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# Collaborative mental health treatment: current practices among mental health providers in Norway

# Samarbeidende psykisk helsehjelp: praksis blant behandlere i Norge

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**ABSTRACT**

The objective of this study is to examine the frequency of collaboration among mental health providers´ and assess perceptions of whether collaborative practices have an impact on the help that patients receive during treatment. This is a cross-sectional study comprising 201 mental health providers recruited from municipal mental health services and specialised clinics across Norway. Participants were asked about their attitudes toward collaborative practices, routines, and beliefs about collaborative mental health care. Regression analyses suggest that frequent contact with social services predicts more perceived adequate psychosocial and socioeconomic help by discharge from the perspective of mental health providers. In addition, results demonstrated a varying degree of frequency and type of collaborative practices. Mental health providers most frequently engage with general practitioners, and least frequently with volunteer services. There are substantial variations in when mental health providers are contacted by external service providers, and when they themselves initiate contact, which may be influenced by a range of factors and vary depending on their professional background and area of service The importance of strengthening collaborative care in mental health treatment and social services is highlighted to tackle overlapping challenges such as financial problems, unemployment, and mental illness.

**SAMMENDRAG**

Målet med denne studien er å undersøke omfanget av samarbeid mellom behandlerne i kommunalt psykisk helsearbeid og psykisk helsevern i spesialisthelsetjenesten og eksterne instanser. I tillegg undersøke behandlernes vurderinger av hvordan slikt samarbeid virker inn på hjelpen pasienter mottar i behandling. Dette er en tverrsnittsstudie som omfatter 201 behandlere i spesialisthelsetjenesten og kommunale tjenester. Deltakerne ble spurt om deres holdninger til samarbeidspraksis, rutiner og tro på et samarbeidsbasert behandlingsforløp. Regresjonsanalyser antyder at hyppig kontakt med NAV predikerer høyere grad av selvopplevd psykososial og økonomisk hjelp ved utskrivning fra perspektivet til behandlere. I tillegg viste

**KEYWORDS**

Mental health services; social services; collaborative practices; interprofessional collaboration; social services

**STIKKORD**

psykisk helsevern; NAV; samarbeidspraksis; tverrprofesjonelt samarbeid; sosiale tjenester

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resultatene en varierende grad av hyppighet og type samarbeidspraksis. Behandlere samarbeider oftest med fastleger, og minst med frivillige tjenester. Det er betydelige variasjoner i når behandlere kontaktes av eksterne tjenester, og når de selv tar kontakt, noe som kan påvirkes av en rekke faktorer og variere avhengig av deres faglige bakgrunn og tjenesteområde. Viktigheten av å styrke samarbeidet mellom behandlere og NAV blir fremhevet for å takle overlappende utfordringer som økonomiske problemer, arbeidsledighet og psykiske lidelser.

## Introduction

In recent years emphasis has been put on collaborative practices between public sectors to provide people with severe mental illness integrated, high-quality healthcare. The term collaborative care can be described as

> the process whereby primary care and mental health providers share resources, expertise, knowledge and decision-making to ensure that primary care populations receive person-centered, effective and cost-effective care from the right provider in the most convenient location and in the most timely and well-coordinated manner. (Kates et al., 2019)

Previous research has demonstrated that collaborative care provides a broader treatment approach and can contribute to ease the process of coordinating service systems (Greidanus et al., 2020), and is arguably a beneficial component in treating mental illness with complex underlying needs (World Health Organization & World Organization of Family Doctors, 2008). For instance, several meta-analyses have demonstrated that collaborative care is more effective than standard care in improving depression, anxiety disorders, and suicidal ideation (Gilbody et al., 2006; Grigoroglou et al., 2021; Muntingh et al., 2016). Complex issues in mental health treatment often require a multitude of approaches, these complex dynamics can be characterised as 'wicked' problems (Bjørkquist & Hansen, 2018; Hannigan & Coffey, 2010; Rittel & Webber, 1973). One characteristic of a wicked problem is how the problem is often intertwined with other similar challenges, e.g. financial problems, unemployment, substance abuse or somatic disease. Consequently, working with such problem requires comprehensive coordination and different professionals and services working together.

The term collaboration conveys an idea of sharing and implies collective action oriented toward a common goal (D'Amour et al., 2005). In Norway, collaborative care has gained attention since the coordination reform in 2009. Similar to health reforms in other Scandinavian countries (Grimsmo et al., 2015), this reform establishes legal requirements for collaboration between health and social care institutions. Although the Norwegian reform has proven effective in terms of strengthened and potentially more flexible interaction between specialised health care and municipalities, such as the Norwegian Labour and Welfare Administration (Norwegian Research Council, 2016), there is little research examining practical implications of the reform in mental health services.

