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Arenas for contact. A study of local collaboration in mental health

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Abstract

Collaboration in the field of mental health involves institutions with differing organizational structures and belonging to different administrative and political authorities. The institutions concerned include professionals with such varying roles as physicians, nurses, psychologists, social welfare secretaries, occupational therapists, home support personnel and others. The purpose of this article is to describe and analyse how different psychiatric and social services in a Swedish municipality can collaborate, in spite of obvious differences in organizational forms, legislative and administrative mandates, professional backgrounds and perspectives. A study of formal agreements and procedures for collaboration and other forms of documentation, in combination with an interview study of persons with different occupational roles in each respective organization, shows the importance of a comprehensive strategy based on a holistic view of the diverse needs of individual patients and clients. Such a strategy requires an overall structure including not only written agreements and procedures, but also arenas for meetings at all levels of the organizations involved, in which the role of leadership is to solidify the structure for collaboration and support individual professionals working in collaboration to provide care and service for individual patients or clients.

Keywords: Collaboration, mental health, psychiatry, social psychiatry, interorganizational collaboration

Arenor för kontakt. En studie över lokalsamverkan kring mental hälsa

Samverkan inom fältet mental hälsa berör institutioner med skilda organisationsstrukturer och tillhörande olika administrativa och politiska huvudmän. Hos respektive institution finns yrkesgrupper med varierande roller såsom läkare, sjuksköterskor, psykologer, socialsekreterare, arbetsterapeuter, boendestödjare m.fl. Syftet med denna artikel är att beskriva och analysera hur psykiatrin och socialtjänsten i en svensk kommun kan samverka, trots uppenbara skillnader i organisationsformer, lagstiftning och regelverk samt yrkesbakgrund och professionell grundsyn. En dokumentstudie av avtal och rutiner för samverkan tillsammans med en intervjustudie riktad mot personer med olika professionella roller inom respektive organisation visar på vikten av en övergripande strategi baserad på en helhetssyn omfattande individen/patienten/klientens sammansatta behov. En sådan strategi kräver en övergripande struktur som omfattar inte bara skriftliga överenskommelser och rutiner, utan även arenor för kontakt på samtliga nivåer inom de berörda organisationerna. Ledarskapets roll blir då att stärka och befästa strukturerna för samverkan samt att stödja samarbetet för att ordna vård och stöd kring enskilda patienter och klienter.

Nyckelord: Samverkan, mental hälsa, psykiatri, socialpsykiatri, interorganisatorisk samverkan

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Background and aim

The Swedish Mental Health Care Reform of 1995 established a separation of the county council health care and the municipal social service, resulting in the necessity for collaboration between psychiatric care and social services (SOU 1992:73). The reform clarified the municipal social service's responsibility for appropriately adapted housing, support in the home, daily training and activities for people with psychiatric disabilities, while the health sector continued to be responsible for psychiatric care. The overall goal of the reform was to improve the life situation for people with psychiatric disabilities and to increase their possibilities of inclusion and participation in the society (Markström, 2003; Rosenberg, 2009).

Various efforts have been made to stimulate collaboration in this area. When, for example, in the years 1996-98 the state appropriated 1.2 billion Swedish kronor through the National Board of Health and Welfare to support new programs in the county councils and municipalities around the country, many were collaboration projects, often focusing on vocational rehabilitation (National Board of Health and Welfare, 1999, 2001). In spite of these and other efforts, the final report of the Committee on National Psychiatric Services Coordination concluded that "many reports and evaluations indicate that the agencies and authorities responsible have major difficulties finding common solutions for providing care and service to the people in need" (SOU 2006:100, p. 20).

Since 2006 several attempts have been made to improve collaboration between the different agencies involved and eventually, in 2009, new legislation in the form of additions to the Health and Medical Services Act and the Social Service Act was passed, requiring all county councils and municipalities to sign local agreements on collaboration concerning care and services for persons with psychiatric disabilities. In this legislation, it was also specified that when an individual patient or client has need of both health care and social service, the responsible institutions for the county council and the municipality form an individual plan for how the person's needs shall be met (SFS 2009:979; SFS 2009:981).

Nevertheless, there are indications that collaboration continues to be a problem. For example, a report from the Stockholm County Association of Local Authorities concluded that collaboration concerning persons with psychiatric disabilities is still deficient in many areas (Strömberg Dominković, 2009). The same year, an audit in the Stockholm County Council reported that the psychiatric sector had major problems in collaboration with the municipal social services (Stockholm County Council, 2009).

According to Sullivan and Skelcher (2002), the need for collaboration in the public sector has exploded since the 1980's, largely due to the fact that market models for providing service have increasingly replaced large welfare bureaucracies, resulting in fragmentation of organizational responsibilities and authority. The Swedish Mental Health Care Reform as well as other developments in Sweden for providing service for people with psychiatric disabilities can be seen

as examples of this type of fragmentation. For this reason, mental health is an important field for collaboration between the psychiatric care sector, the social service as well as other sectors.

The purpose of this article is to describe and analyse how different psychiatric and social services in a Swedish local community can collaborate on meeting individual users' total need for care and services, in spite of obvious differences in organizational forms, legislative and administrative mandates, professional backgrounds and perspectives.

