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Combining diabetes and mental health care: An ethnographic exploration of user involvement in combined care

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Abstract

Purpose: To explore and describe the enactment of user involvement and combined care in a Danish clinic that aimed at providing integrated diabetes and mental health care.

Design: An ethnographic study.

Data Sources and Methods: Data consisted of field notes from 96 hours of participant observations and field notes from 32 informal conversations with healthcare providers, users and relatives as well as 12 semistructured interviews with users. Data were analysed using a thematic analysis. This study reports to the SRQR guidelines.

Results: Treatment was not combined as intended if only one healthcare provider handled the consultations. Here, the healthcare providers' focus was often on their own area of expertise—either mental health or diabetes. If more than one healthcare provider handled consultations, the consultations were often divided between them, focussing on one condition at the time. Healthcare providers noted, that learning from peer colleagues was a way to increase the possibility for combined care. Furthermore, combined care was highly dependent on the healthcare providers' ability to involve users' illness experiences in their own care planning. Here, a high level of user involvement increased the levels of combined care during consultations.

Conclusion: This study set out to explore and describe user involvement and combined care in a specialised diabetes and mental health outpatient clinic. Combined care is complexed and requires that healthcare providers are well-equipped to manage the complexity of delivering care for people with both conditions. The degree of combined care was linked with the healthcare providers' ability to involve users and their knowledge on the condition outside there are of expertise.

The research was conducted in the Fusion Clinic, Region Zealand, Denmark.

Relevance to Clinical Practice: A peer-learning environment in combination with clinical guidelines and joint display could support healthcare providers in involving users in own care and when delivering care outside their area of expertise.

Public contribution: No patient or public contribution. Due to the COVID-19 pandemic, the original user council withdraw their consent to participate due to health-related worries and anxiety concerning the pandemic. The user council consisted of three members diagnosed with diabetes and severe mental illness. They were invited to participate in physical meetings, phone or online meetings. Presenting findings from the study to the study participants were also hindered by the second lockdown. This influenced the possibility for data triangulation.

KEYWORDS
combined care, co-morbid illness, diabetes care, mental health care, psychiatric disorders, support needs, type 1 diabetes, type 2 diabetes

1 | INTRODUCTION

Users living with severe mental illness have a reduced life expectancy of 20 years than the general population. The early death is partially caused by psychical health complications such as cardio vascular difficulties and diabetes (Nielsen et al., 2021). In general, people with severe mental illness receive insufficient diabetes treatment compared with people without a mental illness. This is despite a healthcare responsibility to ensure that this population is not disadvantaged (Hamm et al., 2017). Poor mental health status among people with severe mental illness is noted to be a justification for healthcare providers to decline to intervene on risky health behaviour and physical health conditions such as diabetes (Bellass et al., 2021; Zabell et al., 2021). The ability to self-care is influenced by separate diabetes and mental health care, where healthcare providers have specialised skills limited to one of the conditions (Zabell et al., 2022). However, self-care among users can be improved by cultivating the understanding that diabetes and severe mental illness are more than two separate conditions. Users with both conditions are highly dependent on combined care as the users in most cases view the two conditions as interlinked, which should be reflected in care provision, for example consultations and in healthcare plans (Bellass et al., 2021; Zabell et al., 2022). Combined care interventions have been shown to improve several health outcomes such as blood glucose levels and user experiences with care if the care has an equal focus on both conditions (Zabell et al., 2021). To succeed, combined care needs to build on high levels of user involvement with an incorporation of the users' individual preferences and support needs of both conditions (Hamm et al., 2017; Zabell et al., 2021, 2022). User involvement in health care has gained impact worldwide offering guidelines for involving users during health consultations and care planning (Andreassen, 2018). However, user involvement is complex and can be defined and understood in many ways (Andreassen, 2018). Where mental health services have a long tradition of advocating for recovery-orientated approaches, physical health services is characterised by a biomedical-oriented practice, where user involvement has started to gain impact (Dixon et al., 2016; Walsh, 2019). However, there are no guidelines for user involvement used in both mental health and diabetes care. Guidelines for shared decision-making inform healthcare providers on ways to involve the users' preferences and support needs based on personal and medical history, when making healthcare plans (Edwards & Elwyn, 2016). Shared decision-making is widely used during health consultations, as this approach focus on the users' self-determination and self-management (Andreassen, 2018).

What does this paper contribute to the wider global community?

- To succeed in delivering combined care, healthcare providers have to make sure that the consultations focus on the interlink between the conditions and not the single conditions separately.
- Combined diabetes and mental healthcare interventions require continuously involvement of the users' preference and need for support of both conditions.
- Diabetes and mental healthcare practices should be integrated when delivering combined diabetes and mental healthcare. Furthermore, integration of clinical guidelines and procedures for diabetes and mental healthcare can support healthcare providers when delivering combined care.

1.1 | Combining diabetes and mental healthcare

In 2020, Steno Diabetes Centre Sjaelland and Region Zealand, Denmark, opened the first Danish outpatient clinic, The Fusion

Clinic, to deliver personalised combined care. The care targets people with coexisting diabetes (type 1 or 2) and severe mental illness (major personality disorder, psychotic disorders, schizophrenia including schizoaffective disorder, and major depression).

