; Sibley et al., 2006; Slothuus, 2008).

One of the main factors that has driven opinion leaders in the mental health sector to call for greater intersectoral collaboration has been a perception that services in other sectors are not directing sufficient attention to the needs of clients with mental disorders (Chitsadesan & Bailey, 2006; Herrman & Harvey, 2005; King et al., 2006; Waghorn et al., 2004; Whiteford, 1994) and that an unacceptable proportion of people with mental health treatment needs are not being identified and referred to specialist services (Andrews, Henderson, & Hall, 2001; Chitsadesan & Bailey, 2006; Glazebrook, Hollis, Heussler, Goodman, & Coates, 2003; Harris & Edlund, 2005; Karlin & Fuller, 2007). Consistent with this view there has been a strong emphasis in the mental health literature over many years on increased identification through screening in order to increase rates of referral and treatment (Bailey & Tarbuck, 2006; Glazebrook et al., 2003; Harris & Edlund, 2005; Karlin & Fuller, 2007; Whiteford & Buckingham, 2005), and to facilitate prevention (Klein et al., 2001; Navon, Nelson, Pagano, & Murphy, 2001) as well as the development of more community-based programs tailored to the special needs of clients with mental disorders (King et al., 2006; Waghorn et al., 2004).

It is beyond the scope of this article to assess the merits of this approach. The point is that the approaches and practices being emphasised most strongly by advocates within the mental health sector may be inconsistent with some of the core values driving the agenda in other sectors, and indeed, there has been very little uptake of screening or development of selective or targeted mental health programs in other sectors. Resistance around particular practices does not necessarily imply, however, a generalised resistance to engagement with mental health care.

Reform leaders in the mental health sector may need to revise their approach. Respectful dialogue that seeks genuine understanding of the values that underpin models of care used in other sectors is essential. While it may be possible to ameliorate some resistance to engagement with the mental health reform agenda by helping providers in other sectors to re-frame unhelpful perceptions, it may also be beneficial for leaders in the mental health sector to reflect critically upon their own discourses, values and practice models, and consider how these might be adjusted to better fit and reinforce the strengths of sectors they wish to collaborate with.

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