Previous reviews on collaborative practices identify several barriers and drivers. In healthcare, the systematic review by Schot et al. (2020) found that professionals actively contribute to interprofessional collaboration by bridging professional, social, and physical gaps. This is done by negotiating roles in relevant tasks and developing spaces for such discussions. Similar results were found in the systematic meta review by Wei et al. (2022), where it is argued that collaborative practices are facilitated by organisational, teams, and individuals' joint efforts. In the field of mental health, Greidanus et al. (2020) conducted a scoping review of collaborative practice in counselling. The authors found that barriers often include territorial issues between professionals, a difference in values, philosophical perspectives, lack of time, perceived teamwork, and shared space. On the other hand, facilitators included shared spaces and students' role in initiating contact between professionals. Lastly, based on a systematic review of interorganisational collaboration in healthcare, Karam et al. (2018)

emphasise the necessity of formalising collaboration by using tools such as policies and procedures or through established collaborative processes.

### *The Norwegian context*

In Norway, the mental health care system is broadly organised at two levels – the state level and the municipal level. The municipalities are responsible for providing general healthcare to the population through services such as the general practitioner system, team-based primary mental healthcare and substance abuse care (Ruud & Friis, 2021). Social services in Norway are also organised at the state and municipal levels and are broadly divided into the Labour and Welfare Services and municipal agencies. Social services provide housing assistance, food security and other necessary expenses. However, the homelessness rate in Norway is considered low (0,62 out of 1000), among these, about one third have a mental health issue (Dyb & Zeiner, 2021). In addition to providing employment schemes and a diverse array of employment intervention programs aimed at job seekers in general, the social service sector also offers more specialised programs tailored for people with mental illnesses.

In comparison, the specialist services are organised at the state level and solve tasks that require competence and resources beyond what is covered by the municipalities. These include specialised mental health clinics, specialised drug addiction, and treatment clinics, and hospital wards with specialised units. Mental health care at the state level interacts with the municipalities and social services as well as other departments in the specialist health service (The Norwegian directory of health, n.d).

Guidelines from the Norwegian Directory of health (2022) for collaborative practices for patients receiving mental health care state that collaboration between different providers surrounding the patient must be ensured and adapted to the patient's wishes and needs. The referring agency should be informed about the treatment throughout the course. If the patient is already receiving services from the municipality or other agencies, cooperation between the various agencies should be established as soon as the patient is received at the clinic. If the patient needs and wants follow-up in the municipality during the course, the municipality should be notified as soon as possible. For patients who want assistance with school or work, there must be an integrated collaboration between the municipality/social services and health services. If necessary, meetings can take place by phone/video conference (The Norwegian directory of health, 2022). For the volunteer sector, which often include non-profit organisations such as support groups or work rehabilitation, guidelines state that the health sector must facilitate cooperation with voluntary organisations regarding support for patients and relatives. Municipalities and healthcare organisations should have regular dialogue with organisations about how they can best supplement and support each other to provide the best possible services (The Norwegian directory of health, 2017).

However, although collaboration agreements have been made between social services and the health trusts in most counties in Norway, there are variations in how well the agreements are anchored, and to what extent the content of the collaboration is concretised and reaches its full potential (Proba, 2016). Moreover, literature suggests that equitable health services are not always offered in the specialist service, despite the health services having the tools needed to offer this (Holt, 2020). Nevertheless, efforts have been made in the past decade to reduce access barriers for people with mental health issues. This is primarily achieved through decentralisation, which revealed that patients require services beyond treatment, such as help with housing, finances, and social participation (Bjørkquist & Hansen, 2018).

We have not identified any previous research that have examined the frequency of collaborative practices in mental health systems in Norway. However, a scoping review by Pedersen (2020) found that interprofessional collaboration in Norway's welfare system is not fully achieved. It is argued that lack of collaboration is situated in the autonomy of individual services, which again reflects laws, regulations, funding, and ideological goals. Interestingly, this research suggests that the occurrence

of interprofessional assistance is almost coincidental in cases where it would be beneficial. When it does occur, it can be explained by individual characteristics, such as the professional's particular knowledge or enthusiasm. Challenges with collaborative is also characterised by exclusion of services, and in terms of division of responsibilities (Nærland Skjærpe et al., 2020), and an emphasis on individual characteristics during treatment, rather than aspects surrounding the patient (Rørvik, 2017).

In Norway, as in many other countries, collaborative practice in mental health services has received increased attention with respect to funding and implementation of regulations. Here, partnerships and coordination are considered important to efforts to success health care (WHO, 1988, 2010). However, it is relevant to question how collaborative policies emphasise standardisation in the division of labour (Benzer et al., 2015), and to a lesser extent focus on how and when mental health providers should interact. Although research has examined collaborative practice in health care and the interaction between professionals and organisations, few studies explore the frequency of such contact. Hence, this study has two aims. The first is to examine the frequency of collaborative practices among mental health providers´. The second is to assess mental health providers perceptions of whether collaborative practices have an impact on the help that patients receive during treatment.

### *Collaboration in welfare systems*

To contextualise our study, we have adopted a framework developed by Ashforth et al. (2008) that delineates six distinct perspectives on collaboration. Originally designed to comprehend corruption in organisational settings, this framework has since been extended to examine collaboration in welfare services (Breit & Andreassen, 2021). The six perspectives include (1) the micro view, (2) the meso view, (3) the macro view, (4) the wide view, (5) the long view, (6) and the deep view, each with a unique focus and analytical lens.

