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Original Paper

Nurse & Social Worker Collaboration in Psychiatric Care; KJ Method Used to Identify Cross-Professional Issues

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Abstract

Collaboration between psychiatric nurses (PN) and psychiatric social workers (PSW) plays a significant role for rehabilitation and normalizing behavior of mentally disordered patients. Team care requires liberal exchange of information and cooperative interactions. In this study, a questionnaire survey was mailed to 277 PN and 249 PSW to identify keywords for establishing effective collaboration. Utilizing KJ methodology to analyze responses, the data revealed that requests for information exchange and collaboration were common to both professions. PN wanted PSW to develop closer relationships with patients to improve the nature and quality of social work. PSW wanted PN to understand the PSW's role and to improve the quality of nursing care. To carry out team care for psychiatric patients, the findings showed both PSW and PN must learn to articulate their respective profession's responsibility, the joint areas of activity, and those duties that belong to the other.

Introduction

In Japan, patients with mental disorders were ineligible for welfare services until passage of the *1993 Fundamental Law of the Disabled.* However, the welfare policies for psychiatric patients were noticeably inferior to those of the physically and/or intellectually disabled thereby causing political controversy[1]. This resulted in enactment of the *1995 Law Concerning Mental Health and Welfare for Patients with Mental Disorders* (Mental Health and Welfare Law), which provided the legal basis for the development of welfare policies. This law emphasized "promotion of independence and normalization of the life of patients with mental disorders." It also specified the establishment of *team care* or coordinated care through collaboration among physicians, nurses, occupational therapists, clinical psychologists, and psychiatric social workers and increasing the personnel allotted to psychiatric care to accomplish these goals[2].

To review data pertaining to Japan's mentally disordered patients, the mean duration of hospitalization in psychiatric hospitals is 455 days, which is 14 times longer than hospitalization in non-psychiatric hospitals[3]. However, the numbers of 1/6 physicians and 1/3 nurses working at psychiatric hospitals are

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compared to non-psychiatric hospitals. As of October 1993, Japan had a total of 1,624,012 hospital beds of which 362,136 or 22.3% were in psychiatric wards. No other developed country has as many as 1/4 of its total beds allotted to psychiatric care[4]. A survey conducted in 1993[5] estimated that 330,000 of the 1,570,000 mentally disordered patients were hospitalized in psychiatric hospitals, but that many of them could be discharged to live in the community with better local health and welfare systems.

The percentage of voluntary admissions (64.3%) defined by the amendment of the 1988 *Mental Health Law* for the protection of the human rights was more than twice the percentage of medical protective admissions (31.3%). However, the percentage of open hospitals has increased very slowly, and many patients remain confined in closed or locked wards[6]. Consequently, segregation and alienation persist, and the choice to lead a life based on the same values and conditions as other members of society are denied to patients with psychiatric disorders.

Along with the lack of human resources, the closed nature of psychiatric care environments necessitates collective management of patients[4]. As mentioned earlier, psychiatric hospitals have far fewer staff than non-psychiatric medical organizations. Therefore, many psychiatric patients are forced to accept institutional lives referred to as "living therapy (seikatsu ryouhou)." This condition, of course, is contrary to the individualized care that mentally disordered persons are entitled to by law. Collective institutional care also prevents establishing any normalization program for patients. Therefore, psychiatric personnel must perceive their roles as using the principle of "supporting the lives of people with diseases and disabilities" and to cooperate with other professions and organizations in implementing recent mental health laws rather than to focus narrowly on one's professional tasks[7]. In brief, the establishment of *team care* and *support network for community care* is imperative.

The transition from hospital-centered to community-based psychiatric care requires interdisciplinary teamwork. In psychiatric care, non-physicians such as PN, PSW, occupational therapists, and clinical psychologists directly participate in patient care and assume far greater therapeutic roles than in other medical specialties[8]. To operationalize *team care* for professional collaboration, the work of regular staff members needs to be well-defined and tasks clearly designated[9]. PSW have an important coordinator role in integration of psychiatric patients into the community. Collaboration is essential between PN, who provide direct clinical care to mentally disordered patients, and PSW, who provide direct support for their rehabilitation (community living).

Literature review

A review of the literature using Chuo Igaku Zasshi CD-ROM and MEDLINE found few studies related to liaison among medical care, nursing and welfare[9-12] or reports in English concerning collaboration between PN and PSW [13-15]. Kyogoku[16] stated that no one objects in principle to collaboration between health care and welfare, but there was insufficient research on specific methods for it. Okuda[17] observed that in the absence of social workers, other professions sometimes provided services similar to social services. This can create redundancy in care at times and also areas of omission among service sectors.

