Multidisciplinary Collaboration: Bridging Professional Differences for Service Improvement in Adolescent Mental Health Care

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▪ PART A: APRIL ▪

INTRODUCTION

Paul Homilton, an esteemed academic psychiatrist in the Kesteven area of England, sat in his newly renovated office quite perplexed. He quizzically reflected on his early yet failed attempts to kick-start the new program of applied mental health research. He was initially excited at being a part of this winning consortium on knowledge translation. The launch of the Center had been attended by

high-ranking dignitaries from the Department of Health who celebrated what for many was a revolutionary collaborative approach to research.

It was hard for Paul to get his head around the almost paradigm shift for him following a successful career in conducting traditional research. Before, the design and development of the research had been his domain, and he would publish the results, sharing them when and with whomever he pleased once the research had been completed and validated. He was pensive and a bit tentative therefore in setting up the first research meeting to facilitate collaborative partnerships between healthcare and social care providers. What shift in mindset would be required of him and how might he successfully adapt to this new research approach? Further, how should he best facilitate communication and collaboration across health and social care in establishing the research effort?

Concerning the latter issue, these two services, *health* and *the social services*, together look after the child's welfare. For example, if a child experiences mental health problems that significantly impact upon their behavior and social interaction, then a doctor may look after the medication and talking therapy side of treatment, while social services might be involved in family counseling, providing home support, liaising with teachers or schools, and/or possibly working with the police. However, these two services have typically remained separate, in both aims and practice. In response to complaints about disjointed services and a lack of follow-through, the government administration recently emphasized multi-disciplinary collaboration between these parties as a vehicle for "joining up care" in welfare delivery. In addition, new applied health research streams have been developed that encourage knowledge exchange and translation between academic medical research and local practice communities.

A primary focus of the first set of meetings was to bring medical researchers together with these two provider groups and decide how funding provided by the government for research should be used; that is, what research should be conducted. The funding has been provided for research into adolescent care, but beyond this, decisions about what topics to consider are to be made by Paul and all of those he can persuade to commit to the meetings. Paul was aided by his research associate, Jessica Albright, whose task it was to carry through Paul's ideas and those brought out and defined in the meetings.

The first meeting had been a disaster, as well as something of a shock to Paul. Used to having Jessica arrange all his meetings by email, he had been surprised when he himself had to take a strong role in reorganizing, chasing, and cajoling, just to get the relevant individuals at social services to express a desire to participate, as they failed to reply to Jessica's emails and phone calls. And then,

on the day of the meeting itself, no one had showed up from social services. It had not been a complete waste, as Paul and his research colleagues had used the opportunity to brainstorm their own ideas for the research with the one clinical psychiatrist who had attended (an individual with whom he had worked with on another research project), but he is anxious that the second meeting has more participation from social services.

BRIDGING THE PROFESSIONAL GAP

Paul and Jessica are convinced that a large part of the difficulty is in the strong history of differences between the two professions; indeed, until very recently the social services have resisted being defined as a profession at all. This resistance derives from a markedly different approach to care than that found in the medical profession.

Doctors, psychologists, and the majority of clinicians want to pass on the best possible health-related care to "patients" in a one-way exchange of knowledge in which cost is a largely secondary (though still important) consideration. They are used to relying on research to identify what this best health-related care is. By contrast, social services have so many potential "clients" that they must concentrate primarily on resource-constraints (thus are forced to leave many needs unmet), and the focus of their care is advocacy of their clients' needs in a broader social context, rather than any decontextualized "best practice" per se. It is this focus on advocacy that informs their resistance to professional status as they identify more with their clients than with other professions, seeking to work with them rather than for them.

Social care typically has a much weaker relationship with research, preferring to spend money on implementing its own ideas about what best practice might be, rather than determining precisely what it is through formal research. Recent government policy initiatives were key drivers in changing practice, rather than notable research. Due to their severe budgetary constraints, Paul is aware that most leaders in social care would prefer to spend the allocated money on human resources and the recruitment and training of more staff, than on research, which they had told him was generally "irrelevant, decontextualized and ivory tower like." This of course was a key reason why Paul was motivated to involve the social service workers in the research process—so that it would be more relevant and grounded in real context.