At the micro-level, the focus is on the individual actors involved in the collaboration, including their roles, actions, and motivations. This perspective acknowledges that collaboration is carried out by people and can be influenced by individuals' professional identities and interests. Understanding the roles individuals play and how they view their professions and collaboration is essential in this perspective. The meso view looks at collaboration among organisations and considers factors such as motivation, resistance, and barriers to cooperation. The macro view, on the other hand, is concerned with the national or international level, offering a broader overview of collaboration practices.

The wide view considers the context in which collaboration occurs, such as societal, structural, cultural, or normative features. This perspective is useful for understanding collaboration in various contexts, including organisational, social, cultural, and institutional settings. The long view emphasises the importance of historical and longitudinal processes in shaping collaborative practices, such as how organisational structures and forms have evolved over time. Finally, the deep view offers a holistic and integrated understanding of collaboration across different research traditions and perspectives. This perspective synthesises information across different concepts, terms, and studies, offering a comprehensive understanding of inter-organisational cooperation.

This framework is particularly useful in interpreting the results of our study, as it allows us to appreciate that collaborative practices occur at various levels and that understanding each level is crucial to understanding the complexities of collaboration.

## Method

### *Data Collection Procedure*

The participants in this study consisted of 201 mental health providers across Norway. Data were collected from mental health providers working in municipal mental health services and specialist

health services. This study has been approved by the Norwegian Center for Research Data (reference: 377861). Mental health providers were selected through a combination of snowball sampling and purposive sampling. Participants were recruited through a common e-mail list at a hospital, professional networks and relevant Facebook groups. Participants were also encouraged to forward the e-mail to relevant participants in their professional network. All participants were provided information regarding anonymity, privacy, security, and data management. The majority (84.1%) of the participants were female (Table 1). The mental health providers varied in age; the largest group (29.9%) were between the age of 42-49. Most participants held education higher than a bachelor's degree (97%); 10.9% reported having a master's degree, 6.5% reported having a PhD and 48.3% reported professional studies as their highest education. In terms of educational background, almost half of the mental health providers were clinical psychologist and specialised clinical psychologists (48.7%), followed by social workers (15.9%), nurses (12.9%), psychiatrists (9.5%) and social educators (2.5%).

**Table 1.** Background characteristics of respondents ($N = 201$).

| Sample characteristics | Percentage | Number per characteristic |
|---|---|---|
| **Gender** | | |
| Female | 84.1 | 169 |
| Male | 15.9 | 32 |
| **Age** | | |
| 26–33 | 19.4 | 39 |
| 34–41 | 20.9 | 42 |
| 42–49 | 29.9 | 60 |
| 50–57 | 18.4 | 37 |
| 58–65 | 10.4 | 21 |
| 66–73 | 1.0 | 2 |
| **Level of education** | | |
| Bachelor's degree | 3.0 | 6 |
| Bachelor's degree with continuing education[a] | 30.8 | 62 |
| Master's degree | 10.9 | 22 |
| PhD degree | 6.5 | 13 |
| Professional study[b] | 48.3 | 97 |
| **Job position** | | |
| Clinical Psychologist[c] | 30.3 | 61 |
| Clinical Psychologist Specialist | 18.4 | 37 |
| Nurse | 12.9 | 26 |
| Social educator[d] | 2.5 | 5 |
| Social Worker | 15.9 | 32 |
| Junior Medical Doctor | 1.5 | 3 |
| Psychiatrist | 9.5 | 19 |
| Other Health/Therapy Personnel with a higher education | 6.0 | 12 |
| Other | 4.8 | 10 |
| **Area of service** | | |
| Specialised Mental Health Clinics | 61.2 | 123 |
| Specialised Drug Addiction and Treatment Clinics | 6.0 | 12 |
| Municipal Mental Health Services | 26.4 | 53 |
| Other | 6.5 | 13 |

[a]In the Norwegian context, the term continuing education refers to training, courses and studies taken in addition to a bachelor's degree.

[b]Professional studies are integrated study programs that lead to specific professional titles, such as jurists, medical doctors, and clinical psychologists.

[c]In Norway, a 6-year higher-level professional degree with integrated theory, supervision and clinical practice is required to become a Clinical Psychologist (cand.psychol.). To become a Clinical Psychologist Specialist, an additional specialisation period of at least five years of relevant clinical work under supervision, relevant courses, and written academic work is required.

[d]A three-year bachelor's degree is needed to obtain authorisation as a Social Educator in Norway. The profession qualifies for work in a broad range of public health care, such as mental healthcare, substance addiction treatment, schools/kindergartens and elderly care.