Research on collaboration in the field of mental health has often been concerned with short-term projects or specific problem areas, such as vocational rehabilitation, case management or "assertive community treatment" (National Board of Health and Welfare, 2001; Piuva & Lobos 2007; Malm 2002). This article seeks to give a comprehensive picture of how an overall strategy of collaboration in mental health can be developed in a local municipality. Before the study is presented, however, it is necessary to provide a conceptual framework and an introduction to mental health as a field of collaboration, including an overview of previous research.

Conceptual framework

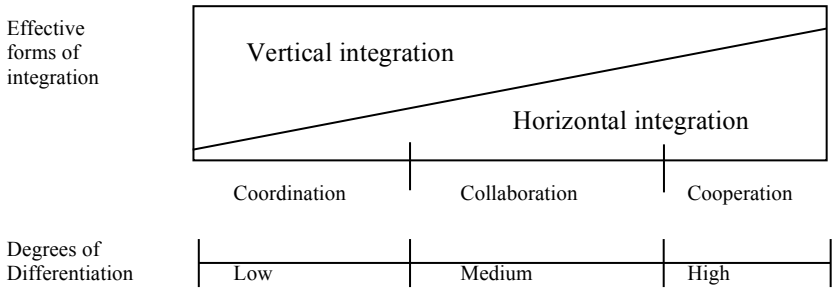
In Sweden, several attempts have been made to define collaboration, based on the concept of organizational integration. Westrin (1986) has constructed the following scale: *consultation*, in which an occupational group from one organization makes a temporary contribution to the work of another organization; *coordination*, in which the work of different organizations are added to each other; *collaboration*, in which cooperation is concentrated to specific problems or areas; and *integration* or *fusion*, in which two or more agencies undertake common tasks.

Axelsson and Bihari Axelsson (2006) have discussed several of these terms based on a "contingency" theory of organizations (Lawrence & Lorsch, 1967). The basic concept is *interorganizational integration*, which can be achieved either by way of a management hierarchy or through contracting on a market. A third possibility is integration by networking, based on more or less voluntary cooperation or collaboration between organizations which do not belong to a common hierarchy or market. This last is called *horizontal integration* and is the opposite of the *vertical integration* which is found in a hierarchy. According to this framework, c*oordination* can be defined as a form with a high degree of vertical but a low degree of horizontal integration, which means that integration is achieved mainly through the existence of a common management hierarchy. *Cooperation* is defined as a form with a high degree of horizontal but a low degree of vertical integration, which means that most integration is accomplished through voluntary agreements. *Collaboration* involves a high degree of both vertical and horizontal integration.

According to Axelsson and Bihari Axelsson (2006, 2007), all of these forms of integration can be effective, depending on the degree of differentiation. In

general, if there are many different kinds of activities and professional roles involved, that is a high degree of differentiation, more horizontal integration between organizational units on the same hierarchical level is required than if there is a lower degree of differentiation. This theoretical relationship is illustrated in Figure 1.

Figure 1. Effective forms of integration for different degrees of differentiation (Axelsson & Bihari Axelsson, 2007)



This conceptualization indicates that, when collaboration is attempted in a comprehensive field such as mental health, which involves a wide variety of professions and services, decisions made within the management hierarchy need not only to coordinate how various types of services are offered (vertical integration), but also to support contacts and communications on the horizontal level between professional workers in the different organizations. These kinds of contacts generally involve difficulties, regardless of model or form. According to Huxham and Vangen's (2005) theory of "collaborative advantage" it is necessary that the advantages of the collaborative activities are clear for all involved if the collaboration is to be successful. Central to the theory is that collaboration unavoidably involves *tension,* not the least because the partners involved nearly always have differing goals, even when there is a supposed consensus on a common objective.

Researchers such as Danermark and Kullberg (1999) have shown that collaboration involves a variety of typical problems resulting from basic differences in *mandates, educational backgrounds, research traditions, theoretical models* and *organizational forms*, and that mechanisms must be found to counter such problems. Andersson and her colleagues (2011), in an overview of research on collaboration in vocational rehabilitation, have also found a number of factors which can be obstacles to or facilitators of collaboration. Some of the obstacles were c*ultural differences*, inadequate *knowledge and understanding* of each other's professions and organizations, problems in *communication,* and professional as well as organizational *territoriality.* The facilitators included a well-defined *target group*, relevant *participants*, *standardization* and *formalization* of

procedures and exchange of information, *common training programs* and *adequate leadership*.

Danermark and his colleagues (2009) have concluded that a well-functioning model for collaboration must have *effective control and structure*, *common perspectives* and a consciousness of the *advantages of collaboration* for public welfare. In another attempt to characterize what is needed to achieve successful collaboration, Fleetwood and Matscheck (2007) have proposed the concept of *collaborative competence*, by which is meant the ability to handle the many and various problems which typically occur in collaboration.