The difference in professional identity and perception is compounded by a distinct difference in status between the two professions. In the run up to the

first meeting, Paul and Jessica spoke with social worker Jane Tome, who summed up the effects of this difference on their respective levels of power and influence:

> *The kind of resentment comes in because social workers feel you go to court and then the court listens to the doctor. The doctor who might see this person once comes along and says "Well this is how it is," and the court listens to that and the social worker might see the person 25 times, or have been working with them for a long period of time, but their opinion still isn't valued as much.*

Jane also discussed the fears held by many social workers, because of recent media scandals linked to severe cases of child abuse and deaths, that any interaction they have with other institutions (such as research organizations) will just leave them open for further scrutiny and judgment. It is this fear that Paul felt might have been responsible for the nonattendance at the first meeting. In his emails to arrange the second meeting, therefore, he was careful to stress his strong desire to solicit the opinions of the social services and to work in partnership with them.

OVERCOMING ONE-WAY KNOWLEDGE EXCHANGE

At first, Paul was hopeful that his reassurances to social services had worked as attendance at the second meeting was notably up. However, some of the key stakeholders were still absent, and even as the meeting was starting, emails of apology were pinging into his BlackBerry® smartphone inbox.

The meeting did not lessen the gaps in work status as Paul had hoped. Some of the problem was in the location and setting of the meeting: Jessica had booked a meeting room in Valerie House, down the road from where Paul's offices are based because this was the closest location where they were able to arrange meetings. While this was somewhat inevitable as Paul's office had set up the meeting, it did place the meeting physically on Health Service's property. This was compounded by the room's set up, with a large board room table dominating the middle of the room and giving a far more formal atmosphere than Paul had hoped to achieve (refer to Appendix B for diagrams of the room layout over time).

Such physical factors were compounded by the propensity of his medical and research colleagues to impart information, and far less so to receive it. The meeting got off to a troubled start when one of Paul's colleagues, John, noted the absence of the local head of social services, Helen. As the group began to discuss how they could get Helen's perspective, John answered, "We couldn't," before

loudly adding that as per the reporting requirements specified in the grant he and his team would be recording who was turning up for meetings.

After this, the team from social services remained fairly quiet, while the health service clinicians and researchers shared the ideas they had formulated in the first meeting. Some social workers did pipe up with their thoughts, but as these tended to be less preconsidered or well-organized, they soon returned to listening in silence.

The unequal exchange of information was compounded by the differing definitions and interpretations held by the groups as the following exchange between Richard, a practicing psychiatrist, and Paul, the academic researcher, demonstrates:

> **Richard:** Children in Need [one of the categories of children within the English care system] are tricky to work with.
> **Paul:** Children in Need are *not* the tricky bit.
> **Richard:** We don't really know who these kids are. It is almost impossible to get information about these adolescents, and few of them have a social services file. This would make it problematic using them as cases for research. Children in Need has become a much vaguer term now, and it is difficult to understand how the category has been defined in the [health service].
> **Paul:** I disagree. I have written a paper about how they should be defined. I can tell you what the category should entail. I am sure that at least 360 of the children have some kind of [social services] record.
> **Richard:** Okay. In theory this should be the case. But I think all will become clearer when you go and track the records in person.

A lot of the meeting was thus spent clarifying the terms and perceptions of different individuals. This sparring was highly useful for professional equals such as Paul and Richard, and for the group, as it necessitated the consideration of different points of view (Richard's highly practical background contrasting with Paul's primarily academic career), but did create an environment of strong personalities, which may have negatively affected the confidence of the social services practitioners.

KEEPING A COLLABORATIVE FOCUS

In their discussion after the meeting, Jessica and Paul highlighted a number of problems with how it had progressed. A notable one of these had been the capacity of certain individuals to dominate the discussion and effectively shut down

conversations from the wider group. One particular instance of this was with George, a psychologist who has experienced great professional success in running a residential care center for adolescents. He demonstrated a resistance to collaboration, stating:

> *I do my bit and I focus on doing my bit well. Rather than trying to do everybody's bit and doing nothing.*

George's reputation for strong performance affords him considerable respect among his colleagues and Paul was reluctant to stop anyone from having their say. However, George is employed on a far more isolated project than most clinicians in the field, and Paul worried that his strong opinions would have a negative impact on group motivation for the project and on collaboration between social and health services in general. Even within the healthcare community he was aware of the need to bridge between those focused on clinical practice and his own concerns for rigorous research.