Previous research has described combined diabetes and mental healthcare interventions using user involvement approaches such as collaborative care interventions (Zabell et al., 2021). These interventions varied, some had focus on either the diabetes or the mental health or an equal focus on both. Often the interventions had focused on health outcomes, for example blood glucose levels, with few descriptions on how the users were involved, how the combined care interventions unfolded, and the accounts from those who delivered and received the combined care (Zabell et al., 2021). This paper aimed at exploring and describing user involvement and combined care in a Danish clinic that targets diabetes and mental health care.

2 | METHODS

2.1 | Design and theoretical perspective

This study is based on the epistemological framework of social constructivism. In social constructivism, meaning, knowledge and social actions play a role in creating different versions of social reality (Burr & Dick, 2019). From this perspective, the world is viewed through patterns defining discourses, while excluding others. Discourses are constructed by what humans define as expected social behaviour and social actions in daily life, and investigating knowledge that is taken-for-grated. Discourses are a constant negotiation of social practices and norms dependent on the social setting in which people engage in (Burr & Dick, 2019; Jorgensen & Phillips, 2002). Social constructivism is useful when investigating and describing the connections and disconnections between the discourses of a medical-driven practice and a recovery-oriented practice service with special attention to how these discourses influence user involvement and combined care. To gain an understanding of how user involvement and combined care unfolded in the Fusion Clinic, this study is based on an ethnographic approach. This approach is placed within social research, and well-suitable when investigating actions and accounts of a group of people in a specific setting. As ethnography recognise the use of multiple data sources and ways to engage with the research (Hammersley & Atkinson, 2019), it can provide a rich understanding of how user involvement and combined care unfold in the Fusion Clinic. The Standards for Reporting Qualitative Research (SRQR) checklist was used (O'Brien et al., 2014; Standards for Reporting Qualitative Research SRQR [File S1]).

Because combined care and user involvement come in many forms, we decided to have a theoretical framework to guide the data generation. The two phenomena were inspired by a scoping review on combined diabetes and mental healthcare interventions (Zabell et al., 2021) and a qualitative interview study on users' experiences with standard diabetes and mental healthcare (Zabell et al., 2022). Table 1 illustrates detailed information of the classification of the two phenomena. This study reports to the SRQR guidelines (O'Brien et al., 2014).

2.2 | Study context

One of the main goals of the clinic is to reduce the high mortality among people with diabetes and mental illness and improve quality of life. Users are referred to the Fusion Clinic by their family doctor or by mental health or diabetes inpatient and outpatient clinics due to complexity in managing one or both conditions. The healthcare providers employed in the Fusion Clinic were all specialised in providing care related to either diabetes or mental illness. The mental healthcare providers received a three-day education in diabetes care, whereas the diabetes healthcare providers did not receive training in mental health care. The Fusion Clinic works within an interdisciplinary user-involving framework with a focus on cross-sectorial

TABLE 1 Theoretical framework.

Phenomena	Clarification
User involvement	Individualised care plans based on the users preferences and values e.g. discussions of support needs, presenting users for different non-medical/medical treatment options, and integration of the users personal background such as family or/and personal history (Edwards & Elwyn, 2016; Zabell et al., 2021). Presenting the users for different care options (Zabell et al., 2021) with respect for the users choice of care and treatment (Edwards & Elwyn, 2016) Users has a fundamental right to decline or consent to care, and the healthcare providers should present different care options including pros and cons. Moreover, the users are required time to discuss the different care options with people outside the clinical encounter (Edwards & Elwyn, 2016). Built on collaboration between users and healthcare providers, user involvement focuses on mobilising users' resources to achieve self-efficacy and to cope with their illnesses (Andreassen, 2018)
Combined care	Equal attention on diabetes and mental illness during the development of healthcare plans and goals for care, during admission, consultations, and in the collaboration with other healthcare settings (Zabell et al., 2021, 2022). A focus during care should be on the interlink between the conditions and how the conditions influence one another to support the users in daily life. Symptoms of a diabetes can exacerbate the mental illness. In contrast, worsening of the symptoms of the mental illness, influence the users' ability to self-manage their conditions. Based on this, people with coexisting diabetes and severe mental illness needs to meet dual expertise when receiving care (Zabell et al., 2022)

collaboration inspired by Flexible Assertive Community Treatment (FACT), designed for people with mental illness (van Veldhuizen & Bähler, 2013). The duration of care provided by a FACT team is dependent on the user's mental health status, where decrease in the user's mental health status, for example risk of admission increases the care visits (van Veldhuizen & Bähler, 2013). The care is delivered in multiple settings, that is primary health care, hospital wards, residential institution, family doctor, the Fusion Clinic, and user's home (view Table 2 for an overview of healthcare services). When enrolled in the Fusion Clinic, users are invited to a coordination meeting where a healthcare plan is created based on the user's preferences and goals. Both diabetes and mental healthcare providers participates in the meeting to ensure an equal focus on both conditions. Coordination of care takes place at team meetings, centred on the FACT board covering descriptions of personal information, care plans and goals.