### Measures

A survey was developed by the first and the last author to understand the practices, routines, and beliefs about collaborative mental health care in Norway. The survey included 49 questions about mental health providers' preferences, expectations, attitudes towards employment for people with mental illness and routines and practices relating to collaborative mental health care, and the frequency of collaborative care with external service providers, such a social service, child welfare services, general practitioners and volunteer services. Four items were used to showcase collaborative practices in this study: 'How often do you collaborate with child services, social services, general practitioners, and volunteer services during the course of treatment?', 'When does external services providers usually contact you regarding a patient (given that they have an open case in the respective service?)', 'When do you usually contact external service providers to collaborate?' and 'When do you think external service providers should contact you regarding the patient?'.

### Dependent variable

Participants were asked whether they believe that their patients have received adequate help with psychosocial and socioeconomic challenges by the time they are discharged. The question included seven possible responses on a Likert-Scale *(strongly agree-strongly disagree)* and is used as a continuous dependent variable in the regression analyses. No validated scales were used in this study, however, we argue that a single item measure is suitable as a dependent variable in this study because the construct is clearly defined, narrow in scope and one-dimensional (Fuchs & Diamantopoulos, 2009).

### Independent variables

To determine how frequent mental health providers collaborate with external service providers, participants were asked how often they collaborate with Social Services, Child Welfare Services, General Practitioners and Volunteer Services. Each question included six possible responses on a Likert-Scale (never-always). *Frequency of collaboration* was dummy coded, based on five response categories (0 = seldom and rarely, 1 = often, very often and always). *Great variation in initiated contact* measures variation in when mental health providers establish contact with external service provider and was dummy coded based on five response rate categories (0 = strongly disagree, disagree, 1 = somewhat agree, agree, and strongly disagree). *Early contact with service providers* measures when external service providers usually contact mental health providers regarding a patient and was dummy coded based on six categories (0 = contact initiated within six months), at discharge or those who do not initiate contact, 1 = contact was initiated within the first conversation, the first week and the first three months after starting treatment.

### Analytic plan

SPSS 27.0 was used to analyse the data. First, we cleaned and inspected the data before calculating descriptive statistics, mean scores and standard deviations for background variables and participant characteristics. Crosstabulation were used to illustrate the relationship between are of practice and contact with external service providers. Means and standard deviations were calculated to examine the differences between expectations towards collaboration and mental health professionals background characteristics. Lastly, multiple linear regression was employed to predict how collaborative work affects perceived psychosocial and socioeconomic readiness for discharge among mental health providers.

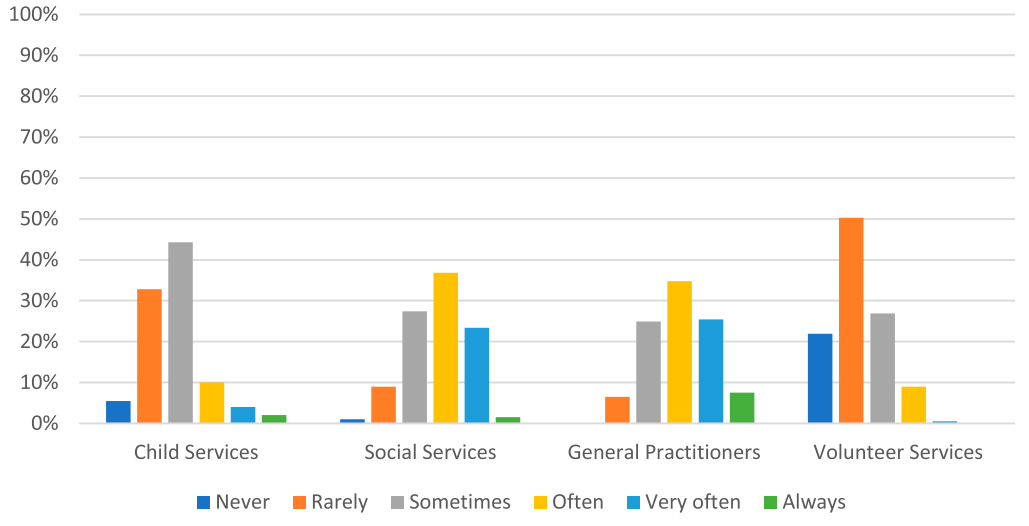


**Figure 1.** Analysis of frequency of contact initiation by external service providers ($N = 201$).

## Results

### *Collaborative practices among mental health providers*

By large, mental health providers reported variations in how often they collaborate with each respective service. As seen in Figure 1, 67% of the mental health providers reported that they often, very often and always collaborate with general practitioners, followed by social services (61%), child services (16%), and volunteer services (9,5%). Although the majority of the participants reported frequent contact with general practitioners, 6.5% reported that collaborations rarely occurred. Interestingly, a total of 62% of mental health providers reported to never or rarely collaborate with volunteer services.

