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Coordinating multiprofessional organizations – the case of Mental Health Service Provision.

Abstract:

This paper deals with the present developments in specialized and municipal mental health services in Norway. In particular, we ask how changes in work organization and strategies for coordinating services influence the structure of professional knowledge. One hypothesis is that three different developments create a crosscutting competence structure that representatives of mental health professions must relate to: a bio-medical approach gaining increased significance in specialized services, a sociological approach gaining increased significance in municipal and local services, and a "new" paradigm related to the introduction of trans-professional coordinating mechanisms as institutionalized organizational standards. These hypotheses are discussed on the basis of in-depth interviews with mental health planners and workers in municipalities and specialized services. The paper is referring to research undertaken in the project "Competence Developments in Mental Health – Strategies to Strengthen Competencies as Part of the Mental Health Reform" (NIBR/HiØ 2003). Here, we are particularly interested in the impact of mental health reform on the development of professional knowledge and performance. Documentary research and case studies are conducted within the national educational system and at mental health agencies. One aim of the project is to analyse how professional knowledge and competence develops in formal and informal arenas, and how mental health services manage the challenges of cooperation and coordination. The project is supported by the Research Council of Norway and implemented from 2002 to 2006.

Introduction.

"Carers get exasperated telling the same story over again, and do not know why service providers cannot talk to each other. Service providers get frustrated not being able to get help or information from other services. Researchers tell managers about the gap between policy and reality and show poor coordination between agencies. ...Everyone blames the government for lack of finance, and the government blames the public for opposing tax increases and providers for inefficiencies" (Øvretveit 1993:201).

Why is it so? And which strategies are available to obtain better coordination in complex, multiprofessional service systems? Here, I will discuss these questions relating to organization and profession theory. First, I address the problems of coordination in professional organizations. Then I discuss how problems of coordination are related to coping with multi-disciplinary knowledge in fragmented organization structures in mental health services. Finally, I sketch some trans-discipline/trans-professional approaches that are now being introduced as managerialist strategies to improve coordination of mental health services.

Background.

In this paper I argue that the status and role of professional knowledge systems are presently undergoing profound changes, in which professionalism and professional knowledge lose some of their status as the prime coordinating mechanism in the welfare state system. The argument goes as follows: In the making of the modern (Scandinavian) welfare state professional rationality represented a glue – a coordinating mechanism embedded in expert knowledge - in the design and implementation of welfare policies. Accordingly, the Scandinavian welfare states were labelled as a "Profession-State" (Dent 2003). This phase has been described as reflecting a "naïve" perspective on professions. In the ideological shift that took place since the end of the 1970's, critical approaches to professionalism and the "profession-state" idea were exposed by both left and right, advocating a "cynical" perspective on professionalism (Brante i Erichsen 1996). Here, the argument was threefold: at the client-professional level, it was argued that professional groups tended to advance personal interests under the cover of helping individual clients. At the organizational level, professions as employees achieved too much autonomy at the operational level, thus obstructing the making of efficient organizations. At a political level, professional iron

triangles – in which representatives of specific professions achieved key positions in the public sectors, by controlling knowledge production and recruitment, administrative systems (ministries and directorates) and operational levels – were said to gain too much influence over state policies. Notwithstanding the differences underlying political sentiments the "cynical" perspective were based upon, the solution would still be to "neutralize" professions at all three levels of professional performance. Accordingly the educational system has been changed, particularly for social and health professions. (Ramsdal 1994) Administrative structures have been thoroughly changed; e.g. in central administration. At the organizational level the introduction of New Public Management in local and central governance has changed the frames under which professional work is performed. At the client-professional level, user perspectives are strengthened at the cost of professional autonomy in the "closed room" at the operational levels of organization.

The efforts to "neutralize" professional power leave, however, new questions. In the modern state, expert knowledge is an inherent characteristic. In Scandinavia, and in Norway in particular, confrontational strategies on behalf of political authorities are most unlikely to be employed, and – with a few exceptions – have not been chosen. There is still a fundamental ambiguity in the relations between state and professions today – at all the levels outlined above. "Knowledge first, then profession" is the slogan of today's policies.

Coordinating professional organizations.

"Five coordinating mechanisms seem to explain the fundamental ways in which organizations coordinate their work: mutual adjustment, direct supervision, standardization of work processes, standardization of output, and standardization of skills" (Mintzberg 1979:3).