In an overview of international research on collaboration in vocational rehabilitation, Andersson and her colleagues (2011) have also identified a number of models for collaboration, which are classified as either structural or process oriented. The structural models include *case coordination*, which is not so much collaboration between organizations as a way of coordinating rehabilitation activities concerning an individual person; *partnership,* which is based on formal agreements on collaboration between the organizations involved; *co-location,* which seeks to create conditions advantageous for collaboration by placing personnel in the same buildings or premises; and *pooling of budgets,* which makes it possible for agencies to share funding and budgets in the interest of collaboration. The process oriented models include *information exchange,* which is the simplest form of collaboration; *interagency meetings,* in which several agencies or organizations hold more or less regular meetings for planning of interventions; and *multidisciplinary teams,* where specialists from different professions and organizations work closely together.

Design and methods

The study was done in 2010 with the aim of showing how psychiatric and social services in a Swedish municipality can develop a long-term strategy for collaboration. The research questions were the following: What organizational and economic conditions exist for collaboration between psychiatric care and social service? In what areas does collaboration occur and with regard to what issues? What are the advantages of collaboration for the respective parties? What are the goals and objectives of collaboration? What obstacles are there? In what ways has collaboration been successful?

A case study with single-study design was chosen as research strategy (Yin, 2009; Merriam, 1988). The approach was explorative, with focus on illuminating the phenomenon of collaboration. Since the processes which were investigated are complex and categorization often difficult, the methods used were primarily qualitative, supplemented in certain areas with quantitative information.

A municipality in the north-eastern part of the Stockholm County was chosen as the object of the study, based on the first author's experience of and access to this municipality as a researcher in the municipal administration. The municipality has a population of about 30,000 and most of the county council's

and the municipality's institutions are located within or near a compact central area. The social service's social psychiatric programs are located within easy walking distance of the community centre.

The study design was based on a parallel collection of two types of data, a document study and an interview study, which were combined in the analysis. The study focuses on collaboration concerning adult persons 18-65 years of age who are subject to interventions based on the Social Service Act. The study focuses on collaboration between different programs and professional groups, which includes "personal representatives" as well as a collaborative program for persons with complex needs in which the county council treatment centre for alcohol and drug abuse is a member, but does not include user collaboration and not collaboration on the political level of the municipality.

The document study has primarily been concerned with mapping of the collaboration. A variety of documents have been studied for information on collaboration between different programs and occupational roles, as well as information on which levels and concerning which issues collaboration occurs. Steering documents were studied for information concerning the official aims and mandates of the respective organizations. Two formal collaboration agreements exist, which contain information on the overall control of collaboration, while written procedures give more concrete information on how collaboration is intended to work in specific areas. Other documents, such as project plans and evaluations, contain complementary information as well as the participants' own analysis of how collaboration works. Quantitative content analysis of minutes from steering groups and collaboration groups has been used to illuminate what types of issues are discussed in each respective group, resulting in a deeper analysis of each group's function (Boréus & Bergström, 2005). The documents studied are mainly from the period 2006-2010 and all documents are or were until recently in current use.

The interview study generated more information for the mapping of collaboration as well as information on the experiences of collaboration. It was based on an interview guide including questions regarding the arenas and issues of collaboration as well as the personal experiences of collaboration. A strategic sample of interview persons was selected with the aim of illuminating as many perspectives as possible within each of the collaborating organizations. 14 interviews were included in the study. Managers, supervisors and officials of different professions and occupations were interviewed, four of them at the psychiatric care centre and one social counsellor at the county's inpatient clinic. In addition, eight persons from the social psychiatric programs within the social service were interviewed. A personal representative, which is an independent role although employed by the social service, was also interviewed. No two persons having the same occupational role within the same organization were interviewed.

A qualitative content analysis of the interviews revealed both common themes and more specific information, which could be classified into categories which were at one time exhaustive of the material and as exclusive of each other as possible (Merriam, 1988). Some categories follow the social administration's

organization, but a simple categorization according to the organizational chart was found not to be adequate. This was, of course, partly due to the fact that the psychiatric care has a different organization from the social administration. Other categories were needed to include the vertical as well as the horizontal nature of collaboration and because certain areas and issues were found to have a specific character and did not fit well in more general categories.

