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Original Article

Cross-sectoral collaboration of mental health problems in children and adolescents

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ABSTRACT

INTRODUCTION. A growing number of children and adolescents (CA) suffer from mental health problems. To provide the necessary investigation and care, collaboration between general practitioners (GPs) and the municipality is essential, but often challenging. This study aimed to identify factors influencing intersectoral collaboration between general practice and municipalities when treating CA with mental health problems and to propose improvements to this collaboration.

METHODS. We conducted interviews with seven GPs and three municipal employees (MEs). The data were analysed with inspiration from thematic analysis. The results were framed within Gittell's theory of relational coordination.

RESULTS. GPs and MEs expressed frustration and challenges encountered when working with CA due to inefficient intersectoral collaboration. Many GPs expressed a need for better communication with municipal authorities or child psychiatry departments. MEs also experienced challenges related to this collaboration. Successful collaboration appeared when dedicated individuals from both sectors actively worked for improvements. Key factors identified for enhancing collaboration included personal knowledge, regular contact, awareness of activities in the other sector and improved communication channels.

CONCLUSIONS. We propose enhanced cross-sectoral communication, routine information exchange and further development of digital tools to improve collaboration. Formalising collaboration through specific agreements is also recommended.

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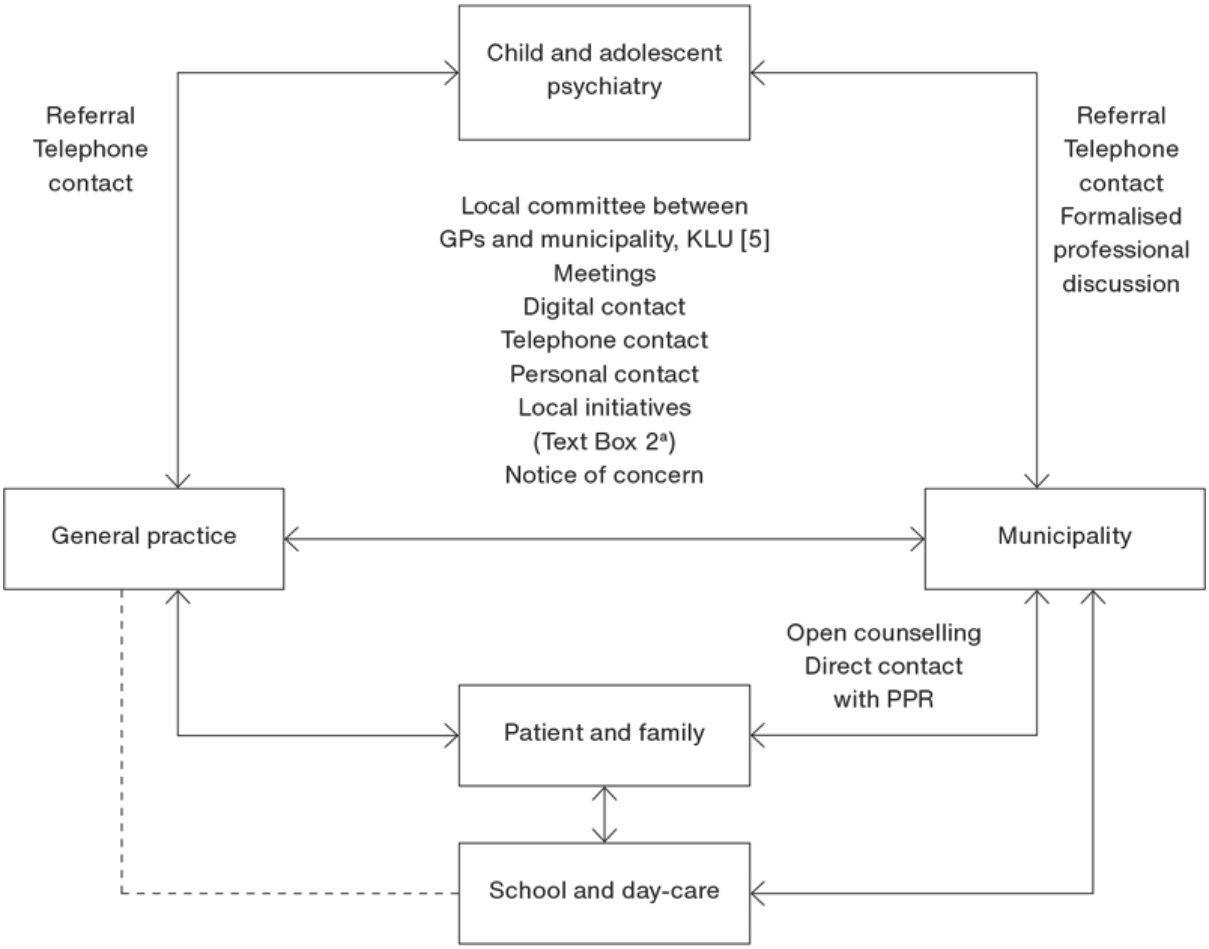
A growing number of children and adolescents (CA) in Denmark and internationally require support and treatment for mental health problems of varying severity [1-4]. General practice and different sectors are involved in investigation, support and treatment (**Figure 1**, **Figure 2** & **Figure 3**), and the local municipality is typically a crucial element in providing optimal care. However, challenges persist in this collaboration. For example, in 2021, the Danish Health Authority expressed concern about the inclusion of general practice in the collaboration, along with issues concerning referrals from general practice to Child and Adolescent Psychiatry (CAP) often being rejected [6].