A crosstabulation was calculated to assess variation within area of service and contact from external service providers. As seen in Figure 2, 43% of the respondents reported that external service

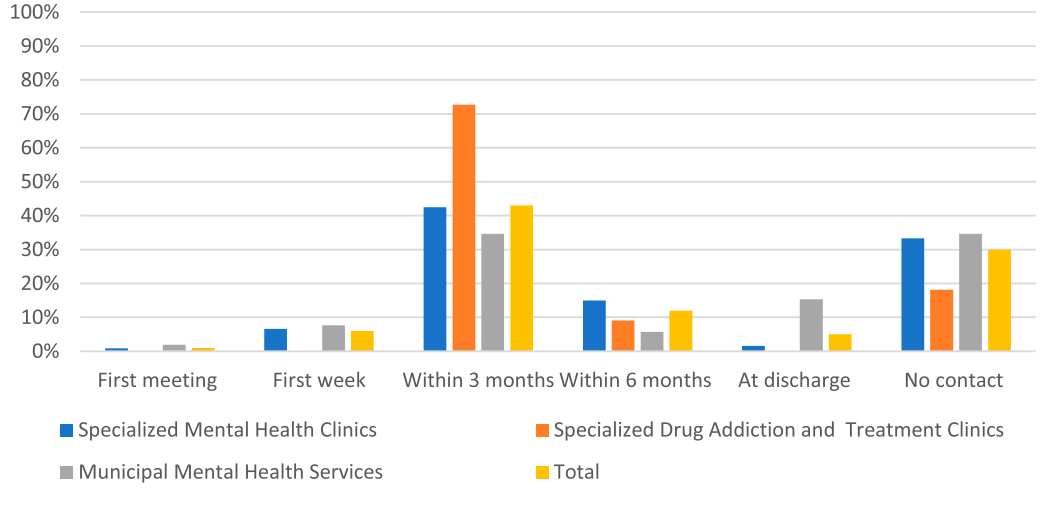


**Figure 2.** Crosstabulation of when external service providers initiate contact with mental health professionals regarding the patient, compared to area of service ($N = 201$).

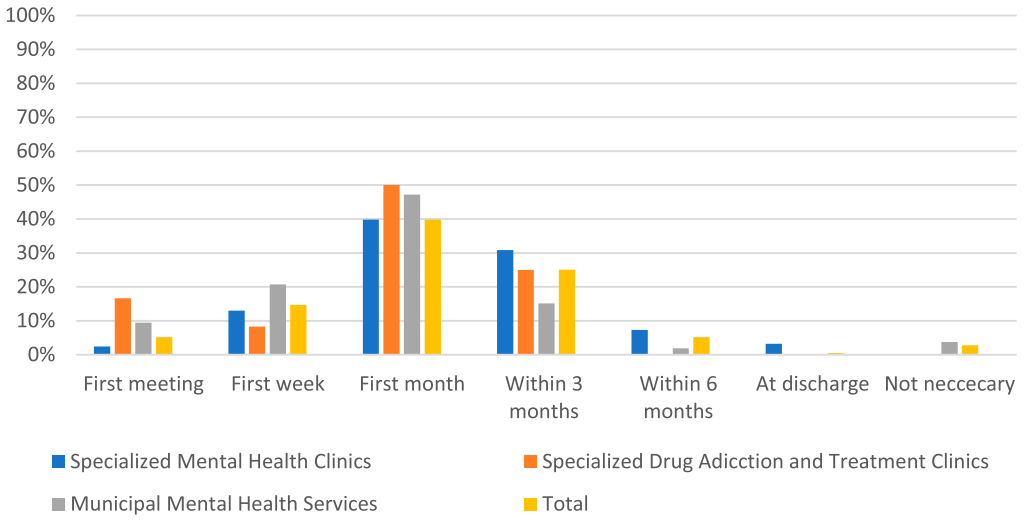


**Figure 3.** Crosstabulation of when mental health professionals' initiate contact with external service providers compared to area of service ($N = 201$).

providers tend to contact them within three months of starting treatment. Surprisingly, 30% reported that external service providers do not initiate contact. As seen in Figure 2, there were substantial variations in when external service providers initiate contact compared to area of service. For instance, 42% of those working in specialised mental health clinics reported that external service providers contact, them in comparison to 72% of those in specialised drug addiction and treatment clinics. Fifteen percent of those working in municipal mental health services report that contact is typically initiated at discharge, in comparison to none of those working in specialised drug addiction and treatment clinics and 1.6% of those in specialised mental health clinics.

When it comes to mental health professionals initiating contact, 40% of mental health providers across area of service initiate contact within the first month (Figure 3). Notably, 16% of those working in specialised drug addiction and treatment clinics initiate contact during the first meeting, compared to only 2.4% of those in specialised mental health clinics and 9% of those in municipal health services. At the same time, very few (2%) believe that it is not necessary to contact external service providers.

On the other hand, results demonstrate that the majority of mental health providers believe that contact *should* be initiated early on (see Figure 4). For instance, 40% of mental health providers believe that external service providers should contact them within the first month, while a minority (5%) believed that contact should be initiated during the first meeting, and very few believe that contact should be initiated within six months (1.4%) and during discharge (0.9%). A larger proportion of those in specialised drug addiction and treatment clinics (16%) and municipal mental health services (15%) believe contact should be initiated during the first meeting, versus 3% in specialised mental health clinics.