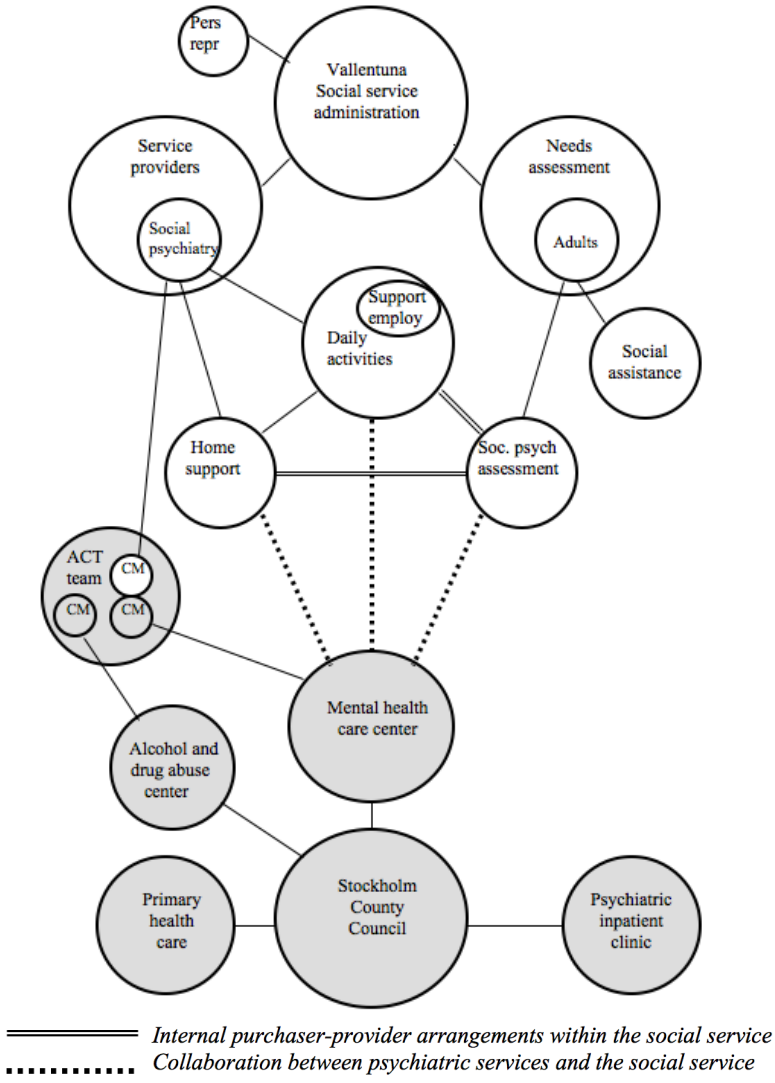
During the period of the study, the psychiatric care in the North-eastern section of the Stockholm County Council was contracted out to a private provider, effective March 1, 2010. No major organizational changes were made, however, which could have affected the study and there were minimal changes in personnel.

Results

There are a number of different programs for psychiatric care and social psychiatry in the municipality, involving the municipal social service as well as the psychiatric care centre and the alcohol and drug abuse treatment centre of the county council. Collaboration concerning persons with complex needs is built on close cooperation among three case managers. One is employed by the social service administration, one by the county council psychiatric care centre, and one by the alcohol and drug abuse clinic of the county council. The case managers are attached to a team inspired by the Assertive Community Treatment method, which involves members from different care professions (Burns *et al*, 2001). The team is referred to as the "ACT-team" and has representatives from each of the three collaborating organizations, including physicians, nurses and social workers.

Both the psychiatric services and the social psychiatry involve a variety of programs, organizational units and professional roles, which means that collaboration occurs, or should occur, along many lines. An overview of the different programs and units in the municipality studied is shown in Figure 2.

Figure 2. Organizational units and programs involved in collaboration



Collaboration levels and arenas

Like the programs and professions referred to above, the documents studied are many and varied. In the county council, there are commitments to collaboration described in the task description of psychiatric care from 2008 and in the requirement specification to the procurement procedure which led to the contracting of a private provider in 2010. The social service's official documents are not as clear in the area of collaboration, but there are formulations in a memorandum

from 2005 on a comprehensive project to develop social psychiatry in the municipality, in the guidelines for home support, in steering documents for a project to start a program for supported employment, and in evaluations of various programs such as supported employment and a new type of group home.

Table 1: Arenas for collaboration in the municipality studied.

Arena	**Participants**
Management	
Steering group	Psychiatric care centre: manager Social service: manager assessment, manager production, investigator
Collaboration group	Psychiatric care centre: manager Social service: manager assessment, manager production, investigator, PR User organizations: chairmen
Steering group - complex needs	Psychiatric care centre: manager Alcohol and drug abuse treatment centre: manager Social service: manager assessment, investigator
Case managers – complex needs	Psychiatric care centre: manager, CM Alcohol and drug abuse treatment centre: manager, CM Social service: manager assessment, CM, investigator
Steering group PR	Psychiatric care centre: manager Social service: managing director, PR
Arenas for collaboration	
Interorganizational meetings	Psychiatric care centre: manager, supervisor, psychologists, nurses, social counsellors, mental health assistants, CM Social service: manager assessment, manager production, supervisor home help, supervisor daily activities, work coach, personnel production
Interprofessional groups	Psychiatric care centre: mental health assistant, nurse Social service: social welfare secretary, personnel home help, supervisor daily activities
Lectures	All, including social assistance and other social service personnel
Training programs	Psychiatric care centre: supervisor, mental health assistants, nurses, social counsellors, CM Social service: social welfare secretaries, supervisors and personnel home help, supervisors and personnel daily activities, CM
Individual care	
Individual care planning	Psychiatric care centre: supervisor, mental health assistants, nurses, social counsellors, CM Social service: social welfare secretaries, supervisor home help, supervisor daily activities, work coach, CM, PR
ACT-team	Psychiatric care centre: supervisor, physician, CM Alcohol and drug abuse treatment centre: physician, CM Social service: social welfare secretary, social assistance secretary, CM
Individual care planning – discharge from inpatient care	Inpatient clinic: social counsellor, physician Psychiatric care centre: supervisor, mental health assistant, CM Social service: social welfare secretary, CM, PR
Social assistance	Psychiatric care centre: social counsellor, mental health assistant, CM Social service: social assistance secretary, CM, PR
Informal contacts	When needed.