FIGURE 1 Diagram of intersectoral communication.



GP = general practitioner; KLU = committee with members from general practice and the municipality; PPR = pedagogical-psychological counseling.
a) Supplementary material.

FIGURE 2 General practice and municipality in Denmark.

Both municipal employees and GPs work in the Danish tax-funded welfare system but hold different professional backgrounds. The municipal employees represent a system rooted in the Danish authorities and political system, based on the law regarding social services. In contrast, the GPs work for the Danish Public Healthcare system. Furthermore, Danish general practices are independent businesses governed by agreements with Danish administrative regions.

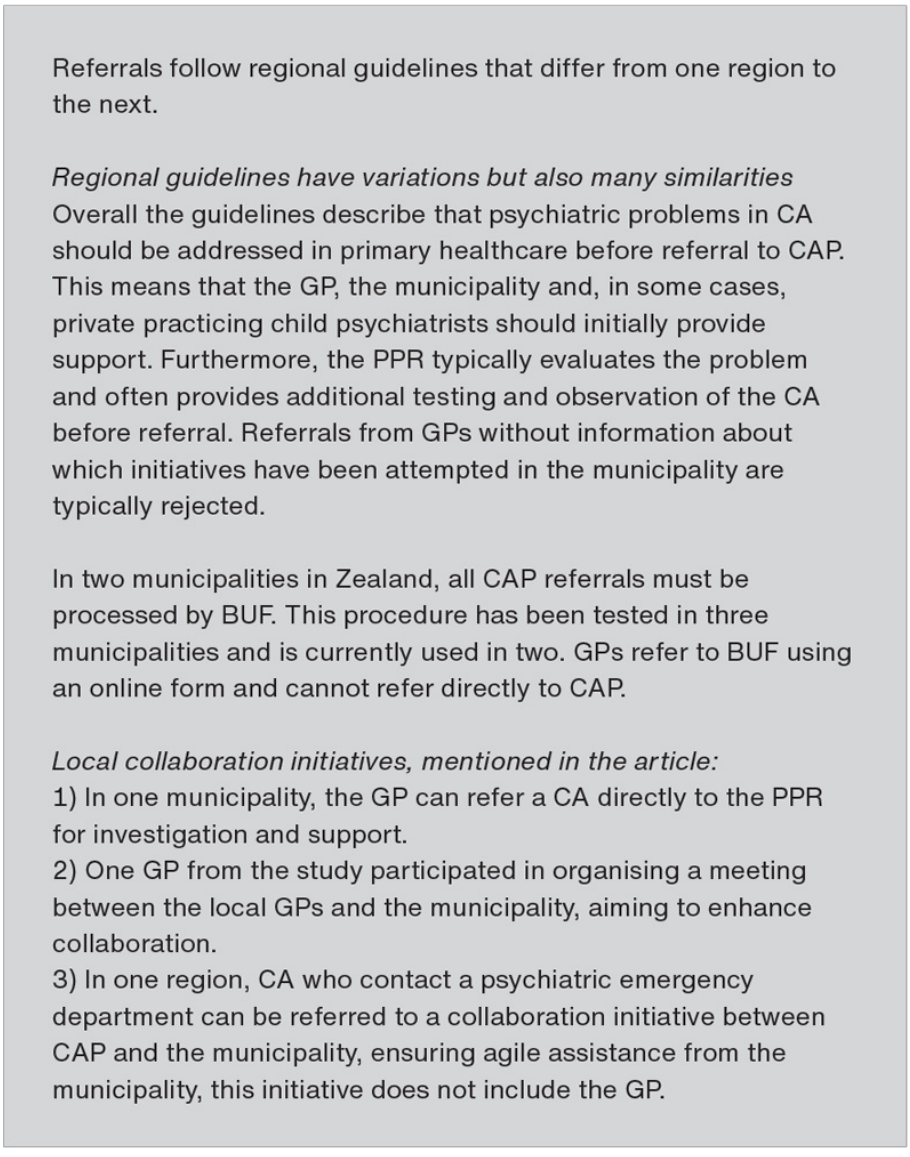
The municipalities are responsible for schools and daycare, PPR provision. Additionally, they have a key role in assessing and referring children and adolescents with mental health problems. Both municipalities and GPs can refer to CAP, following regional guidelines, see Text Box 2[a].