The current status of care for mentally disordered patients shows minimal improvement. Systems of *team care* require developing patient-centered support, but there is little progress to date.

Today, with demand for team care among the professions, colleagueship or egalitarianism is ensured not by the quantity of individual knowledge but by the ability to perform activities of the specialty and being responsible for it, thereby inspiring confidence from members of other professions[18]. Kamiya stated that various sectors including medicine, nursing, and welfare (administration) must function together for the common aim of "wholesome continuation of living" for patients to be rehabilitated. She also suggested that

PN contribute to improvements in welfare services of the local community rather than provide only one-way support and that development of a support system that links hospital care and community care is the first step to achieve this goal[19]. Therefore, it is important to evaluate a method that promotes exchanges of information and collaboration between PN and PSW for developing a system that rehabilitates and integrates mentally disordered patients into the community.

According to the extensive review of the literature by Griffith et al. in 1980[20], the contents of work of care-givers including PN, psychiatrists, and social workers operating in the field of psychiatry are so similar that research to avoid discord or conflict among roles is needed.

Sakuraba[21] suggested that PN suppressed self-expression of patients because of their restrictive and directive attitude to patients and that it was a factor that invited questions about the quality of psychiatric nursing. This problem runs counter to normalization, a basic concept of the Mental Health and Welfare Law. This situation has been put eloquently in the remark, "Institutions in Japan are still equivalent to jails in spirit[22]." We must endeavor urgently to establish the system of community care to realize the concept of normalization so that patients may "enjoy living despite their disorders[23]." Correct understanding of the meaning of normalization serves greatly to improve services to and conditions of living of patients with mental disorders and to enhance their dignity[24].

In summary, clarity of PN and PSW role and the mutual understanding of their respective functions would facilitate the transition of mentally disordered patients from institutional to community-based care and toward normalization of living. PN and PSW are two major professions critical to the development of "team care." This study seeks to identify *key words* to conceptualize factors important to effective PN-PSW collaboration.

Methods

1. Subjects

Using the lists of *Facilities for Members and Executives of the Japanese Psychiatric Nursing Association, Co* and the *Membership List the Japanese Association of Psychiatric Social Workers*, forty-five institutions were selected from psychiatric hospitals and mental health centers throughout Japan (Kyushu to Hokkaido) where many PSW and PN worked. A total of 277 PN and 249 PSW working were chosen as research subjects from these institutions.

2. Investigation methods

In August 1998, hospital directors, nursing directors or persons holding similar positions in the 45 institutions were contacted by telephone and asked for their cooperation in the study. Questionnaires were sent to the hospitals that consented to participation, and the completed tool was returned within eight weeks.

3. Response rate

Of the 526 questionnaires distributed, there were 479 returned for a response rate of PN 91.3% (n=253) and PSW 90.8% (n=226).

4. Attributes of responders

The mean age of respondents was PN 43.06 ± 8.97 years (mean $\pm$ SD) and PSW 32.92 ± 10.4 years. The male-female ratio was PN 46: 54 and PSW 63:37. The education of PN was 79% occupational school (11% practical nurses) and PSW was 92% college.

About 87% PN and 92% PSW worked in psychiatric hospitals and about 80% of both PN and PSW in private hospitals.

5. Framework and methods of analysis

The research questionnaire, therefore, was created to elicit "free" comments from respondents, that is, (1) What PN wanted from PSW and (2) what PSW wanted from PN for effective collaboration in team care.

This study utilized the method of *Kawakita Jiro* (KJ Method) with its AB type diagram method to analyze responses to the questionnaire[25-26]. Meaningful sentences found in free responses were transcribed one sentence per card, qualitatively analyzed, grouped and categorized. Next, each category was given an appropriate name. The procedures thus far followed the KJ method (1). The named categories were arranged in a spatial pattern that gave the most logical explanation (A-type diagram method), and then their interrelations and cause-effect relations were evaluated (B-type, description of interpretations) (2). Using the KJ Method, key words that pointed in the direction of sharing information and collaboration between PN and PSW were identified by analyzing (1) and (2) above.

Four persons, highly qualified by education and experience and representing three different professions (psychiatry, psychiatric social work, psychiatric nursing) individually applied the KJ Method in analyzing the data. The concurrence of inter-rater reliability was 70 % agreement using assessment score sheet.

Results

Data on requests to PSW by PN were classified into 8 categories, and those to PN by PSW into 6 categories (Table).