Abbreviations in Table 1: CM – case manager, PR – personal representative

There is an agreement on collaboration between the psychiatric care centre and the social welfare board from 2000, which has been updated three times, most recently in 2010. It defines a structure for collaboration, including a steer-

ing group, interorganizational collaboration meetings and work groups for specific questions such as plans for individual care. In addition, the social service has been granted funds from the National Board of Health and Welfare for a common training program 2010-11. A separate agreement on collaboration exists for the case manager program, with a steering group as well as the ACT-team, and the personal representative has a steering group with a representative from each of the parties involved in the collaboration. There are also procedures for collaboration with the psychiatric inpatient clinic.

An analysis of these documents, as well as other documents including minutes from meetings of the various groups, shows that there are many forms for collaboration. In the interview with one of the managers in the social services, she expressed the need for arenas where managers and personnel from the various professions and programs involved can meet, get to know each other, and discuss common issues or problems. Some of these arenas deal with issues on a top level, where only managers participate, while others are interorganizational meetings for personnel from various occupational groups and programs. Other arenas, on a third level, are concerned with individual patients and clients. Besides these arenas, or forums, there are many direct contacts between individual professionals and personnel. Table 1 shows an overview of arenas for collaboration.

Areas and issues for collaboration

The interviews show that collaboration is needed around most issues and problems that can be concerned with an individual patient's or client's life. Besides psychiatric and social psychiatric problems, many patients and clients also have problems with alcohol or drug abuse and many have somatic problems which involve the need for collaboration with other care agencies. The areas where collaboration is needed were classified as *care, daily activities (including work training), housing* and *other economic issues*. The following special classifications were also included: *residence homes, complex needs* and *inpatient psychiatric care*. The interviews showed that there is a tradition of collaboration between the psychiatric care centre and the social services in the areas of care and daily activities.

One of the less expected results of the interviews was the need for more collaboration around the individual patient's or client's economy, both housing and other types of economic issues. Many people with psychiatric impairments have difficulty in keeping track of papers and taking the necessary steps to apply for assistance and there are often requirements for a physician's certificate. These issues require cooperation between the psychiatric care centre and the social assistance, which is a sub-department within the section for needs assessment, but collaboration in this area is much less developed. Another area is residence homes, which is a special intervention for living arrangements. The psychiatric care and the social service are not in agreement about how costs for placement in residence homes should be divided, however only a very small number of individuals are affected.

Several interviewees pointed out, that individuals with complex needs often are the patients or clients with the greatest total need of help and, at the same time, the ones most difficult to help. The psychiatric problems are difficult to treat as long as the alcohol or drug abuse continues, and the abuse problems are difficult to treat due to the underlying mental health problems. Within the county council there is a separate treatment centre responsible for the treatment of abuse or addiction problems, which brings about the need for collaboration also between this treatment centre and the psychiatric care centre. As mentioned earlier, there is also a special collaboration program for persons with complex needs. Regarding inpatient psychiatric care, there is an official procedure specifying that the inpatient clinic's social counsellor has a responsibility for calling both the psychiatric care centre and the social service to a meeting before a patient is discharged, in order to work out a mutual plan for continued care. However, there is no support structure for this collaboration.

Experiences of collaboration

The main part of the interviews focused on the persons' experiences of collaboration, particularly the goals for collaboration, the barriers and the factors facilitating collaboration. The results can be grouped according to the following main areas: *leadership and organization*, *care and other activities*, *housing and financial support*, *complex needs*, *personal representative* and *inpatient psychiatric care*. Leadership and organization was included because both the documents studied and the interview material showed these factors to be important. Care and other activities was found to be an appropriate name for areas relevant for individual care planning, while housing and financial support follows the social administration's organization. Complex needs and personal representative are special forms for collaboration and are therefore reported separately. Inpatient psychiatric care, finally, is a specific form of care with a separate organization within psychiatric care which affects other areas within the collaboration, since the patients involved often are released to outpatient care and social psychiatric service.

In the area of *leadership and organization,* one of the managers from the social service administration pointed out that she had been given the task of developing collaboration. She and another manager in the same administration stressed the importance of individual managers and supervisors having a personal commitment to collaboration. Both of these managers and a manager in the psychiatric care centre saw the goals of the two sectors as complementary. According to these managers, their goals are the same, but the tasks and areas of responsibility are different. Their views on the goals of collaboration were also similar, referring to the need for flexible solutions, easy access and achieving a holistic view of the individual user. They spoke of mutual respect and understanding of each other's roles. Close geographic proximity and the small size of the municipality were seen as factors facilitating collaboration.

All these three managers and one supervisor considered the different legislation for the respective sectors to be an obstacle, or at least a difficulty. One of the

managers in the social service administration saw this problem as part of the need for understanding of each other's conditions and roles, which she expressed as avoiding "unreasonable expectations". She pointed out the importance of resources available, "what is possible" as she expressed it. She also described the tendency to "defend territory" as an obstacle. She saw her task as a leader to support her personnel and take care of problems in time to avoid conflicts. A particular economic circumstance was the county council's system for compensation of health care providers, which gives points for collaborative meetings concerning individual care planning, but not for interorganizational collaboration meetings.