The GPs, along with other public employees have a strict obligation to notify the municipality if a child's welfare or development is threatened. This is done through special notifications of concern. The municipality is obliged by law to investigate these cases when receiving a notification.

Apart from these notifications, few formal descriptions or provisions aiming to ensure collaboration exist between GPs and municipalities.

CAP = child and adolescent psychiatry; GP = general practitioner; PPR = pedagogical-psychological counseling.
a) Supplementary material.

FIGURE 3 Referral from general practitioners and municipalities to the child and adolescent psychiatry services.



BUF = Child and Adolescent Psychiatric Forum; CA = children and adolescents; CAP = child and adolescent psychiatry; GP = general practitioner; PPR = pedagogical-psychological counseling.

Local municipalities, often responsible for support and treatment, collaborate with municipal family departments and pedagogic-psychological counselling (PPR) services, working with daycare and schools. The role of municipalities in managing mental healthcare has increased, with CAP referrals now mainly being effected through municipalities and only to a lesser degree via general practitioners (GPs) (Figure 3).

However, it remains unknown how GPs and municipal employees (MEs) perceive the collaboration.

This study aimed to identify and describe the experiences of GPs and MEs concerning factors that influence intersectoral collaboration between general practice and municipalities regarding CA with mental health problems and to propose changes that may improve this collaboration.

The study was conducted in accordance with The COREQ Checklist (Supplementary material) [7].

Recruitment targeted various municipalities, including the PPR and family departments. Out of nine e-mails sent, three MEs agreed to participate, whereas 26 letters and e-mails to GPs yielded seven participants. The GPs' ages and work experience varied considerably; the three MEs differed in work experience and professional roles (**Table 1**). In total, two GPs and two MEs were involved in specific collaboration initiatives or referral systems. The participants received written information about the study and the interviewer. The participants represented a wide range of socio-economic areas in Eastern Denmark. Four of the GPs were previously known to the author.

TABLE 1 Participants.

Identification	Age, gender	City/countryside	Particularexperience/ collaboration project	Seniority	Type of practice	Professional role	Size of municipality, inhabitants
General practitioners							
A	52 yrs, F	Small town	Previous experience with child psychiatry	11 yrs	Partnership	-	-
B	72 yrs, F	Provincial town	Interest in psychiatry	38 yrs	Solo practice	-	-
C	59 yrs, M	City	Has worked with the subject in educational group in collaboration with the municipality	20 yrs	Owner of practice, 2 doctors employed	-	-
D	69 yrs, F	Big provincial town	None	21 yrs	Partnership	-	-
E	59 yrs, F	Small town	Prepared education in local group about the subject	21 yrs	Partnership	-	-
F	49 yrs, M	Small town	Local collaboration project with PPR	9 yrs	Solo practice	-	-
G	43 yrs, F	City	None	4 yrs	Partnership	-	-
Municipal employees							
H	-, F	-	-	Several yrs	-	Psychologist, responsible for local referral pathway between GPs and PPR	70,000
I	-, F	-	-	Unknown	-	Leader at the PPR	31,000
J	-, F	-	-	4 mos.[a]	-	Psychologist	33,000

F = female; GP = general practitioner; M = male; PPR = pedagogical-psychological counseling.
a) Several yrs in other municipalities.

The study employed purposive sampling to capture a broad range of experiences with collaboration. We aimed to maximise variation in experience, age and gender. Data saturation was achieved by including participants until the same themes started reemerging [8]. The author (GN), a general practitioner with many years of experience and a novice researcher, conducted semi-structured individual interviews in 2021 (six in-person, two online and two by telephone), lasting 1-2 hours. GN transcribed the recorded interviews except for one that was transcribed simultaneously for technical reasons. The interview guides for the GPs and for the MEs featured open-ended questions.