A further difficulty was in staying on topic. The meeting was very long and in places circular in the material it covered. Although he feels this is inevitable in the first few meetings as people get to know each other and the concepts involved, Paul feels that it is vital that they learn to tread a path through this and to keep the meetings on track, if they are ever to make any decisions at all.

Though not quite as disastrous as the first meeting, there were still a lot of problems to be addressed. Paul and Jessica have arranged to discuss how to proceed and what Jessica should be doing to follow up the outcomes of the meeting, but Paul is unsure what to tell her. Where should they go from here to ensure engagement and input from practicing clinicians (e.g. psychologists and psychiatrists) as well as social workers into the research project?

CASE STUDY DISCUSSION QUESTIONS

Collaboration Theme Questions

1. What issues has Paul faced in attempting to create a collaborative working environment? Please consider broader organizational goals as well as professional differences between the groups.

2. How was the spatial arrangement of the room influencing the collaborative context?

   a. Reflecting on your own work environment, how does the arrangement of space and artifacts influence collaboration?

Knowledge Transfer Theme Questions

1. What types of knowledge boundaries are evident in the case and how might this influence collaboration?

2. Consider your own work practices. What knowledge boundaries have you and your colleagues faced, and how did you overcome them?

   a. Think about how Paul could use some of the examples from your work practices to facilitate sharing in his team.

Activity

In small groups, role-play a third meeting between the clinical and academic psychiatrists and the social services, attempting to avoid the issues of the second meeting.

- From the perspective of either the academic doctors or a member of the social services (depending on which part you are playing):
  - Write down your current position, stating your interests, your role, and your hopes and fears for the collaborative process.
  - Write down where you would like to progress to as a result of the collaboration.
  - From the perspective of your role, write down how you think the opposite group would have described where they are and where they want to be.
- Using what you have written, begin to role play, keeping in mind your own interests and the purpose of collaboration.
- Feel free to think about actions outside of simply what each group says might affect the process: for example, how are you going to sit?

■ PART B: SEPTEMBER ■

A POSITIVE ENVIRONMENT FOR COLLABORATION

One of the first meetings Jessica attended after her summer holiday was the September meeting between Paul, his clinical and academic colleagues, and the social services to determine the purpose and objective for the research funding. Though

she knew that Paul had been working hard in her absence to improve the collaborative environment, Jessica was still pleasantly surprised by the far more positive attitude she experienced.

Key stakeholders were present at the meeting, even though it was still being held at Valerie House, on health service premises. The large table was no longer present, and people sat mixed together whereas before they had remained clumped together with those with whom they worked. The effect of this interaction was clear to see: at one point, while summarizing decisions that had been made, Paul was able to say, "This is the research question you [social services] really got excited about and wanted us to look at—this was never part of our initial research project." However, what surprised Jessica most was that, with a few moderations, the social workers seemed to have agreed on the importance of the research proposal initially suggested by Paul in their earlier meeting.

After the meeting Paul shared with Jessica that useful interaction was occurring in other, more informal areas, as well, spanning the traditional boundaries of how the two organizations interacted. Not only had Helen, the local head of social services, begun to attend the meetings, she had also begun an email exchange with Paul, seeking his advice on different issues and sharing news; something to which Paul had been pleased to respond in kind.

CREATING A TWO-WAY KNOWLEDGE EXCHANGE

In response to Jessica's queries as to how such an encouraging change in attitude could have been effected, Paul responded that the crucial factor had been in getting his clinical and academic colleagues to "shut up." As they had noted back in April, the greater confidence of the psychiatrists in sharing their views had led to an unequal information exchange: the psychiatrists knew the psychiatrists views, as did the social workers, but only the social workers knew the social workers' views as they were being denied the opportunity to express them.