In the area of *care and other activities,* attempts were made to establish collaboration in the years following the Mental Health Reform, when the psychiatric care centre was new in the municipality and the social service's home support and daily activity programs were initiated. Since then, regular collaboration meetings are held several times a year with personnel from all the professional groups except physicians and these meetings are used to exchange information and discuss common issues. Also in this area, all of the interviewees saw their different orientations as complementary. For example, a mental health assistant expressed that the goal of the psychiatric care centre was broader than only medical, and that the patient should in the long run be able to live a normal life with regular employment and a family. Most of the interviewees saw the objective of collaboration as getting everybody to "pull in the same direction", to "give the same message to the patient or client", or similar formulations. Several stressed economic factors, in particular to use resources as cost-effectively as possible and to avoid expensive interventions such as inpatient care or residence homes.

Collaboration was considered to work well in the area of individual care planning, as well as in acute situations when individual patients or clients are in crisis. Continuity of personnel was regarded as a factor facilitating collaboration. On the other hand, individual factors were in some cases considered to be an obstacle. For example, a social welfare secretary found that she received information of better or worse quality from the psychiatric care centre, depending on which person she had contact with. Several interviewees considered the psychiatric physicians' prestige to be a problem and one person told of an occasion when a 15-minute meeting between a physician and a patient was given more importance for the diagnosis and treatment of the patient than a comprehensive assessment from the social service.

In the area of *housing and financial support*, there was a lack of structure for collaboration. The social assistance group had a representative in the ACT-team and the social assistance secretaries had been invited to lectures which were offered in collaboration between the psychiatric care centre and the social service, but that was all. A supervisor of the social assistance secretaries had not even understood that their work was included in the collaboration agreement. Both she and a supervisor at the psychiatric care centre described difficulties in cooperation concerning individual clients. The supervisor of the social assistance secretaries observed that the goal of social assistance is not only to grant acute

financial support, but also to make the client gain (or regain) the ability to support himself. This goal can create anxiety for the client, since it involves demands, and both the psychiatric care centre and the social service see this anxiety as a problem. The supervisor at the psychiatric care centre named lack of continuity as an obstacle in cooperating with the social service, where there have been frequent changes in personnel.

In the area of *complex needs*, the case managers from the psychiatric care centre and the social service have their work rooms next to each other at the centre. The third case manager has her work room at the county council's alcohol and drug abuse treatment centre, which is only two blocks away but even so, the distance is experienced as a barrier. A physician at the psychiatric care centre takes responsibility for all the patients of the case managers and the alcohol and drug treatment centre has only one physician. The goals of the case managers and the physicians were expressed similarly as to reduce suffering, but also to help the patient or client to as normal a life as possible. Both the manager of the psychiatric care centre and a manager of the social service administration considered the complex needs program to be among the most meaningful collaborative activities, since it shows that it is possible to work effectively with the patients and clients who are the most difficult to help. Other interviewees expressed their appreciation of the case managers' work in keeping order in what otherwise can be chaotic cases. As a result of the program, the psychiatric care centre has changed its policy of automatically referring patients with alcohol or drug problems to the treatment centre and has instead begun offering treatment for abuse and addiction to this particular group with the aim of gaining the patients' trust by preserving continuity.

The ACT-team, which has existed for about two years, has meetings every other week. There were some difficulties in establishing the team, not least regarding the continuity of professionals. Written procedures for the team have been reworked twice. One of the case managers from the social service described the team as "a lively group, where there is a lot of prestige to defend". The ACT-team works mostly with individual care planning.

Collaboration with the inpatient psychiatric clinic is complicated by the fact that the clinic is situated about 10 miles from the municipality and serves six other municipalities as well. Because of travel time, meetings require half a day, instead of an hour or two. There are no collaboration meetings between the inpatient clinic and the social service, only joint planning of individual care. Both the social counsellor at the inpatient clinic and those interviewed at the psychiatric care centre and the social service described difficulties in achieving effective cooperation.

The *personal representative* emphasized his goal as that of supporting and "strengthening" the clients, helping them to realize their own role in the healing and recovery process. On a general level, his wish was to have arenas to discuss problems in the system and he saw the steering group from the county council and the municipality as such an arena. Several interviewees described the personal representative's role as similar to that of the case manager's, although,

unlike the case managers, he represents only his client. The personal representative considered good personal contacts both within the in- and outpatient psychiatric services and the social service as a factor which facilitated his work.

In addition to the main areas described above, a theme in many interviews was the importance of *informal, non-structured contacts*, where one professional simply calls another when a problem arises or when one has need of information or consultation. These types of contacts are facilitated by continuity and by seeing each other at collaboration meetings. Another theme was the different use of *medical diagnoses*. For a physician, the diagnosis is an indispensable tool, necessary as a first step towards finding an adequate treatment. But for someone from the social service, a diagnosis is seen as having little significance in assessment or intervention. Instead, they want to know the capabilities of the person, what tasks he or she can do, and what difficulties he or she has in daily living. All the interviewees were, however, in agreement that medication is necessary for patients in this target group and that the physicians are responsible for the prescriptions.