Methods

Thematic analysis was conducted by GN using an inductive, bottom-up approach, where themes were derived directly from the raw data [9]. The interview data were coded by marking of the digital text and, from these code groups, the themes were identified and subsequently reviewed. We adopted an open and reflective approach to explore experiences and attitudes regarding collaboration. This enables researcher subjectivity to serve as a resource rather than constituting a problem.

After the analysis, we found it relevant to apply Gittell's theory of relational coordination to put into perspective our results, as it describes challenges in inter-professional collaboration while proposing an approach to achieving well-functioning and effective cooperation.

Trial registration: not relevant.

Results

We found that GPs and MEs had only a few positive collaborative experiences. These were often linked to well-organised cross-sectoral meetings, collaboration with proactive individuals, understanding of key municipal support areas and building knowledge of the areas of expertise of peers. Two GPs involved in collaborative projects involving the municipality and generalpractice described fewer negative and more positive experiences than the other GPs. Most results, however, comprised collaborative challenges.

The results were divided into three themes: 1) Communication between GP and municipality, 2) Collaborative roles and tasks and 3) Knowledge and legislation.

Communication between general practitioners and municipality

The GPs had various ways of communicating with municipalities, including passing letters via families, directing families to schools or PPR, direct notifications, digital messages, phone calls and meetings (Figure 1). However, they often faced communication barriers. For serious concerns, GPs typically used notifications of concern (Figure 2). Meetings were seen as beneficial for resolving misunderstandings and aiding families, but were limited by time and scheduling issues. The GPs often wished to contact the municipality but had no contact information.

Referrals to CAP and municipal services frequently posed challenges, as one GP explained:

"... and it is a very heavy road forward. We can almost never refer directly to the CAP, even though we have a presumption that it is where they belong. We have to go through the municipality, and that makes the process very, very long and slow", GP D.

MEs reported positive experiences with specific projects and with direct phone access to GPs. The MEs' negative experiences included difficulty in contacting the GP and uncertainty concerning referral procedures. Pressure and increasing workload from a growing number of CAs with mental health problems and increasingly challenging assignments were also an obstacle to communication with the GPs.

A GP expressed satisfaction with the open counselling service of a municipality. Additionally, a project in which GPs could refer CA directly to the municipality was described as positive:

"It was very helpful that we could refer CA with poor mental wellbeing, and we experienced that they received help quickly... our referral was taken seriously, and it carried weight with the municipality. Previously, our ability to help children and families with their problems was much more limited", GP F.

Five GPs described missing information from the municipality:

"Well, we don't receive any feedback. And that's really too bad, because many of them, well, we are their doctors, they will come back, they will come when things are not working out, right?", GP D.

Four GPs adopted unconventional shortcuts due to limited options. Two referred CA directly to psychologists, while others used child safety notifications for less critical concerns (Figure 2). In one region, GPs suggested visits to the psychiatric emergency department, as a local initiative (Figure 3) facilitated collaboration between this department and the municipality. Furthermore, some GPs referred to private psychiatrists, an option mainly available for well-to-do families.

The communication between GPs and MEs was described as ad hoc without formal agreements or descriptions. The communication and relations varied between areas, often depending on the commitment of the local participants. The GPs described that this affected their ability to provide efficient help for the families.

To improve collaboration, five GPs highlighted the value of knowing MEs personally. Another five GPs were open to joining intersectoral meetings, though time constraints were a concern. Better channels for digital

communication with municipalities would help most GPs. Four GPs preferred direct patient referrals to municipalities. Five GPs missed feedback on municipal procedures. MEs desired better IT systems for communication and were open to meet with the GPs.

Collaborative roles and tasks

The GPs emphasised the importance of addressing mental health issues in CA, noting their impact on entire families. They perceived their role as project managers who were responsible for caring for the families over long periods and requested information about municipal care to better support families. The GPs expressed that their expertise was often ignored during municipal case assessments.

One GP described her role as follows:

"Well, I think that we often see ourselves as a project manager and, in practice, I also think that we are the ones that the families keep returning to if it does not work where their case is currently being processed", GP A.