Table Requests to the other profession

	Categories	Requests
	1	To exchange information about the patients
	2	To make joint conferences
Requests to	3	To be counselors to the patients
PSW by PN	4	To organize the environment of care
	5	To support the families of the patients
	6	To provide social resouces
	7	To provide community-oriented support
	8	To have closer contact with the patients
	1	To exchange information about the patients
Requests to	2	To work for effective collaboration between two professions
PN by PSW	3	To deepen understanding of patient normalization
	4	To support the whole person
	5	To improve the quality of nursing care
	6	To understand the work of PSW

Using the KJ method and its AB types diagramming, categories related to exchanging information and collaboration were common to both groups. The requests to PSW by PN were to improve the contents of social work while developing closer relations with the patients. The requests to PN by PSW were to understand the work of PSW and to improve the quality of nursing (Figures).

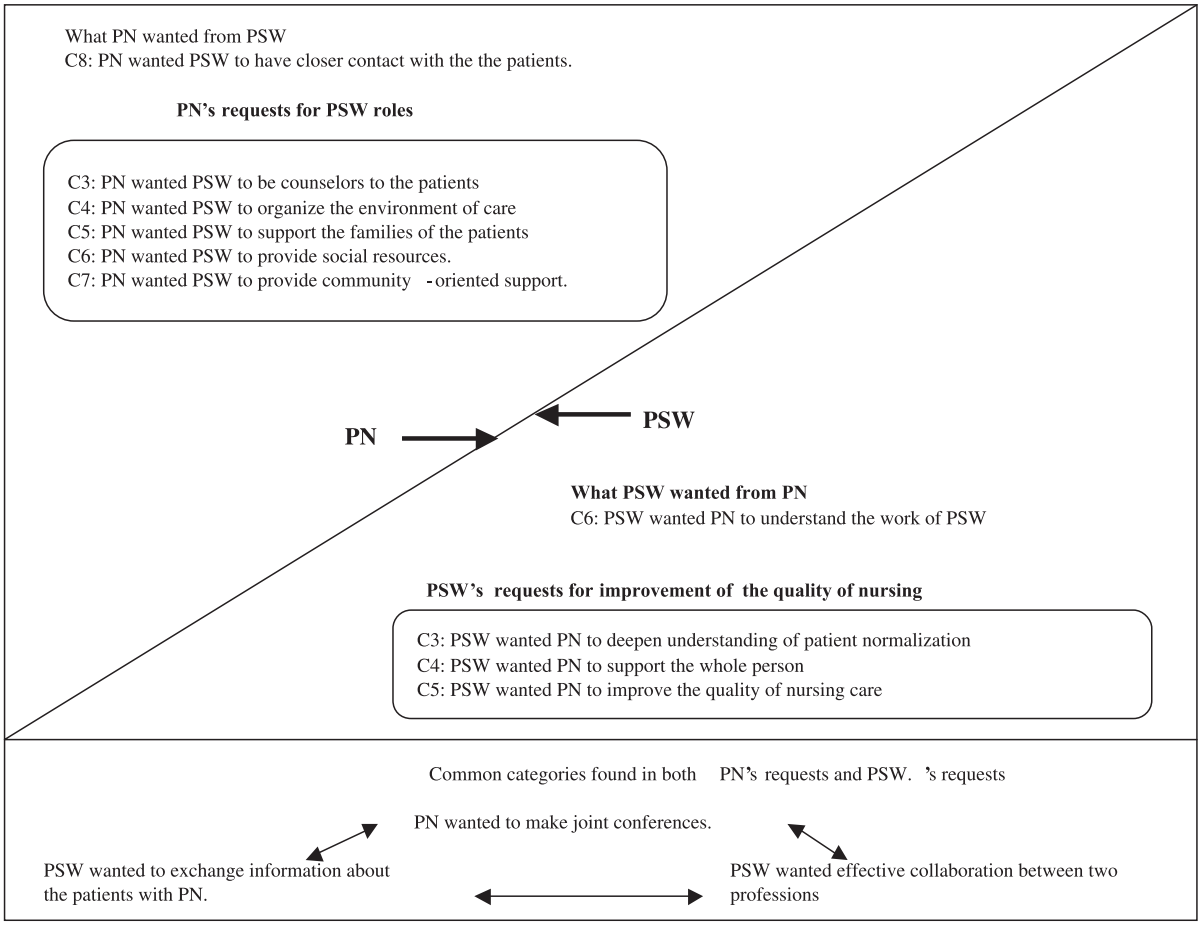

Fig. Analysis of requests to the other profession using the KJ method-AB type diagram method

Discussion

As for requests in common, each profession wanted to have more information about the other and to achieve liaison and collaboration through joint conferences. Why would they want to have information about the other profession?