Analysis

Seen as a whole, the interorganizational contacts between the psychiatric care and the social service in the municipality can be defined as a complex form of what according to Westrin's (1986) scale is termed as *collaboration*. At the same time, both authorities retain their own organizational forms and responsibility, so there is no suggestion of *fusion*. Within this framework, the vertical and horizontal axes discussed by Axelsson and Bihari Axelsson (2006) are of essential importance. The psychiatric care centre and the social service are each highly differentiated, involving a wide variety of professions and activities. On the vertical axis, there is *coordination,* in that each agency is organized according to areas of responsibility, which are on the whole separate from each other and supposed to be complementary. At the same time, there is also a great deal of horizontal *cooperation* between the different professionals and officials concerning individual patients and clients. Figure 2 and Table 1 illustrate in different ways that a strategy for collaboration has been developed which deals with the high degree of differentiation by systematizing interorganizational contacts in a kind of puzzle involving forms and functions on all levels. This puzzle has both structural and process oriented features and includes specific solutions for special areas.

The *effective control and structure*, which Danermark and his colleagues (2008) have stressed the need for, is provided in a number of ways. The document study shows that the Stockholm County Council has formulated conditions and demands for collaboration in the steering documents for the psychiatric services and these demands have been made even more distinct in the contract with the private provider from 2010. The control is not as distinct in the case of the municipality's social service. The two collaboration agreements are the only documents which clearly give the social service administration the task of col-

laborating with the county council's psychiatric services. But there are references to collaboration in several other documents and one of the managers in the social service administration said that she was assigned the task of developing collaboration in this area. Structure can also be seen in the documentation from the steering group that holds regular meetings, as well as in references in the interviews to regular collaboration meetings for personnel and work groups which are assigned for certain issues, and in the common training programs which have been funded by the National Board of Health and Welfare.

Some of the structural models proposed by Andersson and her colleagues (2011) are also found in the study. According to their classifications, the collaboration studied may be characterized to a large degree as a *partnership,* since there are formalized agreements or contracts which specify structures for collaboration and in two specific areas, home support and complex needs, there are written procedures. *Case management* is also used as a structural model of collaboration in a specific area, complex needs involving psychiatric problems in combination with alcohol or drug abuse. The personal representative has a case management role for other patients and clients. Although there is no use of *co-location* (with the exception of two of the three case managers), the various institutions and programs are all located in or very close to the center of the municipality, which gives nearly the same effect. It should be noted, however, that there are no *pooled budgets* between the different authorities and in one area, the residence homes, there is a lack of agreement about how to distribute costs. It should also be noted that there is a lack of structure for collaboration in the area of housing and financial support. In connection with psychiatric inpatient care, both the document study and the interview study have shown that structural support is inadequate, despite the existence of written procedures for individual care planning.

At the same time as the structure is complex, other aspects of collaboration are also in evidence. The need for *common goals and perspectives*, which Danermark and his colleagues (2009) have emphasized, is one such aspect. According to the collaboration agreement, the goal is that "it shall have no significance for the individual that there are two different authorities or different programs within each authority". However, this general objective can be interpreted in different ways and there can be different perspectives, assumptions and goals within the respective authorities. In the interviews, the objective of collaboration was usually expressed as "working together for the welfare of the individual patient or client". Some interviews stressed that there is also an economic objective to use resources as cost-efficiently as possible and to avoid expensive interventions such as inpatient care or residence homes. But most importantly, it was clear that most of the interviewees did not see any differences in goals between the different professions and programs as a problem and all appeared to see the different orientations rather as complementary.

Nevertheless, there were differences regarding goals and perspectives in certain areas. Concerning housing and financial support, there was a view that the goal of social assistance, to make the client self-supporting, was sometimes a

problem for the psychiatric services as well as for programs in the social service trying to reduce the patient's level of anxiety. A more general difference concerns the use of medical diagnosis, which the physicians see as a necessary tool, but social workers find insufficiently helpful in providing relevant information for supporting the client in his or her daily life.

Other obstacles to collaboration are also found in the interview material. *Lack of knowledge and understanding* of the laws and regulations controlling each other's organizations and professions as well as lack of knowledge of each other's modes of operation were the factors most often named in the interviews as obstacles to collaboration. Finding suitable *roles in collaboration* was considered another obstacle, as was the tendency of the participants to defend their territories. In particular, the physicians' prestige was considered by several interviewees to be a problem and it was noted that the physicians participate much less in collaborative meetings than other professionals and officials. *Personal factors* were also stressed by several interviewees. In addition, *lack of continuity* appears to have been a problem in certain areas, due to frequent changes in personnel.

These kinds of obstacles are not surprising or specific for the organizations studied. On the contrary, they are typical and can be found among the obstacles which are discussed by researchers such as Danermark and Kullberg (1999) and Andersson and her colleagues (2011). According Huxham and Vangen (2005), such obstacles unavoidably lead to *tension* in collaboration. To be successful, it would seem clear that a comprehensive strategy for collaboration must involve ways to overcome these types of obstacles and the resulting tensions inherent in collaboration. In spite of their overall complexity, the structural forms described above do not fully account for the overall strategy for collaboration in the municipality, but are supplemented by a variety of process oriented features. One example is the meetings held for the purpose of planning individual care, which can be seen as a form of *interagency meetings.* Similarly, case management is combined with a team inspired by the ACT model, and this team can be regarded as a *multidisciplinary team* (Andersson *et al*, 2011).