### *Mean and standard deviations for mental health professionals' preferences*

To assess the observed differences between gender, age, area of service, profession and the preferred contact with external service providers, means and standard deviations were calculated. As seen in Table 3, minor differences were observed across gender and profession. On average, men prefer contact with external service providers to be initiated later in comparison to women ($M = 3.1$ versus $M = 2.81$). In terms of profession, nurses and clinical psychologist prefer later contact

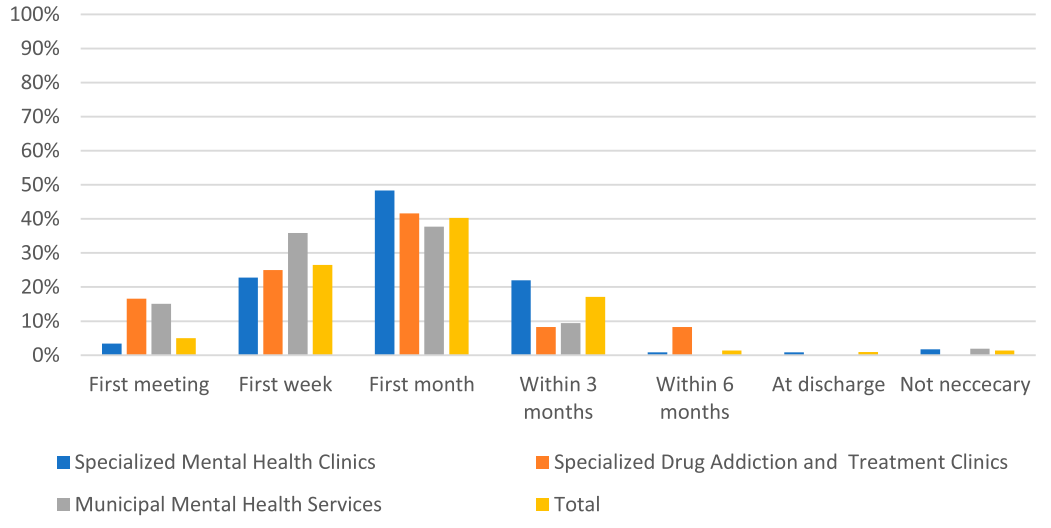


**Figure 4.** Preferred contact with external service providers ($N = 196$).

(M = 3.12, M = 3.11), compared to social workers and health workers who prefer earlier initiation of contact with external service providers (M = 2.66, M = 2.00). Overall, the findings suggest that mental health professionals' preferences regarding the timing of contact with external service providers are influenced by a range of factors and vary depending on their background and area of service (Table 2).

## *Associations between frequency of contact with external service providers and perception of psychosocial and socioeconomic readiness for discharge*

Regression analyses were used to determine associations between the dependent variable measuring perceived psychosocial and socioeconomic readiness for discharge and the independent variables measuring age, gender, frequency of contact with social services, primary physicians, volunteer services as well as the mental health providers' self-perceived initiation of contact with external service providers, and when they perceive external service providers contact them (see

**Table 2.** Means and Standard deviations for preferred contact with externals service providers and background variables.

| Variable | M | SD | *N* |
|---|---|---|---|
| **Gender** | | | |
| Male | 3.13 | 1.38 | 31 |
| Female | 2.81 | 0.99 | 165 |
| **Profession** | | | |
| Nurse | 3.12 | 1.36 | 25 |
| Clinical Psychologist Specialist | 3.11 | 1.10 | 35 |
| Psychiatrist | 2.94 | .899 | 17 |
| Clinical Psychologist | 2.90 | .91 | 60 |
| Junior Medical Doctor | 2.67 | 1.15 | 3 |
| Social Worker | 2.66 | 0.93 | 32 |
| Health nurse | 2.00 | 1.00 | 32 |
| **Area of service** | | | |
| Specialised Mental Health Clinics | 3.03 | 0.98 | 118 |
| Specialised Drug Addiction and Treatment Clinics | 2.67 | 1.15 | 12 |
| Municipal Mental Health Services | 2.51 | 1.06 | 53 |

Note: M = mean; SD = standard deviation; *N* = sample size; scale range 1–7, (meeting, first week, first month, within three months, within 6 months, at discharge, not necessary), higher mean values indicate preferences for later contact.

**Table 3.** Summary of multiple linear regression analyses for variables predicting perceived psychosocial and socioeconomic readiness for discharge ($N = 201$).

| | Perceived psychosocial and socioeconomic readiness for discharge | | |
|---|---|---|---|
| Variable | B | SE B | $\beta$ |
| Age | −.111 | .077 | −.100 |
| Gender (f) | .186 | .280 | .047 |
| Frequent contact with Child Welfare Services | −.418 | .273 | −.108 |
| Frequent contact with Social Services | .425 | .216 | .145* |
| Frequent contact with Primary physician | .188 | .219 | .061 |
| Frequent contact with volunteer services | −.571 | .343 | −.117 |
| Great variation in initiated contact | −.294 | .224 | −.117 |
| Early contact from external service providers | .251 | .204 | .088 |
| $R^2$ | .053 | | |
| F | 2.399 | | |

Note. *$p < 0.05$.