At the time of this study, there were 50 users enrolled in the Fusion Clinic, two mental health nurses, two diabetes nurses, one endocrinologist, one psychiatrist, one dietitian, one podiatrist, and two peer support workers.

2.3 | Data generation

Participants eligible for this study were users receiving care at the Fusion Clinic, relatives of users, healthcare providers in the Fusion Clinic and from other services such as residential institutions. The first author was the primary investigator of the study and was in charge of data generation. The data comprised of field notes from informal conversations and participant observations, and transcripts semistructured interviews, collected between August 2020 and May 2021. The concept of information power was used to determine data saturation (Malterud et al., 2016).

2.3.1 | Participant observation, field notes and informal conversations

Over a period of five months, a total of 96 h of participant observation and 32 informal conversations were conducted with 24 users, 16 healthcare providers and two peer support workers from the Fusion Clinic, 15 healthcare providers from other healthcare services (e.g. hospital departments and residential institutions) and seven relatives of users. The observations were guided by the two phenomena *combined care* and *user involvement* described in Table 1, which were based on descriptions from a scoping review and semistructured interviews on user account on diabetes and severe mental illness (view Table 3 for information on observations).

To get an overview of the users, healthcare providers and activities in the Fusion Clinic, the first author participated in the daily board meetings. In some cases, the observations were carried out at a specific activity such as home visits. In other cases to follow a specific user or healthcare providers throughout the day, set the frame of the observation. The level of researcher participation varied and depended on the activity. The passive observer role was used during consultations, but often supplemented with informal conversation before or after the consultation. In some situations, (VZ) approached the users with follow-up questions to gain insight into their perception of a specific event. In other situations, it was the users who approached (VZ). Field notes were generated during and after each activity (Hammersley & Atkinson, 2019). Informal conversations often took place before or after an activity and focused on gaining in-depth understanding of participants' account of the activity.

TABLE 2 Overview of healthcare services in the Fusion Clinic.

Healthcare services
• Diabetes management and support
• Screening of diabetes complications i.e. eye examination with retinal photo, foot status, measurement of cholesterol, and blood glucose levels
• Psychiatric assessment
• Psychoeducation
• Adjustment of medical treatment related to diabetes and the mental illness

2.3.2 | Semistructured interviews

The interview–participants ranged in age from 26 to 67 years (mean 43.8). Seventeen people were invited to participate. Two declined due mental distress, one was hospitalised, and two did not respond to our invitation. The 12 semistructured interviews (4 face-to-face, 8 phone) varied between 20–60 min in length. Eligible participants for the interviews were identified by healthcare providers at the Fusion Clinic, or by the first author. As this study draws on knowledge from a literature search (Zabell et al., 2021) and a qualitative interview study describing users' experiences with care (Zabell et al., 2022), the focus of these interviews was the users' experiences with combined diabetes and mental health care. To be included, the participants had to have received care for at least six months to be acquainted with combined care. Moreover, participants had to have taken part in the observations or informal conversations. The interview guide included interview specific and elaborating questions based on the observations and informal conversations. These questions were used to gain in-depth descriptions of specific events such as presentation of new medication. The interview-specific questions made the interview situation a more relaxed atmosphere, similar to a conversation, as the researcher and participant had meet each other on several occasions and were both equitant with daily routines in the Fusion Clinic. The interview guide consisted of six overall themes: (1) Living with diabetes and severe mental illness, (2) Focus on diabetes and severe mental illness, (3) Goals of care, (4) Peer support, (5) Family and close relations and (6) Collaboration across healthcare settings.

After each interview, the first author noted reflections and contextual information in a memo sheet. Memo writing continued while transcribing the interviews (Phillippi & Lauderdale, 2018). Demographics such as age, gender and mental illness diagnoses were self-reported (view Table 4 for further details). Data saturation

TABLE 3 Overview of observations (including field notes and informal conversations).

Activities	Elaborating information	Duration
Staff meetings	• Team meetings • Meetings between The Fusion Clinic and other healthcare providers (family doctor, residential institutions, community care)	10 h
Peer support workers	• Recovery group • Conversations between group members and peer support workers	8 h
Consultations	• User consultations (With or without relatives or healthcare providers from residential institutions) • Visits during hospitalisation • meetings with residential institutions • Home visits • Larger meetings with healthcare providers, relatives, and users	78 h

TABLE 4 Demographic and clinical characteristics of interview participants.

	Interview participants ($n = 12$)
Sex, *n*	
Female	7
Male	5
Age	Range 26–67 (mean 43.8)
Diabetes, *n*	
Type 1	6
Type 2	6
Mental illness, *n*	
Schizophrenia	8
Schizo affective disorder	1
Major depression	1
Bipolar disorder	1
Personality disorder	1

was reached at interview number 12, that is the interviews did not provide new information (Malterud et al., 2016).