Besides such process oriented forms of collaboration, a factor which appears to have been particularly important for meeting the need for a high degree of horizontal integration within the framework of collaboration has been the *arenas* for meetings which have been created both on the management level of the agencies concerned, on an interorganizational level and on the level of care and support for individual patients and clients. There are several steering groups, as well as regular interorganizational meetings for personnel. Concrete procedures for individual care planning and for the ACT-team have been developed by work groups with professionals representing both authorities. Common training programs have been used to develop a mutually shared base of knowledge and competence.

The interviews show that all of these arenas are meeting places with the more or less clearly articulated objective of stimulating discussion, in order to improve mutual understanding of each other's roles and professions, and facili-

tating contacts, not the least concerning individual patients or clients. In this sense, such arenas are process oriented. There is also individual care planning, which is seen as a structural guarantee that there will be cooperation concerning individual patients or clients, but unplanned contacts between meetings appear to play just as important a role. This structure of arenas is not complete, however, since certain groups – social assistance, physicians and inpatient care – are not represented in arenas on the management or interorganizational levels.

Discussion

The analysis above shows that collaboration in the municipality studied can be seen as involving both structural and process oriented features. Especially interesting is the concept of arenas, meeting places, which are organized in a complex and comprehensive structure which in turn stimulates and facilitates contacts and discussion between roles and professions on all levels of the organizations involved. It is also interesting to note that in all the interviews the various roles and professions were considered to be complementary, which means that the different modes of operation concerning care, treatment and rehabilitation were not regarded as obstacles to collaboration.

Some of the factors which facilitate collaboration and some of the obstacles hinge on preconditions which cannot be influenced by either the model or structure for collaboration or by collaboration processes. One of these is the resources, especially financial resources, which the programs have at their disposal. One of the managers interviewed stressed that collaboration is dependent on available resources. The county council's system for compensating care providers is an example of appropriation of resources decided at a central and not a local level. In spite of the fact that health care providers have been given the task of collaborating with the municipal social service, no compensation is awarded for participation in collaborative meetings. In this respect, the compensation system becomes an obstacle to collaboration, since all the meetings and also the training of personnel take time. However, the system also facilitates collaboration in that compensation is awarded for meetings concerning care planning for individual patients.

Another important precondition is the municipality's size, both in geographic area and population. The administrations and programs concerned are located near each other in a dense central area and the programs are of moderate size. In fact, it is of decisive importance that there is a psychiatric care centre for outpatients in the municipality – many municipalities do not have one. The interviewees expressed the common opinion that the municipality is of more or less ideal size and that collaboration is facilitated by the near proximity to each other. Collaboration with the inpatient psychiatric clinic, which is located much farther away, is not working equally well. This result could lead to a hypothesis that collaboration works best in municipalities which are as nearly as possible of ideal size and geographic distribution. Such a hypothesis may, of course, be correct, but would appear to be of limited use for other settings. A more interest-

ing hypothesis would be that county councils and municipalities with other geographic preconditions can facilitate collaboration by establishing programs and units of moderate size and placing them in close geographic proximity to programs and units belonging to the collaboration partners.

According to the conceptual framework, which has been applied in this study, collaboration is strongly influenced by organizational factors. In the municipality studied, one of the partners, the Stockholm County Council, has recently contracted the psychiatric services out to a private provider. This has taken place without any major changes in structure or personnel. The county council has given the private provider the task of further developing collaboration with the social service and nothing in the study indicates that collaboration has been negatively affected. However, the question is whether or how collaboration will be affected in the long run and how collaboration would have been affected if the private provider had acted differently. If it had, for example, restructured the psychiatric services and closed the local psychiatric care centre? On the other hand, the county council could have constructed a different system for compensation, which might either have created a greater barrier for collaboration or, alternatively, facilitated collaboration better than the current system.

Concluding remarks

The purpose of this article has been to describe and analyze how different psychiatric and social services in a Swedish local community can collaborate on meeting individual users' total need for care and services. The study illustrates the complexity of mental health as a field for collaboration, not only because of the large number and variation of programs, occupations and professional roles, but also because of the complexity of the needs of the patients and clients for whom the different institutions are collaborating.

In the municipality studied, an overall structure for collaboration has been developed where vertical coordination supports horizontal cooperation by creating not only procedures, but also arenas where process oriented features of collaboration can happen. It can be said that these arenas have as their objective to improve collaborative competence. Leadership's role is to solidify the structure for collaboration and support individual professionals working in collaboration to provide care and services for individual patients or clients. Organizational factors, such as the moderate size of the programs and units involved and their geographical proximity, have been important in making this structure possible. In the course of the study, certain gaps were exposed in the structure, which the leadership has the possibility of bridging with the benefits of the results of this study.

At the same time, the need for this type of long term strategy brings up new questions. In the municipality studied, most care is provided either through own programs or, in the case of the county council, a single care provider. Today, both health care and social services are often privatized and consumer choice models are becoming more common. The existence of even a small number of

care providers in competition with each other would cause the complexity of collaboration to increase exponentially. An important question for further research is therefore how, given the complexity, difficulties and tensions, collaboration can successfully be combined with market-based models for providing care.

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