I will here concentrate upon how coordination and cooperation in multiprofessional systems are influenced by the arguments above. The relationship between professional knowledge and performance on the one side, and the concept of "coordination" on the other, is complex and ambiguous. First of all, professionalism relates to specialized knowledge, and represents the foremost expression of differentiation in modern societies. In the wake of – or rather as a hallmark of – the Scandinavian welfare state model professional expertise designed and implemented welfare policies in education, social welfare and health. In this respect, welfare

professions represented coordinating mechanisms, primarily by establishing “professional triangles”. Still, professionalism and specialization are generally considered not the solution to but the reason for coordinating problems.

Standardization of skills as prime coordinating mechanism is related to the archetype of “the professional bureaucracy”, in which the organization relies on the standardization of skills and knowledge of trained specialists. Professionals obtain skills and knowledge from outside the organization in which they work; in universities and profession schools. These professionals are hired to work at the operational level in the organization, and are given considerable control over their own work. “*The coordination of skills and knowledge works because everyone knows everyone else knows roughly what is going on*”. (Meyer quoted in Mintzberg 1979: 349)

In many ways, this is the description of an ideal type organization, scarcely found in real world organizations. Even as an ideal type, the professional bureaucracy has problems: first of all, even if we talk about a simple, uniprofessional structure, coordination problems are imminent. This is due to the way the professional bureaucracy functions in the operating core: the professional is expected to use a repertoire of standardized programs – in effect, the set of skills the professionals stand ready to use. These programs are applied to predetermined situations, so-called contingencies, also standardized. This process is known as *pigeonholing*, in which the professional has two basic tasks: 1) to categorize the client’s need in terms of a contingency, and 2) to apply, or execute, that program. In order to execute professional knowledge in this way, the organization has to decentralize its structure: A “great deal of the power over the operating work rests at the bottom of the structure, with the professionals at the operating core” (Mintzberg op.cit, p. 357).

The decentralized structure of professional organizations does not only hand over most influence over client-related work to professionals. Administrative and strategic power is considered an *extension* of professional knowledge. Thus, while the professionals are looking towards protecting the operating core, administrative and strategic functions suffer. Since outcomes are difficult to measure or translate to the outside world, their goals cannot easily be agreed upon. So the notion of a strategy – a single, integrated pattern of decisions common to the entire organization – loses a good deal of its meaning in the professional bureaucracy. The strategies of the professional bureaucracy are largely those of the individual professionals

within the organization, as well as the professional organizations at the outside. (op.cit, pp. 363 - 364).

The problems of coordination is one classic aspect of the literature of profession theory. In the terminology of Mintzberg these problems are related to a) the looseness of standardized professional knowledge, simply because this knowledge develops from "beneath" or from "the outside" - as scientific knowledge never stands still (Abbott 1989), and b) the pigeonholing process, in which an integrated strategy for the organization taken as a whole is hard to achieve. Coordinated strategies for structural change are particularly difficult to formulate if they are not being generated from within; i.e. from the developments of scientific knowledge itself, as other kinds of structural change transcend the borders of jurisdiction of the professionals' work.

Consequently, change in professional organizations is a slow process. It does not sweep in from government technocracies intent on bringing the professionals under control.

"Rather, change seeps in, by the slow process of changing the professionals...." (Mintzberg op.cit. p. 379).

Coordinating multiprofessional systems.

The problem with the professional bureaucracy is, however, that it presupposes that the knowledge – the expert status of the knowledge system represented by the profession is accepted as relevant for "solving" the problem at hand. If there is an acceptance of the uniqueness of the profession's knowledge system, there will be compatibility between a uni-professional system and the knowledge base. This is of course not always the case: in most fields of knowledge, different perspectives, approaches and paradigms might compete over which one would decide the design and performance in the particular work field. In a broader perspective, this relates to the "governability" approach (Foucault 1991, Johnson 1995).

The arguments put forward here indicate that even in a uni-professional organization problems of coordination and strategic change do occur. When we have health or social needs, it is rare that one profession alone is able to untie all the knots. As Øvretveit (1993) maintains, different specialists are needed, and *"often these specialists are employed by more*

than one agency, making coordination even more important but the difficulties of achieving it greater” (Øvretveit, 1993, p. 1) .

In a multi-professional setting, these problems are even harder to cope with. Firstly, while the individual profession (at least in theory) is working on the basis of standardized programs, coordinating multiprofessional systems requires knowledge, mentalities and/or attitudes that are not embedded as professional skills in the first place. Generally, coping with coordination in multiprofessional systems seems to evoke three alternative strategies:

- hierarchy – in which one profession gains the power to set the premises for how to coordinate the work,
- cooperation and collaboration – in which professionals labour together, act jointly, unite for a common effort,
- trans-disciplinary – usually managerial strategies.