Table 3). The variable 'frequent contact with social services' significantly predicted adequate psychosocial and socioeconomic help by discharge among the mental health professionals, with an effect size of .145, which is relatively small, indicating that the frequency of collaboration with social services may be just one of several factors contributing to the perception of adequate help. Variables measuring contact with child welfare services, primary physicians, volunteer services or self-perceived contact with and from external service providers were not significantly associated with the readiness for discharge.

## Discussion

This study had two aims. The first was to examine the frequency of collaborative practices among mental health providers. The second was to assess mental health providers perceptions on whether collaborative practices have an impact on the help that patients receive during treatment. The main finding in this study, derived through regression analyses, indicates that frequent contact with social services positively and significantly predicted perceived psychosocial and socioeconomic readiness for discharge. The relationship between the variables suggests that mental health providers who more frequently engage with social services during the course of treatment generally believe that their patients have received more adequate psychosocial and socioeconomic help by the time they are discharged.

Mental health providers collaborated most frequently with general practitioners and social services, while collaboration with child services and volunteer services was less common. Timing of contact with external service providers varied by area of service, with specialised drug addiction and treatment clinics reporting the highest percentage of contact initiation within three months of treatment. Mental health professionals' preferences for contact timing were influenced by factors such as background and area of service, with nurses and clinical psychologists, and on average, those working in specialised mental health clinics expecting later initiation of collaboration.

The main finding in this study that frequent contact with social services positively and significantly predicted perceived psychosocial and socioeconomic readiness for discharge highlights previous research on the importance of strengthening collaborative care between mental health services and social services to tackle aspects described in the concept 'wicked' problems (Bjørkquist & Hansen, 2018) that is, overlapping challenges such as financial problems, unemployment in combination with mental health issues (Hannigan & Coffey, 2010; Rittel & Webber, 1973). Although these findings do not provide evidence of patient outcomes, they emphasise the need for collaborative interplay between different services, as suggested in previous research (Gilbody et al., 2006; Grigoroglou et al., 2021; Muntingh et al., 2016).

The data presented in this study do not explain why some mental health providers more frequently engage in collaborative practices, however, the variation in the dependent variable may be understood considering the micro view, or individual-level factors (Breit & Andreassen, 2021). Our data demonstrates that male participants on average believe that contact should be initiated later in comparison to women. Previous research suggests that the occurrence of interprofessional assistance is to a large degree dependent on individual characteristics such as knowledge or enthusiasm (Lillehaug Pedersen, 2020; Wei et al., 2022). For example, some mental health professionals may have more knowledge of the benefits of collaborative care, greater enthusiasm for working with other professionals, or a stronger belief in the importance of social services in supporting mental health.

Moreover, division of responsibilities may also have an impact on collaborative care (Nærland Skjærpe et al., 2020). For instance, findings illustrate that mental health providers are most frequently contacted within three months of treatment, although most wish contact was initiated within the first month. Although the results demonstrate variations, they indicate that mental health providers want earlier collaborative efforts between sectors. Another micro-level factor that may influence collaborative practices is the division of responsibilities between mental health providers and social services. The finding that mental health professionals wish for earlier collaborative efforts between sectors may reflect their desire to work more closely with social services earlier in the treatment process. However, as seen in previous literature (Greidanus et al., 2020), factors such as territorial issues, differences in values or philosophical perspectives, and concerns about professional identity may hinder collaborative practices at the individual-level (Breit & Andreassen, 2021).

Another explanation may be local variation in collaborative practices between mental health clinics and social services (Proba, 2016), that is, the context in which collaboration occurs. In this case, collaboration is placed in a national context, which can be understood considering both the meso view and the wide view, where emphasis on collaboration focuses on cultural and normative factors that influence cooperation, such as national guidelines which state that cooperation in the early phases are important (Norwegian Directory of Health, 2022). The meso view highlights collaborative practice between organisations, and it is argued that attention should be placed on what motivates and prevents cooperation. Schot et al. (2020) suggest that these processes often include negotiating roles in relevant tasks and developing spaces for such discussions, which include bridging social and physical gaps. Nevertheless, guidelines from the Norwegian Directory of health (2022) state that contact with external service providers should be established as soon as the patient is received at the clinic. Currently, only 5% of mental health professionals across area of services initiate contact with external service providers during the first meetings. While mental health clinics and social services may differ in their approach to collaborative care, which could affect the frequency of contact between professionals, collaborative practices between mental health clinics and social services may be influenced by wider social, political, and economic factors. For example, funding structures may incentivise or discourage collaboration, depending on how resources are allocated.