2.4 | Data analysis

All data were analysed using a reflexive thematic analysis within a contextualist/constructivist framework as this gives the flexibility of combining several data sources (Braun & Clarke, 2020), which makes this approach suitable for social constructivism and ethnography. The analysis embraced data from the observations, informal conversations, semistructured interviews, reflections and memos. The analysis was driven by the two phenomena *combined care* and *user involvement* to code directly in parallel to our research question. As this study was based on social constructivism, codes were centred on how user involvement and combined care were accounted for by the participants and unfolded in the interactions between the participants. This resulted in themes around the two phenomena *User involvement in diabetes and mental healthcare- Setting goals for own care?* and *Challenges and possibilities when combining care in a combined diabetes and mental health clinic*.

First author thoroughly familiarised herself with the data, and compared the interview data with memos from interviews and observations. All data were compared and discussed against the reflections from the observations. Two researchers (the first and last author) independently read, coded and analysed the material. This was done to establish trustworthiness, but also to find nuances of the findings (Braun & Clarke, 2021). Preliminary themes were generated, revisited and finalised into two themes and four subthemes. The final stage of the analysis, producing the report, included selecting illustrative quotes for each theme. The quotes were translated from Danish into English. Table 5 illustrates an example of the analytical process.

2.5 | Research team

The research team consisted of, one psychiatrist (SA), three registered nurses with PhD degrees (RJ, LLB and BL), one PhD student with a Master's in Public Health (STR) and a PhD student (VZ) with a Master's in Health Science and a nursing background. Except for RJ and BL, all were employed at a hospital in Region Zealand, Denmark.

2.6 | Ethical approval, considerations, and informed consent

The Danish Data Protection Agency was notified about the project [jr. nr. 19-000067]. The Ethics Committee of Region Zealand is not required to approve of a project of this nature [REG-014-2019]. Oral and written informed consent were contained prior to participating in the semistructured interviews, whereas oral consent was contained from participants that only took part in observations and informal conversations. Participants were asked for consent prior to observations and informal conversations and had the possibility to withdraw their consent without consequences for current and future treatment. Field notes and memos were anonymised. All interviews were audio-recorded with permission from the participants, and all interviews were transcribed in the original spoken language

TABLE 5 Example of the analytical process.

Illustration	Initial codes	Themes
User explains that he was diagnosed with diabetes, eight years ago. The mental illness for a shorter time. He believes that his psychoses started due to metformin treatment. The physician shakes (…) head a little, and it seems that user gets the understanding that the physician does not agree. This is expressed as he continues to tell that he has several printed articles at home, which he will take with him at the next consultation. This is not answered by the physician. The physician quickly tells user that (…) would like to start him on a new treatment (ozempic), as (…) can see that his blood test results indicates that his diabetes is in a new phase, where it requires more treatment than what he has now. The physician tells the nurse to take over in relation to the psychiatric part of the consultation. The nurse asks users about his life, childhood, and about his upbringing. Meanwhile, the physician is sitting and looking at the computer	User wants to participate in the discussion on new diabetes treatment using articles and medical experiences	User involvement in diabetes and mental healthcare- setting goals for own care?
	Physician's attention on new diabetes treatment overshadows user involvement	
	Evidence based knowledge overshadows user's experiences and preferences for care	
	Diabetes and mental healthcare, divided between the healthcare providers	Challenges and possibilities when combining care in a combined diabetes and mental health clinic
	Physician does not participate in the conversation focusing on the mental illness	

while maintaining anonymity. None of the interview participants wanted to review the transcripts.

3 | FINDINGS

The analysis resulted in two themes and four subthemes. The findings cover how user involvement and combined care were constructed in a clinic that delivers combined diabetes and mental healthcare.

3.1 | User involvement in diabetes and mental healthcare—setting goals for own care

This theme illustrates how user involvement was and was not incorporated in the interactions between the users and the healthcare providers in the Fusion Clinic when setting care goals, during team meetings, and consultations. In most cases, elements of user involvement were initiated by the healthcare providers when users had to set care goals and define the foci of each consultation.

3.1.1 | Involving user's preferences—an initiative from healthcare providers

As a part of the field notes, daily routines and care in the Fusion Clinic were written down. This to provide an illustrative description. When users start in the Fusion Clinic, they are invited to a coordination meeting with two healthcare providers representing diabetes care and mental health care. This meeting aimed at identifying the user's preferences and defining an overall goal for care. All of the users had a care plan from previous diabetes and mental healthcare services, which included descriptions of their medical treatment. The care plan was negotiated between healthcare providers and users in the Fusion Clinic. The goal of this negotiation was to reach an agreement on how to combine diabetes and mental health care. Often the healthcare provider explored user preferences by asking questions related to changes in medical treatment, duration of future consultations, support needs and to set the care team. Based on this coordination meeting, the care goals were defined. The healthcare providers often asked the users about their personal preferences and experiences of living with both conditions to integrate this in the new healthcare plan. Although the users rarely brought it up on their own accord, when asked, they shared their experiences of previous care. The users often had ideas for ways to change the care plans, and in collaboration the healthcare providers and users found ways to integrate these ideas in the care plan:

> [The care goal] was that my diabetes was regulated to a fairly normal level. That I got down to where I could have it normal instead of it being towering all the time. And the schizophrenia it was just that I was able to live with myself. That I could function. I was involved in the process and I was asked several times whether I was completely sure and completely involved. And I was.
>
> (Interview with user 2)

Generally, the care goals were based on the need for support to manage one or both conditions, for example stabilising unregulated diabetes or manage mental health, or to manage weight loss. Some of the users wanted the mental health residential institutions to gain knowledge on how the coexistence of the two conditions could increase complexity of their self-management. Hence, care goals could also be based on imparting knowledge on diabetes and mental illness to the residential institution, where the user lived.

