Cross-sector problems of collaboration in psychiatry

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ABSTRACT

INTRODUCTION: Some mental health service users need support from both hospital-based and community-based services. Treatment requires well-functioning collaboration practices between different mental health organizations and professions. However, serious cross-sector problems of collaboration have existed in Danish psychiatry since the 1980s when mental health service provisions were split into two psychiatric systems.

MATERIAL AND METHODS: We report from two qualitative studies: STUDY#1 (n = 24) consisted of twenty-four individual, qualitative interviews with the staff and management of a psychiatric emergency unit, a closed psychiatric ward, and a community-based residential facility, respectively. STUDY#2 (n = 22) consisted of four individual interviews with service users and mental health staff, and three focus group interviews each including six staff members from both hospital- and community-based services.

RESULTS: Staff and management experiencing cross-sector problems of collaboration point to ineffective coordination of services between systems and lack of mutual understanding of how systems other than the staffs' own systems work. Solutions include specific procedural changes during service users' admission to and discharge from hospital and during hospitalization and measures to increase cross-sector knowledge about each system's practices and methods.

CONCLUSION: Improvement of cross-sector collaboration in psychiatry should take the form of a *multi-faceted approach* embracing measures to improve coordination of service users' treatment and care and to increase interaction, understanding and respect between the two systems.

FUNDING: not relevant.

TRIAL REGISTRATION: not relevant.

Some mental health service users need support from both hospital- and community-based services. Treatment and care provided by hospital settings and community settings must therefore be coordinated between various mental health organizations and professions and this requires well-functioning collaboration practices. However, serious cross-sector problems of collaboration have existed in Danish psychiatry since the 1980s when mental health service provisions were split into two psychiatric systems comprising hospital (acute in-patients hospital units, out-patient and ambulatory clinics) and community (community mental health teams, community-based residential facilities) care, respectively.

Studies indicate a cause of cross-sector problems of collaboration is that community settings and hospital settings have different cultures and different approaches to service users, which emphasize the medical and social aspects of treatment and care differently, and staff members therefore perceive their services as competing rather than synergistic [1-6]. The relationship between the community and the hospital setting is often characterized by mutual criticism of each other's work and by an unclear division of labour [1, 5, 7]. Another study has shown that problems of collaboration in mental health care persevere despite the introduction of comprehensive cross-sector collaborative agreements aiming at improving collaboration between the community setting and the hospital setting [8].

In this paper, we inquire into *what* those cross-sector problems of collaboration in mental health care are about and ask *how* they may be resolved from the perspective of staff and management in both the community setting and the hospital setting. In contrast to previous studies, our results suggest that the major obstacle to cross-sector collaboration is ineffective coordination and lacking interaction between systems rather than different approaches to service users and an unclear division of labour. Our focus on potential resolutions to collaborative problems is generated through a change theory perspective [9], which analyses specific collaborative problems from a problem-solving perspective and which generates concrete, practical and viable solutions.

MATERIAL AND METHODS

We report from two qualitative studies exploring staff and management experiences of cross-sector collaboration in psychiatry in the Copenhagen area. Interview questions asked interviewees' about their positive and negative experiences with cross-sector collaboration. STUDY#1 (n = 24) was conducted in 2010-2011 and consisted of 24 individual, qualitative interviews with staff and management from three units: A psychiatric emergency unit, a closed psychiatric ward and a community-based residential facility. The study investigated staff and management experiences of working in psychiatry including cross-sector collaboration between community and hospital settings.

STUDY#2 (n = 22) was conducted in 2012 and consists of four individual interviews with a service user, a family member of a service user, a community residential worker and a psychiatric ward nurse, respectively, and three focus group interviews each with six staff members from both hospital-based and community-based services. In one of the three focus group inter-

ORIGINAL ARTICLE

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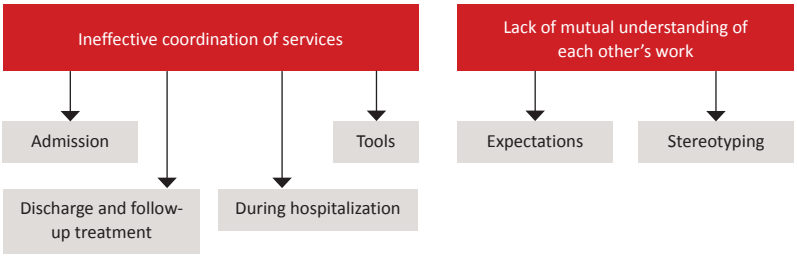
Dan Med J 2013;60(9):A4707

FIGURE 1

Thematic map showing two main themes and sub-themes.



views, staff from both the community setting and the hospital setting were brought together to discuss potential long-term resolutions of the cross-sector problems of collaboration identified in previous interviews. Nurses, psychiatrists and social workers participated in both studies, but general practitioners did not.