Matsuoka et al. [12] surveyed nurses and found their order of priority in obtaining patient information was body > psychology > society, but social workers priority was the opposite: society > psychology > body. Thus, nursing based on medical and nursing sciences emphasized physical aspects of patients while PSW with a background of social welfare science emphasized information concerning social aspects. Because of this difference in priorities, PN and PSW need information that the other obtains. Ironically, due to their perceived differences, they may actually fail to exchange information or be dissatisfied with the kind of information being exchanged.

Next, opportunities for exchanging information are necessary to achieve collaboration between PSW and PN, and properly structured joint conferences provide such. They permit both sides to share information from different viewpoints. A system that encourages joint participation of both PSW and PN in case conferences is expected to promote team care and to lead to better service for the patients. However, the fact that both PN and PSW want more information exchange means that it is currently unsatisfactory.

First, there is the problem of discord between the professions. At present, each profession arbitrarily tends to claim their areas of work and leave that which is unclaimed to others. For successful team care, the

roles of all participants must be understood, and work must be shared through conferencing. Also, efficient team care requires clarifying areas of overlap. Thus, PN and PSW collaboration means scheduling regular opportunities to exchange information that includes mutual knowledge about work unique and special to each profession and those matters where the two professions overlap. Effective collaboration would foster more complementation between professions.

Second, PN want PSW to have closer contact with the patients. The shortage of PSW is a major contributor to the problem, and the situation should improve shortly with the expected increase in mental health welfare professionals. However, developing closer relationships with patients means PSW must be willing to enter the psychiatric wards from which they are too often absent. Concerning the requests by PN to PSW "to be counselors to patients," "to organize the environment of care," "to support the families," "to provide social resources," and "to provide community-oriented support" all are the purview of social work. However, it can be argued that "to organize the environment of care" and "to support the families" are mutual areas of responsibility and PN & PSW, together, should determine what are appropriate contribution and responsibilities for each. Also, PN and PSW should decide which of the professions can provide the most appropriate support on individual cases.

Third, PSW wanted more understanding of their work role by PN. There was an informational gap between what PSW consider their work and what PN consider it to be. This created discord between the two professions. Shiraishi[27] noted that PSW needed more active and consistent public relations activities with other professions so that their work may become better understood. Also, PN at the clinical site need to learn about PSW and create an environment receptive to PSW as specialists in social welfare. Finally, nursing needs to educate its students to the work of not only social work but also other professions and to the philosophy of interdisciplinary team care as an integral part of the curriculum.

Fourth, social workers must persist in establishing their professional position in medical care and to move from the areas of administrative and clerical activities. For the profession to claim its position in the health care system, social workers must clearly demonstrate their areas of expertise by identifying the patients and families that need social services and support, providing social welfare and institutional resources and by evaluating effectiveness of casework. This means that PSW must enter the clinical wards, have closer contact with patients, and provide expert counsel for various patient and family problems concerning social rehabilitation (living) and managing in the community.

Finally, PSW requested PN to "improve the quality of nursing" or, more specifically, to "support the whole person" and noted a "lack of understanding about (patient) normalization." That is, they wanted nurses to be mindful of the patient's and family's social context and community. PSW believed that PN are either incapable of making social assessments on patients or, if capable, do not use the information due to their focus on illness and disease. The data revealed that PN tend to see patients from the perspective of hospital in-patient care. Therefore, PN might additionally learn to expand nursing care to include community-oriented care. Conversely, PSW might contribute to effective team care by utilizing the PN's clinical information on patient conditions and provide the necessary supplemental social data when appropriate. As regards the quality of nursing, PSW requested "improvements in the skill of nursing" that included better scientific understanding of diseases and treatment. PSW wanted nurses to learn about community-oriented care and to improve their general professional skill.

Conclusion

Collaboration among the professions is imperative for developing team care for mentally disordered patients. To promote better understanding between social workers and nurses, they must learn to articulate

their respective profession's responsibility, the joint areas of activity, and those duties that belong to the other. PN should learn more about PSW and their role with social aspects of patient and family care, and properly utilize PSW by welcoming them to the clinical unit. PN also must educate themselves about the concept of normalization to improve the quality of nursing service. For their part, PSW need to make their presence known at the clinical site and to implement their professional expertise. For the near future, social workers must familiarize their colleagues about the role and duties of their profession and demonstrate its unquestionable value. Instituting regular conferences for professional interactions and exchange of information is one place to begin nurturing collaboration.

A system of team care that implements knowledgeable and efficient social work and nursing is fundamental for patient normalization programs. All disciplines involved in psychiatric treatment and services need further research on methods for designing and establishing effective systems of team care.

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