Hierarchy has generally been associated with the ”pure” or ”archetypical” professions, first of all the medical profession. Based upon the scientific stronghold of medical science – and bio-medical knowledge in particular – doctors have gained the well-known position of controlling work at the operational levels, administrative and – until the last decades – the strategic level. This situation – which placed other professionals as ”assistants” to the doctors, is still being confirmed at the operational level, leaving decisions about treatment to the doctor, in accordance with the legal responsibilities of the medical profession. The more multi-professional the service system becomes, the more a uni-professional hierachial modell will be challenged

Cooperation and collaboration are strategies of cooordination that takes into account the multi-disciplinarity of complex service systems. ”Teams” and ”network organizations” generally presupposes that professionals both ”hand over ” to the team/network their knowledge capital, and are willing to compromise between different, sometimes opposing or contradictory approaches in order to make coordinated action take place. Accordingly, one must expect making teams and networks coordinated their effort in efficient (and not just symbolic) ways, is easier the more equal (similar) the scientific approach and the knowledge base is.

Trans-disciplinary (or trans-professional) strategies implies some kind of knowledge that transcends the specialization and differentiation of professionalism. While cooperation and collaboration means that actors (representing different professions) compromise through adaptation in a situational manner, trans-professional knowledge is formalized, generic and universal. Generally this knowledge is de-differentiated, managerial. Most often it is embedded in instrumental organization theory. Often these approaches to overcome coordination problems might be labelled "institutional standards", being a part of "modernization" strategies of service production. In a profession theory perspective these approaches are generally described as "heteronomization" or "bureaucratization" (Freidson 1994).

Empirical background.

Here, I will discuss how peculiarities in the multi-professional knowledge system and organization structure generates coordination problems in mental health services, and how strategies are developed to overcome these problems. The empirical study is based upon a longitudinal research project of mental health reform policies in Norway, and a case study of the dynamics of change in one county, including both municipal and specialized (regional/state) services. The study deals with how organizational change is performed in order to improve coordination and cooperation, which professional (and other) competencies are needed in order to achieve better coordination, and which responses are given to comprehensive change strategies by professionals at different levels and agencies in the mental health organization. The study is based upon data gathered in a 10 years span, from the beginning of the 1990s and the beginning of the new millenium, and comprises interviews with service providers and managers in 18 municipalities and the specialized services, and documents about the development of the service system.

Here, I will relate the findings to current reform policies – particularly the Mental Health Action Plan, and from the first study, and relate to tentative findings from the latest one. I will concentrate upon coordination problems and solutions at a general and strategic level, and particularly relate to the peculiarities of mental health knowledge and organization: to which extent and in which way is pigeonholing generating coordination problems in mental

health? And which responses are given to strategies to overcome coordination problems by service providers in the mental health organization?

Mental Health – Professional Knowledge Systems and Mental Health Policy

The World Report on Mental Health 2001 reflects an optimistic view on the present knowledge status of mental health disorders and future treatment strategies ("Mental Health: New Hope, New Understanding"): "*Efficient solutions for mental disorders are available. Advances in medical and psycho-social treatment means that most individuals and families can be helped*" (WHO 2001:109). Still, the present status of mental health policies worldwide is critical: "*Only a few countries have adequate mental health resources. Some have almost none*" (ibid.). The World report states that one third of the European countries still do not have a specific mental health policy, and among those that do, 70% were developed in the last ten years. As Knapp et al. argue, being generally neglected as a policy field, there is a huge variety in service provision, as well as in professional capacity (Knapp et al. 2002).

According to Knapp et al., this view on political neglect and service provision variation represents a challenge to policy makers, and particularly those seeking to harmonize healthcare provision in Europe. While actual policies vary substantially, there seems, however, to be agreement about the road ahead for mental health reforms. First of all to establish national policies, programmes and legislation, to de-institutionalize services by reducing hospitalization (i.e. "*non-institutional based care should be provided wherever possible*"), to strengthen community and primary care through decentralization, and evidence-based policies. These developments are, as pointed at in the WHO report, "*interestingly, ... initially stimulated by ideology, the development of pharmacological and psychotherapeutic treatment models, and the belief that community treatment could be more cost-effective*" (op cit 105).