Data analysis

We used thematic analysis [10] to analyze the data as this method is productive in terms of learning about themes and patterns in large qualitative data sets. In STUDY#1, all interviews were transcribed and coded inductively by AP using Nvivo9. In STUDY#2, all interviews were audio-coded by both ENM and AMLK to ensure consistency between relevant themes and the reported data. Both studies were shaped by phenomenology [11] in that their focus was on psychiatric staff members' lived experiences of cross-sector collaborative problems.

Trial registration: not relevant.

RESULTS

Cross-sector problems of collaboration

The data analysis produced two main themes describing how staff and management experience cross-sector problems of collaboration: 1) as ineffective coordination of services between hospital and community settings, and 2) as lack of mutual understanding of each other's work (**Figure 1**).

Ineffective coordination of services between hospital and community settings apply to service users' admission to and discharge from psychiatric hospital settings as well as the hospitalization period and follow-up treatment after hospitalization. The social workers who provide care to service users stated that they were often not informed when service users were admitted to hospital. They explained that this lack of information gave unnecessary problems and worries and that they had to spend valuable resources trying to locate the service user and find out what had happened. The social workers similarly emphasized that they were rarely informed about service users' discharge from the psychiatric wards or about follow-up treatment.

"When service users are discharged from the hospital, we have no idea whether there is a change in the medication, what has happened during hospitalization or what will happen now" (social worker).

They stress that this lack of information impede their efforts to provide care to service users after hospitalization, particularly their efforts to support service users in taking their medication. The social workers explained that this ineffective coordination resulted in a chaotic discharge for many service users.

The medical staff in the hospital setting also called for a more effective coordination with the community-based social workers, but their emphasis was on coordination during the service users' hospitalization. They explained that it is a huge problem that social workers rarely visit service users during hospital treatment:

"When they are discharged from the psychiatric ward, it sometimes feels like discharging them to *nothing* until the next time they are admitted" (hospital nurse).

They explained that important information about the treatment progress was lost and assumed that the relationship between service user and social worker must be strained due to the lack of interaction during hospitalization.

Both hospital staff and community staff repetitively emphasized that successful treatment and care needed to incorporate well-coordinated elements of both hospital and community care. This, however, is easier said than done because of lacking coordination of the tools used by the two systems. A social worker explained:

"In the community-based services, we work with action plans, crisis plans, focus areas, and compass change, and in the hospitals they work with ten other tools. I really do understand if service users feel like fifteen folders instead of a person."

Cross-sector problems of collaboration also concern lack of mutual understanding of each other's work. Both hospital staff and community staff and management often felt that their work effort and work conditions were misunderstood. Community-based social workers described that the hospital staff unrealistically expected them to make daily visits or provide 24-hour care once a service user is discharged from hospital treatment, which far exceeds the limits of what community-based services can offer. The hospital staff described that community staff expected them to keep service users hospitalized until they are fully recovered, which far exceeds the hospital settings' purpose of stabilizing service users.

This lack of mutual understanding of each other's work leads to negative stereotyping, which impedes a constructive collaborative relationship. The negative stereotyping has dire consequences for particularly the community social workers, who do not feel that their knowledge about the service users' daily life is as important as the medical knowledge practiced in the hospitals:

"It is not because I think they look down on our professionalism, but we are at the bottom of the hierarchy, in one way or another" (social worker).

While the hospital staff confirmed this negative stereotyping, the community staff criticized hospital-based services for being out of touch with the everyday life of service users and therefore able only to stabilize service users during hospitalization.

The negative stereotyping obstructed a constructive collaborative relationship between the systems and overshadowed the positive experiences of collaboration:

"There are many stories about the absence of community-based services, and these influence our interaction with the social workers in a negative way, because once they step in the door, my idea of them is that they don't do their job properly" (hospital nurse).

The negative stereotyping obstructs cross-sector collaboration simply because it produces a fundamental distrust of "the other".

Proposed solution elements

According to the interviewees, resolutions to the ineffective coordination should include the introduction of specific procedural changes during service users' admission to and discharge from hospital and during hospitalization to avoid relying on individual staff members' ability to coordinate treatment and care between the systems. Specifically, as a standard procedure, the associated social worker should be informed of a service user's admission to and discharge from hospital. This may be ensured by introducing "associated social worker has been informed" as a category to be ticked off with date and signature on the informed consent form or the paperwork that is routinely completed during admission and discharge. When possible, the associated social worker should be invited to a discharge meeting to ensure her involvement in the service user's follow-up treatment. During hospitalization, a service user's associated social worker should be required to make, or offer to make, weekly visits to sustain the dialogue with the medical staff about treatment progress and to maintain a relationship to the service user. Additional solution elements encompass the establishment of formal meeting procedures to ensure that the two psychiatric systems' use of tools such as action plans, crisis plans and medication schemes is compatible and is coordinated into consistent treatment and care for individual service users. Both hospital- and community staff emphasized that efforts aiming to coordinate their use of tools should be centered on supporting the treatment and care of the individual service user.