So Paul had briefed and rebriefed his medical colleagues for the third meeting that they were not allowed to talk. The purpose of the third meeting had been to understand the thoughts and perspectives of the social work team. This had been a great success, allowing the social workers to establish confidence in their work and its relevance for the meetings and to actively be able to discuss the fears and reservations about being judged that Paul had attempted to address by email back in April. Just being given the opportunity to have their opinions listened

to seemed to go some way to redressing the status gap perceived between the two professions.

There were two important outcomes of this session. First, word had clearly gotten back to Helen about the advances being made, and from this point, she began to attend and contribute to meetings. Second, it had emerged that, resource constraints aside, many of the views held by individuals in both groups were very similar; hence the agreement over the initial proposal for which adolescents should be researched.

AN OUTSIDE PERSPECTIVE

For Paul, a crucial factor in getting the teams to communicate more effectively, and to break down some of the conceptual boundaries between them, was his invitation to academics from the Engineering Department service design center of the nearby university to join the meetings. Paul had initially involved this group with the idea that they might serve as mediators, providing a neutral presence through which both social and healthcare professionals could present their ideas. However, these outsiders, with their interests in service design but with no understanding of the specific field under consideration, had proved to have a greater value than in mediation alone, and were helpful in asking the questions that others felt were too basic to ask. Their presence allowed everyone to get a clearer handle on the differences in perception that characterized the health and social services groups as they used the whiteboard to develop schemas and draw summary pictures.

The engineers' presence had two other major benefits in facilitating collaboration. Their outsider status ensured that they focused less on determining straight off what research the group should be funding and more on finding ways the different individuals could work together. Further, by considering ideas diagrammatically and encouraging lateral thinking, it was Paul's impression that they pushed everyone out of their "comfort zones" and created a sense of solidarity and wider meta group identity.

SCALING UP

Paul is greatly satisfied with how collaborative efforts in the meetings have advanced; however, he is aware that there is a great deal of work to be done. Although collaboration has been effective in determining the purpose of the research for

which there is funding and ensuring that the research will be of interest to both healthcare and social services communities, it will have little long-term merit unless its impact can be sustained and widened out beyond the bounds of the meeting room.

The individuals from social services who have attended the meetings seem committed to the idea of joint endeavor, seeing it as a means to help combat their resourcing issues as well as gaining some insight into improving practice, and the numbers from this group attending the meetings are noticeably up. But Paul recognizes that there is a huge task ahead to convince the rest of social services, outside of the handful of committed individuals, that there is merit to be found in conducting and using research and in working with those from whom they have typically been quite separate. They would also need to address the sensitivity around issues such as external judgment and status perceptions to gain widespread support.

Another challenge will be in convincing psychiatrists and doctors to work outside the healthcare silos in which they have typically operated and to accept the validity of external viewpoints. This has the potential to be particularly problematic at times, such as in this case, where the healthcare professionals will need to take a distinct backseat in order to allow other ideas to be voiced and heard. Team collaboration is a difficult concept to scale up in order to influence and engage the broader community, but Paul is convinced that there is, in his case, evidence of the benefits that can be achieved through its achievement.

CASE STUDY DISCUSSION QUESTIONS

Collaboration Theme Questions

1. What was different about the third team meeting that better enabled collaboration?

2. Consider Appendix A, which stresses that it "is essential for patient outcomes that health and social care services are better integrated at all levels of the system."

   a. Is the document framed from a health or social services perspective? Why?

   b. What impact might this framing have?

   c. Consider an integration story in your local context. How might its framing affect the issues involved?

Knowledge Transfer Theme

1. Describe the features and boundary objects of the third meeting that facilitated greater knowledge sharing.

Looking Forward (Both Themes)

1. How can the positive improvements in the third meeting be scaled up beyond the initial participating team?

2. Using Appendix C as a template, think about the stakeholders who would need to be recruited and their likely attitudes and levels of influence.

RECOMMENDED READING

Gray, B. (2004). Strong opposition: Frame-based resistance to collaboration. *Journal of Community and Applied Social Psychology 14*, 166–176.

Newell, S., Robertson, M., Scarbrough, H., & Swan, J. (2009). *Managing knowledge work and innovation* (pp. 78–104). New York: Palgrave Macmillan.

Oborn, E. & Dawson, S. (2010). Learning across multiple communities of practice: An examination of multidisciplinary work. *British Journal of Management 21*(4), 843–858.