In most cases, the healthcare providers asked the users to articulate their own goal during the consultations, whereas a small number of users had planned a care goal in advance. For users

who were unable to define a care goal, the healthcare providers initiated a dialogue about the users' daily life management of diabetes and severe mental illness to uncover possible challenges. Based on the user's descriptions, the healthcare providers suggested possible care goals. The goal definition was often related to the condition that the healthcare providers considered the most challenging in regard to illness management and quality of life. Subsequently, the user and healthcare providers would discuss which care goals were best suited for the user's preferences and support needs.

Most of the users felt involved in the negotiation of their own care goals. The conversation was often based on how the Fusion Clinic could support the user in achieving the goal. Furthermore, the agenda for the next session would often be discussed.

Even though, most users felt involved in the conversation about defining a care goal, some of the healthcare providers expressed concerns about respecting the users' preferences when planning care related to the care goal. The healthcare providers felt that the FACT model was in some cases rigid when it came to integrating users' preferences. This, as the model had a predefined framework for the duration of care visits and a timeframe for when the users were supposed to achieve the goals:

> The user wants to leave the Fusion Clinic once again. This is discussed (at the weekly team meeting). The user feels that he is being pushed too much in relation to having to improve, which he has expressed. He does not really feel that he needs this right now.
>
> (Field notes from a team meeting at the Fusion Clinic, 19th of October 2020)

Some of the healthcare providers felt that they overstepped the users' boundaries due to the predefined framework, for example number of visits, or procedure for achieving care goals, making it difficult to individualise care.

3.1.2 | Change of predefined focus in consultations—an appreciated possibility when self-determined

Besides setting an overall care goal at the coordination meetings, almost all consultations at the Fusion Clinic had an agenda, which was mostly defined in collaboration between the users and healthcare providers. The focus was based on the user's current support needs and preferences for care, which was defined at the end of the previous consultation. In some situations, the focus was related to testing new medication, managing the users' job situation, or participating in social activities. Setting the focus was often driven by the healthcare providers, but in general, the users experienced being involved in the planning of the consultation and expressed collaboration between themselves and the healthcare providers.

> They (healthcare providers) ask back and forth to my thoughts on how they can help me in the best way. If I have any ideas or if there is something I do not think I am ready to do. Then we will wait.
>
> (Interview with user 8)

Even though there was a predefined focus for each consultation, during the informal conversations, the users stated that it was possible to bring up subjects outside the agenda. In consultations, the users' need for change of focus was often related to their mental health status, as they explained that poor mental health tended to overshadow diabetes and daily living. However, daily life activities, such as work, were also represented in the users' need for changing the agenda in the consultations.

The users' need for adjustment did not only involve the focus of the consultation itself, but also where the consultation took place. Sometimes the users changed physical consultations to phone consultations at the last minute due to poor mental health status, or in situations where the users were not able to transport themselves to the clinic. Most consultations took place at the Fusion Clinic, although on several occasions the healthcare providers and users agreed on combining the consultations with home visits or consultations by phone. Home visits were preferred by many of the users. The shift of setting from hospital to home made them feel more as a person instead of a patient.

> He tells that he is glad that the healthcare providers can see how he lives and get an idea of who he is as a person. This makes him feel more comfortable. Moreover, that they can see that his home is proper and he is not one of those who do not live properly.
>
> (Informal conversation with a user during a home visit)

Changing focus in a consultation was not exclusive to users. In some situations, the healthcare providers changed the focus of the entire consultation without involving the users. This was noted during the participant observations. Often the change of focus was related to the introduction of new treatment, but this only happened in relation to diabetes. Occasionally, the unexpected suggestion of new medical treatment lead to disagreements between the healthcare providers and the user. A few of the users described how these disagreements were caused by lack of being involved in the planning of their own care. This was also described in the field notes, which reflected how a medical driven discourse influenced the level of user involvement.

> The nurse asks him about his diabetes. The physician interrupts and asks if he would like to try new medicine for injections. The user express that he does not want to be injected but he has read about a new oral medication, which should be particularly good. The physician does not comment on this. The nurse asks if she

should get the medicine for injection so the user could see that the needle is not that big. The physician thinks it is a good idea. The user does not comment on this. The physician asks once more. The user is frustrated.