Elements aiming to solve the lack of mutual understanding of each other's work included the establishment of cross-sector meeting forums where staff can meet and learn about each other's work and coordinate their efforts. Meeting forums could be organized as: 1) Regular network meetings with representatives from both staff and management from hospital-based as well as community-based services operating in the same district rather than only including the management level as is current practice. Such network meetings would sustain ongoing dialogue about general cross-sector collaboration and coordination. 2) Job rotation where staff from the two systems visit each other to learn about how work is done in the two psychiatric systems. 3) Local Learning at Work Days, where staff from the two systems are invited to talk about their specific work efforts with the service users. 4) Joint training in areas of mutual interest such as new approaches and methods. Joint training organized across the two systems would increase awareness and understanding of each other and interaction between groups of staff.

All these meeting forum variations would, a) increase cross-sector knowledge about each system's practices and methods, b) dispel many of the prejudices that the two groups have about each other and increase respect and trust between the two systems. Together with the procedural changes presented above, meeting forums would improve cross-sector collaboration and coordination of service users' treatment (**Figure 2**).

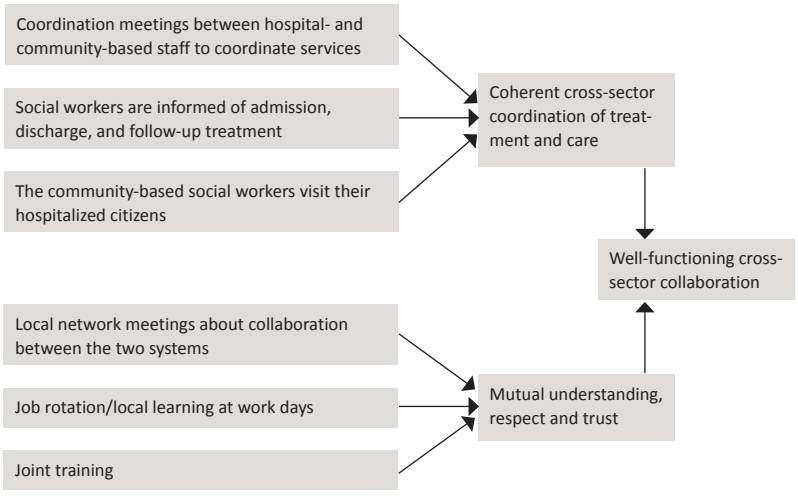
DISCUSSION

The idea behind cross-sector collaboration is that the sharing of information and capabilities between organ-

Collaboration.
Photo: Bigstock.com

FIGURE 2

Solutions to cross-sector problems of collaboration.



izations in different sectors can achieve an outcome that could not be achieved by the organizations in one sector alone [12]. Yet, obstacles to cross-sector coordination of care are manifold, and lack of trust between organizations and differences in status are prevalent [13] and the feedstock to cross-sector interpersonal conflicts [14]. Concurringly, interviewed staff from both hospital and community settings saw the problem as a matter of ineffective coordination and lacking interaction between systems and they emphasized that the negative stereotyping was sustained mainly because they did not meet and dialogue about each other's work efforts with the service users.

Given that trust is an important lubricant in cross-sector collaboration [12, 15], trust-building activities such as meetings and work groups [13] should be central to any effort directed at improving cross-sector collaboration. In line with this, the solutions reported in this paper comprise regular meeting forums to facilitate the sharing of information and nurture cross-sectoral understanding among care providers. These measures should be supported by the implementation of sustainable routines for achieving coordination of tasks. Routines are an ideal means for transforming individual capabilities into organizational capabilities [13]. Collaboration requires staff time and attention, resources that are in short supply in today's health care. We nevertheless recommend a *multi-faceted approach* for resolving cross-sector problems of collaboration in psychiatry. Actions should embrace measures to (a) improve coordination of service users' treatment and care, and (b) increase interaction, understanding and respect between the two systems as the first steps towards a synergetic work effort.

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ACCEPTED: 17 July 2013

CONFLICTS OF INTEREST: none. Disclosure forms provided by the authors are available with the full text of this article at www.danmedj.dk.

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