To tackle these challenges, previous research has emphasised the necessity of formalising collaboration by using tools such as policies and procedures or through established collaborative processes (Karam et al., 2018), such procedures are apparent between health and social services in Norway (Proba, 2016). Considering aims from the Norwegian coordination reform (Norwegian Research Council, 2016), findings suggests that these practices are not achieved between mental health services and public services. This is problematic not only for mental health treatment but considering that mental health problems are often intertwined and require comprehensive coordination for multiple services, (Bjørkquist & Hansen, 2018; Hannigan & Coffey, 2010; Rittel & Webber, 1973), hence, the results highlighting the need to strengthen the coordination between services.

In sum, our results suggests that there are substantial variations in when mental health providers are contacted by external service providers, and when they themselves initiate contact and believe that contact should be initiated**.** Some professions believe contact should be initiated later, such as nurses, clinical psychologist specialists and psychiatrists, and on average, those working in specialised mental health clinic. These barriers may be dependent on several issues. Using a theoretical framework on collaboration (Ashforth et al., 2008; Breit & Andreassen, 2021), we identified five barriers that can be placed in the micro, meso and wide view; (1) territorial issues: Mental health providers and social services may have different roles and responsibilities, and this can lead to territorial issues that make it difficult for them to work together, (2) differences in values or philosophical perspectives: Mental health providers and social services may have different values or perspectives on how to best help patients, and this can lead to disagreements or conflicts that hinder collaboration, (3) concerns about professional identity; Mental health providers and social services may be concerned about preserving their professional identity, and this can make it difficult for them to work together as equals, (4) funding structures; Funding structures may incentivise or discourage collaboration, depending on how resources are allocated, and (5) lack of formalised collaboration: Without formalised collaboration, mental health providers and social services may not have clear procedures or processes in place for working together, which can lead to confusion and misunderstandings.

In line with previous research, we suggest that collaborative care is important in addressing complex issues such as financial problems, unemployment, substance abuse and mental health issues, which are often intertwined (Gilbody et al., 2006; Greidanus et al., 2020; Grigoroglou et al., 2021; Muntingh et al., 2016; World Health Organization & World Organization of Family Doctors, 2008). While the Norwegian coordination reform (2009) has proven effective in terms of strengthened and potentially more flexible interaction between specialised health care and municipalities, such as the Norwegian Labour and Welfare Administration (Norwegian Research Council, 2016), our findings suggests that collaborative practices are not achieved in accordance with national guidelines (Norwegian Directory of Health, 2022). To better understand how collaborative care is carried out in Norway, more research on *how* collaborative care is carried out and examine the interplay between mental health providers and external service providers. Thus, this study underscores the need for future research that examines facilitators for collaborative interplay between service providers. Such research may help ensure that collaborative care efforts are patient-centered and effective in improving patient outcomes.

### *Limitations*

There are some limitations to consider in this study. First, this study consists of 201 mental health providers. Using snowball sampling makes it difficult to determine representativeness of the sample and the distribution of the population and calculating the sampling error. Since mental health providers were recruited across Norway from different municipal mental health services and specialist health services using snowball sampling, comparisons with the population are particularly challenging. One notable characteristics of the sample is that the majority were female (84.1%), which is not surprising considering about 82% of professionals employed in the health-and social sector in Norway are female (Statistics Norway, 2022). In terms of demographic variables such as age and educational background there is no comparable population data to determine representativeness. Generalisation of results is therefore difficult.

Second, the low number of participants impacts the statistical power of the study, which reduces the chance of finding true effects in the regression outcome. Third, the dependent variable used in this study is not part of a validated scale, which might limit its explanatory power. For instance, results from regression analyses demonstrates a low $R^2$, which means that some of the independent variables are not explaining the variation in the dependent variable.

Third, while the measure of 'adequate help' regarding psychosocial and socioeconomic challenges may provide valuable information about participant perceptions of patient care, it has

limitations related to the subjectivity of the term. The definition of 'adequate help' may vary across participants, leading to subjective assessments. Additionally, this measure does not provide a comprehensive assessment of the specific types of psychosocial and socioeconomic challenges patients face, nor the interventions and resources used to address these challenges. Consequently, determining the specific factors contributing to participants' perceptions of whether patients received adequate help could be difficult. Collecting more data, such as clinical outcomes, utilisation of additional services, or patient-reported outcomes, may provide a more complete picture of the effectiveness of the services provided.

## Conclusions

Findings from this study demonstrate that there are substantial variations in how collaborative practices are anchored in mental health services in Norway. Strengthening the collaboration with social services may help to tackle overlapping issues related to mental health treatment, such as economic hardships and unemployment. Although the research in this study highlights future collaborative agreements between public and private welfare services, more research is needed to explore the interplay collaborative efforts in welfare settings and the delivery of mental health treatment. We suggest multimethod approaches to better understand the complexities that influence collaboration.

## Ethics approval

This study has been approved by the Norwegian Center for Research Data (reference: 377861). In addition, all methods were performed in accordance with the relevant guidelines and regulations following the Declaration of Helsinki Ethical Principles. Informed written consent was obtained from all participants before the start of this study. Participants were informed about the purpose of the study, privacy and confidentiality and their possibilities to withdraw from the study at any time.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

## Data availability statement

For access to the data please contact the corresponding author.

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