(Field notes from a coordination meeting with a diabetes healthcare provider, mental healthcare provider, and a user, 19th of October 2020)

Several users described the introduction of a new treatment for diabetes as unexpected:

Oh, I think it was a bit. I do not want to say pressured. I could see that it was a necessity

(Interview with user 9)

The observations also reviled that, even though the users understood the importance of the new diabetes treatment, some experienced that they felt forced to make a decision immediately. In these circumstances, they expressed a need for time to assess whether the treatment suited their needs and preferences. However, often they did not feel that their need for time to process were met.

Presenting new treatment was in most cases related to diabetes. If the healthcare providers considered new psychiatric medicine or changes in the current psychiatric treatment, they generally presented the users for different possibilities. On rare occasions, the healthcare providers only presented the user for one solution. In both cases, the users and healthcare providers discussed pros and cons in collaboration, which the users explained increased their experiences of involvement in own care planning.

3.2 | Challenges and possibilities when combining care in a combined diabetes and mental health clinic

This theme describes how combined care unfolds in the interactions between users, the healthcare providers employed at the Fusion Clinic, and healthcare providers from other healthcare settings such as residential institutions and during hospitalisation. Maintaining a focus on both conditions was in some cases challenged by the way the conditions influenced one another. These challenges were often noted when the healthcare provider had to deliver care outside their area of expertise. In contrast, the healthcare provider tried to accommodate some of the challenges by teaching each other on the care outside their area of expertise.

A combined focus on diabetes and mental health care was challenging for the healthcare providers if the consultations with users were handled by one healthcare provider. In these cases, the healthcare provider's primary focus was often related to their professional area of expertise (mental health or diabetes) following the patterns of previous work practice. During informal conversations with the healthcare providers, they explained that they felt more confident having consultations in collaboration with a colleague within the other area of expertise to ensure a combined focus. If both healthcare providers were present, they often divided the consultation between them concentrating on one condition at time to ensure a combined focus. This way of practicing combined care was captured in the field notes from a home visit.

One of the nurses started the conversation by asking questions related to the new diabetes care and the user's feeling on this. Asked if he remembers to measure his blood sugar levels during the day. After starting the conversation with a focus on diabetes, the other nurse shifts the focus to the mental illness, the voices, and suicidal thoughts.

(Field notes from a home visit, diabetes healthcare provider, mental healthcare provider, and a user, 1st of September 2020)

Structuring the consultations with a divided focus between diabetes and then the mental illness, did not only take place during regular consultations, but also during the coordination meetings, or consultations in other healthcare settings. Almost all of the users noted the division but did not view it as a barrier to combined care because of the equal attention.

They do try to separate it a bit (diabetes and mental illness) but I don't think that it is something they do on purpose. It's where their training lies. But you bring it into the conversation yourself. This is why you're there

(Interview with a user 8)

In some situations, the users were able to minimise the division of the conditions by frequently involving their lived experiences. Based on this, they were able to maintain a more equal focus on both conditions. Challenges in combining care especially became evident if one or both conditions required special attention. This influenced the healthcare provider's ability to maintain an overview of the user's situation. In these cases, most of the healthcare providers consulted with a colleague.

Healthcare provider (experienced in mental health) ask the user about his blood sugar levels. The user explains that he is worried, that as the blood sugar levels has started to rise. They review possible reasons such as changes in diet or exercise (…) The healthcare provider is in doubt whatever the user is in need for further treatment and calls the department's endocrinologist, who does not answer the phone. Since there are no diabetes healthcare provider at work, the healthcare provider and user agrees that the user will be contacted as soon as possible.

(Field notes from a consultation at the Fusion Clinic, with the participation of a mental healthcare provider and a user 2nd of September 2020)

Occasionally, the healthcare providers chose to focus attention on one of the conditions. During team meetings they argued, that taking care of the unstable condition would prevent further aggravation of symptoms of this condition. Additionally, they elaborated that stabilising one condition would have a positive effect on the other condition as well. Therefore, leaving one condition unattended for a short time was not a major concern.

This view was in accordance with the view expressed by the users. Several of them described the two conditions as influencing each other and that this often challenged their ability to maintain an overall focus. This especially became evident if one of the conditions became unstable and thereby challenge the ability to self-manage both conditions. Focussing on the unstable condition, often became the users' primary preferences of current care plans, leaving the other condition unattended.

> Well, they (the conversations in the Fusion Clinic) are very much focused on mental health. If there is no surplus of energy then there is no surplus to take care of the diabetes. Hence, that is what we have to have under control. The mental health.

(Interviewer): How is your diabetes right now?
(User): It is really bad. Really bad. I have a blood sugar level of 18–20 at all times (Interview with user 12)

Challenges in maintaining an overview of both conditions were also related to healthcare settings outside the Fusion Clinic, for example residential institutions and during hospitalisation at the psychiatric or medical ward. The users also expressed a need for a combined focus on both conditions within these healthcare settings. The users explained that the Fusion Clinic often took charge of their care, but they did not feel a collaboration between the Fusion Clinic and the healthcare setting. As a result, the healthcare setting had little insight into agreements made between the users and the Fusion Clinic.

Even though the healthcare providers accounted for challenges when providing care outside their area of expertise, the healthcare providers tried to find ways to accommodate these differences.