Appendix A

An excerpt from the July 2010 Whitepaper from the Coalition Government concerning its plans for the care structure in England.

EQUITY AND EXCELLENCE: LIBERATING THE NHS

Presented to Parliament
By the Secretary of State for Health
By Command of Her Majesty
July 2010

## THE NHS OUTCOMES FRAMEWORK

3.5   The current performance regime will be replaced with separate frameworks for outcomes that set direction for the NHS, for public health, and social care, which provide for clear and unambiguous accountability, and enable better joint working. The Secretary of State, through the Public Health Service, will set local authorities national objectives for improving population health outcomes. It will be for local authorities to determine how best to secure those objectives, including by commissioning services from providers of NHS care.

3.6   A new NHS Outcomes Framework will provide direction for the NHS. It will include a focused set of national outcome goals determined by the Secretary of State, against which the NHS Commissioning Board will be held to account, alongside overall improvements in the NHS.

3.7   In turn, the NHS Outcomes Framework will be translated into a commissioning outcomes framework for GP consortia, to create powerful incentives for effective commissioning.

3.8   The NHS Outcomes Framework will span the three domains of quality:

- the effectiveness of the treatment and care provided to patients—measured by both clinical outcomes and patient-reported outcomes;
- the safety of the treatment and care provided to patients; and
- the broader experience patients have of the treatment and care they receive.

For example, effectiveness goals might include how we compare internationally on avoidable mortality and morbidity across a range of conditions. The criteria used will ensure that we do not exclude outcomes for key groups and services such as children, older people, and mental health.

3.9   The Department will launch a consultation on the development of the national outcome goals. We are committed to working with clinicians, patients, carers, and representative groups to create indicators that are based on the best available evidence. Later this year, in the light of the Spending Review, the Government will issue the first NHS Outcomes Framework. We intend it will be available to support NHS organisations in delivering improved outcomes from April 2011, with full implementation from April 2012.

3.10   The NHS Commissioning Board will work with clinicians, patients, and the public at every level of the system to develop the NHS Outcomes Framework into a more comprehensive set of indicators, reflecting the quality standards developed by NICE. The framework and its constituent indicators will enable international comparisons wherever possible, and reflect the Board's duties to promote equality and tackle inequalities in healthcare outcomes. It will ensure that clinical values direct managerial activity and that every part of the NHS is focusing on the right goals for patients. The main purpose of the programme of reform set out in this White Paper is to change the NHS environment so that it is easier to progress against those goals.

3.11   It is essential for patient outcomes that health and social care services are better integrated at all levels of the system. We will be consulting widely on options to ensure health and social care works seamlessly together to enable this.
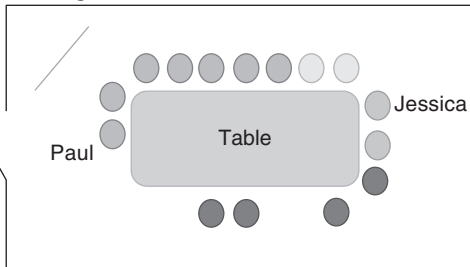
Appendix B

Meeting One

Meeting Two
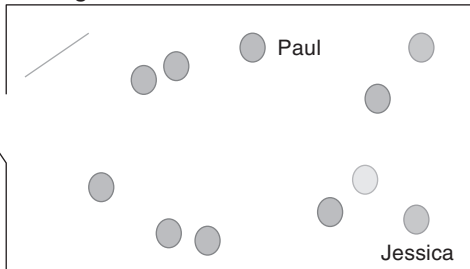
Meeting Three

Key

Whiteboard

Healthcare Academic

Healthcare clinician

Social Services Personnel

Observers

Engineers

**Analysis of the Layout of the Meeting Room
Over the Course of the Collaboration Period**

Appendix C

READINESS FOR CHANGE:
Beckhard and Harris (1987)

Please describe a change effort that you would like to undertake.

Stakeholder	1	2	3	Readiness for Change	Resources for Change

Which stakeholders do you need to influence first? How might you do so? Which aspect of change is most critical for you, mobilizing resources or generating a sense of readiness for change?