The MEs viewed GPs as one of several referrers, but noted limited involvement in most cases. One employee shared:

"I have primarily experienced that it works when the GPs send referrals to us... but when we contact the GP, things become difficult... I find that the GP is very rarely involved in anything", ME J.

MEs valued information provided by GPs before the municipality begins planning support initiatives. Thus, one ME mentioned that testing for anxiety and depression, along with thorough examination, was very valuable information. Similarly, information about Body Mass Index in the case of eating disorders was also important. Another ME mentioned a need for assessment of suicidal risk from the GP to underpin support planning. In contrast, a lack of contact with the GP could lead to negative stereotyping regarding the other profession, affecting mutual respect:

"Yes and then it becomes a story, you tell yourself that this doctor is hard to work with, right? Well, it does, sadly", ME J.

Knowledge and legislation

Most municipalities had supportive initiatives for CA with minor mental problems. GPs experienced a lack of information about these projects, noting their brief duration.

MEs experienced challenges related to the laws of consent and IT system issues.

Some GPs reported that confidentiality laws limiting information exchange when consent was lacking restricted their access to municipal information. A ME noted that legal information sharing required an efficient, secure IT system. Another ME learned at a seminar that intersectoral communication to aid families is often allowed:

" .... also without consent, as far as I understand, you are actually allowed to communicate, but this is the kind of thing that is really unclear, and I think its... we are almost sort of *vaccinated* with the notion that we are not allowed to talk with anyone", ME J.

These statements suggest that the law on confidentiality [10] was unclear to the MEs, which would result in an unnecessary fear of acting unlawfully when communicating with the GP. Another ME mentioned that it was unethical to "talk about the families behind their backs".

Discussion

This study identifies major challenges in GP-municipal collaboration, with GPs using unconventional methods to

overcome communication barriers and feeling undervalued despite their key role in patient care. Most participants agreed on the need for improved communication and collaboration, highlighting the GPs' need for more direct involvement and feedback.

An important finding was the intersectoral, cross-professional and *ad hoc* nature of the collaboration between GPs and MEs. This collaboration was mainly characterised by sporadic information exchange and lacked continuous interaction, reflecting findings in earlier studies [11], which highlighted GPs' challenges in obtaining psychiatric assistance for adolescents and when attempting to collaborate with municipalities.

The identified communication and collaboration challenges between GPs and MEs are underpinned by other studies highlighting the importance of regular, formal avenues of communication in facilitating collaboration within healthcare settings. A recent Norwegian study found similar communication challenges between GPs and child welfare services [12]. In another study non-hierarchical environments are considered beneficial for enhancing teamwork among healthcare professionals and improving the quality of care in primary care settings [13].

The different professional backgrounds and operational frameworks of the two groups add another layer of complexity due to their different perspectives and working languages. Furthermore, while MEs operate within a structure influenced by the Danish authorities and the political system rooted in the Danish Social Service Act, GPs are governed by the public health system governed by the Danish Health Care Act.

Our findings resonate with Gittell's emphasis on the need for shared goals, knowledge and mutual respect to improve interprofessional coordination [14]. This connection suggests that the principles of relational coordination could be beneficial in addressing the issues identified in our study.

Effective communication closes gaps, minimises readmission rates, reduces errors, increases worker retention and promotes patient-centred care. A collaborative environment allows healthcare professionals to share vital information, new techniques and new technologies, leading to more efficient care and improved outcomes [15].

Strengths and limitations

A key strength of this study is its commitment to transparency in reporting [7].

The GP majority among respondents and the interviewer's GP background might have affected the interpretation of the data. Interviews conducted by fellow professionals may provide deeper information, capitalising on mutual knowledge and trust, but also affect the participants' answers, e.g., to avoid feeling judged by a co-professional [16]. Involving clinicians and non-clinicians in this study may have balanced any such drawbacks.

This study brings insights into GP experiences. Furthermore, as the MEs add perspective to GP experiences, the study placed less emphasis on MEs' different professional backgrounds and experiences, which could potentially have highlighted differing views within the municipal sector.

Conclusions

This study highlights the complex challenges in collaboration between GPs and municipalities and identifies areas for improvement through enhanced communication. An integrated, respectful and goal-oriented collaboration model is crucial, valuing the roles of GPs and MEs in public health.

Future research should explore the perspectives of MEs, CA and families to enhance our understanding of support needs.

Enhanced cross-sectoral communication, routine information exchange and further development of digital tools

are recommended to improve collaboration. Formalising collaboration through specific agreements may potentially ensure consistency and effectiveness in partnerships.

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