> Diabetes healthcare provider (…) says that she thinks there is a lot of psychiatry and ways of working that she does not have complete control of right now (…) she is used to having a checklist at the diabetes clinic and says that she would really like to learn the other way of working. This approach does not fit in diabetes clinics nor does it make sense there. Only in the Fusion Clinic. Mental healthcare provider indicates that she has the same experience with diabetes. The two healthcare providers agree, perhaps, to switch roles with patients they are comfortable with, in an attempt to create learning in this way
>
> (Informal conversation with a diabetes and mental healthcare provider)

This quote illustrates the conflicting discourses between the work practices of diabetes and mental health nursing. The conversation between the nurses became a way to discover the taken-for-granted knowledge between diabetes and mental health nursing. By discovering the taken-for-granted knowledge, it allowed the two nurses to find possibilities to adjust the discourses by combining their views on care and learning from each other. Even though there have been many challenges when combining diabetes and mental healthcare, learning from a peer colleague or involving users more in care could be a possibility to share knowledge on the condition outside their area of expertise. Even though this quote illustrates the possibilities of combining care and the connection between the discourses of diabetes and mental healthcare services. However, this was not reflected in the work practices during the study.

4 | DISCUSSION

The aim of this study was to explore and describe user involvement and combined care in a Danish clinic that targets diabetes and mental health care. Findings were described in two overall themes. The first theme *User involvement in diabetes and mental healthcare- setting goals for own care* described the differences between diabetes and mental healthcare providers' ability to involve users in their own care. This was exemplified in situations where new medical treatment was introduced. The second theme *Challenges and possibilities when combining care in a combined diabetes and mental health clinic* revealed disconnections in the discourses from previous work practices, which became a challenge for the integration of diabetes and mental health care. Based on these themes, this discussion will focus on (1) *Differences in user involvement* and (2) *Disconnected discourses creates challenges in combining diabetes and mental healthcare*.

4.1 | Differences in user involvement

Health care is compartmentalised into mental and physical health services, creating a structural division between physical and mental health care (Glew & Chapman, 2016). This has been noted to have an impact on the training and specialisation of healthcare providers such as nurses (Glew & Chapman, 2016; Nielsen et al., 2021) creating differences in the work practice between a medical driven practice within physical healthcare (Walsh, 2019) and recovery-orientated practice guiding mental healthcare providers (Farkas, 2007). User involvement is gaining impact in health care (Dixon et al., 2016), highlighting that no single care option is appropriated for all users (US Department of Health and Human Services, 2009).

We found that diabetes healthcare providers could be influenced by old patterns of a medical driven practice, as our findings revealed a low degree of user involvement during care planning and the introduction of new diabetes treatment. This became visible through the discrepancy between the users and healthcare providers specialised in diabetes regarding the users' need for time to process new information. Often the users had to make decisions on new

diabetes treatment immediately, which in some cases, lead to disagreements between the users and healthcare providers. A change of focus of the consultations without the users' consent influenced the users' abilities to make immediately health-related decisions. These findings are similar to an American intervention study, which indicates that people with diabetes and severe mental illness have difficulties in understanding health information essential to make informed health-related decisions (Cimo & Dewa, 2018). It has been highlighted, that this population has less knowledge about diabetes compared to people with only a diabetes condition, as they receive significantly lower amount of diabetes-related education and written material on their diabetes (Mitchell et al., 2009). Based on this, this group of people is in need of education to understand management and treatment related to their diabetes (Cimo & Dewa, 2018; Hamm et al., 2017). Healthcare providers must take into consideration that both diabetes and severe mental illness influence the cognitive functions in ways that reduce the problem solving abilities and the processing speed when receiving new information (Cimo & Dewa, 2018). Literature on user involvement, such as shared decision making, underlines the need for time to process new information on both nonmedical and medical treatment outside the clinical encounter. Moreover, that the user should have the possibility to discuss pros and cons related to the new treatment with others (Edwards & Elwyn, 2016). Introducing new diabetes care should be considered in relation to user involving approaches such as shared decision-making. Especially as our study revealed, that it is possible to involve this group of users, as shown when the consultations were manage by mental healthcare providers. This became visible, in the presentation of new mental health care, which included different care options followed by a conversation between the users and healthcare providers to discuss pros and cons, and reflects user involvement based on patterns from a recovery-oriented practice. The users in our study indicated the value of predictability of the focus of the consultations. Likewise, our study adds to previous literature by showing that users with coexisting diabetes and severe mental illness needs flexibility in terms of regular conversations of care goals with healthcare providers as preferences and need for support changes based on current health status. Moreover, that physical healthcare providers can be inspired by mental healthcare providers when it comes to involve users in own care.

4.2 | Disconnected discourses creates challenges in combining diabetes and mental healthcare

We found that the establishment of a clinic that delivers combined diabetes and mental health care was challenged in the delivery of combined diabetes and mental health services. We found that healthcare providers employed at the Fusion Clinic had challenges when combining care, which were often caused by the disconnection of discourses between the work practices of diabetes and mental healthcare. Disconnection in discourses created difficulties in supporting the users in managing both conditions, where diabetes and mental illness were treated as isolated conditions. This became evident, when the healthcare providers divided the consultations between them instead of an integration of diabetes and mental illness.

Delivering care for people with multiple chronic conditions depends on the collaboration between diabetes and mental healthcare providers, to ensure proper coordination of planned care (Steihaug et al., 2016). However, barriers between care disciplines limit the possibility of an optimal collaboration, due to different value systems and practice styles (Kohn et al., 2022). Differences that are increased by the subspecialisation of healthcare providers' education (Glew & Chapman, 2016). This indicates, that there is a need for supporting and educating healthcare providers who delivers combined care for people with coexisting diabetes and severe mental illness. However, there are limited guidelines to support healthcare providers in delivering user involving care for people with both conditions, as these guidelines focus on one condition at time (Hamm et al., 2017). This indicates that there are structural challenges in combining physical and mental healthcare services. Our study found that the degree of user involvement was limited when healthcare providers had to involve users in care outside their area of expertise. However, the healthcare providers found ways to solve the difficulties in delivering care outside their area of expertise by collaborating on connecting the discourses of diabetes and mental healthcare. This was either done by involving users' experiences, or by learning from a peer-colleague during consultations. Finding solutions seem to reflect that the healthcare providers are aware of their limitations in providing combined care. Solutions that were found through a reflective process discussing new work practices in a new setting of the Fusion Clinic. We find it important that research examines ways to develop guidelines for peer education of colleagues and for support of healthcare providers when combining physical and mental healthcare to support the development of new work practices.

4.3 | Strengths and limitations

To our knowledge, this study is one of the first qualitative studies to investigate combined diabetes and mental health care. A strength is the ethnographic approach, where the use of different data generation methods illuminate misunderstandings and provide different perspectives on the generated data (Hammersley & Atkinson, 2019). The use of examples from the data demonstrates the transparency between the data and findings. Moreover, by using participant observation as a part of the ethnographic study, the researcher engage with the research, that is informal conversations. This means that data generated is co-constructed between the participants and the researcher, and this could have an influence on findings, making the participants reflect and/act in ways that was not originally intended. To avoid own biases, (VZ) wrote reflections on her own position during the participant observation were written in the daily field notes, and discussed with the research team. Discussions were often focussed on, the researcher's

presumptions on the two care services, how to involve users in own care, but also the presence of the researcher during the consultations. However, the use of this approach gave us new ways to gain insight into the possibilities and challenges when combining diabetes and mental health care. VZ who collected all data for this study has no experience in diabetes or mental health care, which also can be reflected in the findings. However, data analysis were made in collaboration with all co-authors to ensure expertise within diabetes and mental health. The strength with unfamiliarity lies within the limited risk of overlooking events due to unrealized assumptions (Hammersley & Atkinson, 2019). The participants of the study did not review the research findings, and therefore it was not possible to make a data triangulation. Another limitation is that the study was conducted in a relatively new outpatient clinic. Work practices and the delivery of combined diabetes and mental healthcare were new for all healthcare providers and users, which might be reflected in the findings of this study.

5 | CONCLUSIONS

This study aimed at exploring and describing user involvement and combined care in a new Danish specialised diabetes and mental health outpatient clinic. We found that user involvement and combined care was structurally challenged by old work practices of diabetes and mental health services, where healthcare providers experienced difficulties in supporting users in the condition outside of their own area of expertise. The findings highlighted that it is required that healthcare providers are well-equipped to manage the complex task of involving and providing sufficient care for people with coexisting diabetes and severe mental illness. To accommodate this complexity, learning from colleagues supported by clinical guidelines and joint display on both conditions were discussed by the healthcare providers as a possible solution.

6 | RELEVANCE TO CLINICAL PRACTICE

Our study revealed following implications for future research and clinical practice.

First, healthcare providers should be offered relevant peer education focussed on learning on the condition outside their area of expertise. Hospital management should consider planning the time and space to integrate a peer-learning environment. Moreover, peer education should also address ways to involve users in care. Our study revealed that diabetes healthcare providers could learn from mental healthcare providers on ways to involve users during consultations, as this study shows a high level of user involvement when the consultations were handled by mental healthcare providers.

Second, there is a need for developing clinical guidelines and joint healthcare plans with a focus on coexisting diabetes and mental health. This study found that current guidelines tends to be focused on one care practice and on the basis of this, missing a focus on both conditions. Qualitative research interviews with healthcare providers can be used as an approach to develop guidelines supporting healthcare providers that delivers combined care.

AUTHOR CONTRIBUTIONS

First, second and last author collaborated in designing the study. First author collected data of this study. First, second and last author were responsible for the data analysis. All authors participated in varying degrees to the writing of this the article.

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CONFLICT OF INTEREST STATEMENT

There are no conflicts of interests.

DATA AVAILABILITY STATEMENT

The data that supports the findings of this research paper is available on request from the corresponding author. Due to privacy and ethical restrictions, the data are not publicly available.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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