Thus, the development of mental health service systems are grounded on a "field logic", in which it is primarily the capacities of professional knowledge in mental health and psychiatry that have triggered the reforms, and also pointed at recommended system changes. However, as Saltman (2002) maintains, health reform is not a linear function. On the contrary, reforms typically take place in a variety of political and operational levels, often with different paces and with different degrees of success. In the case of present mental health reforms, the "field

logics” or professional knowledge on its own terms is not a unified, integrated, evidence-based knowledge system, but rather a diverse, disintegrated and often conflicting field, where professional actors seek political legitimacy and support for a variety of ideological approaches and treatment strategies. As many authors argue, these ideological foundations function as a mirror to reflect the way society at large understands human nature and human rights in general – through its treatment of deviant behaviour and devalorized persons (Kristiansen 1996). Professional knowledge thus represents more than scientific evidence – it is by its nature interacting with political and ideological sentiments as well. More than many other fields, mental health service provision, ideological grounds and treatment models are embedded in scientism, and scientific knowledge lays the groundwork for reform policies and political decisions.

Historically, the dynamics of mental health services are thus reflected in the struggles between scientific paradigms and developments in scientific knowledge more than political and administrative initiatives on their own terms. The problem of governance in mental health services indicates the relationship between different ideological and professional approaches that were achieving a political mandate at different times in the development of the welfare state (Kickert et al 1999, Bogason 2000). Thus, it seems necessary to understand the intrinsic dynamics of mental health knowledge in order to understand the way service provision is organized.

In accordance with the World Report mental health disorders might be understood differently from the angle of a biological, psychological or sociological paradigm respectively. While the biological explanations of mental disorders concentrate upon ”understanding the brain” and emphasize the advances in neuroscience, psychological explanations stress the need for un- or re-programming the personality, while sociological approaches generally see poverty, urbanization, and deterioration of social networks in the local community as the main explanations to mental health problems (WHO 2001:6).

Epistemologically speaking these basic understandings are regarded as alternatives, and are often seen as theoretically contradicting. This is particularly the case when it comes to implications for the esteem and power of mental health professional groups – where the biomedical profession has had the upper hand in modern mental health through psychiatry as a medical speciality. In addition, competing ideologies and therapeutic approaches imply

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different principles of organizational design. As a deduction of the biomedical paradigm, the principles of service provision organizations were hospitalization and institutionalization. A psychological approach is individualistic or group oriented, but are adaptable to both hospitalization and community work frames. Psychosocial and sociological approaches strongly oppose institutionalization, favouring preventive strategies and normalization as a "new" paradigm in service provision.

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Still the World Report maintains that the " ...artificial separation of biological from psychological and social factors has been a formidable obstacle to a true understanding of mental and behavioural disorders. In reality, these disorders are similar to many physical illnesses in that they are the result of a complex interaction of all these factors" (WHO 2001:10). Consequently, an "integrated knowledge model" of mental health service provision is recommended. The problem is, of course, that in making the service provision integrated, you have to clarify which professionals are to do what and where in the service chain, which distribution of resources between hospital beds, community care, and preventive strategies are considered adequate, etc. Here, one would expect professional pigeon-holing and parochialism, often in the shape of symbolic struggles on "how many beds are necessary in 'modern' mental health treatment?". The lack of political responses to mental health problems in society is consequently not merely a simple lack of interest in deviances and stigmatized groups, but also the lack of scientific unification upon which social engineering and political clout can be constructed.

Mental Health Policies and the Dynamics of the Service System in Norway

The development of psychiatric and mental health services in Norway follows the general pattern of welfare state dynamics, but with some peculiarities. Modernization of national welfare policies has up until recently, in general terms, primarily been the result of broad alliances between political and professional actors. The health sector – by some authors labelled "the Queen of the Welfare State" (Slagstad 1998) - incarnated the integration of political ambitions and professional management. From their beginning psychiatric services have, for their part, been dominated by the medical profession and political bodies were reluctant to challenge suggestions put forward by psychiatrists. Thus, psychiatrists attained monopoly over what was regarded as relevant knowledge, simultaneously administrating the

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mental health central administration and dominating the local implementation of mental health policies in the capacity of combined professional and administrative leaders in the mental health hospitals (Ludvigsen 1997).

The "professional iron triangle" of the medical profession thus dominated education and research, central administration (the Directorate of Health in particular) and service provision. One aspect in this development was a strong emphasis on hospitalization and institutionalization. The peak of hospital bed numbers was reached in 1965, with more than 8500 patients. Since then there has been a substantial reduction up to now; the number of patients is currently 2000 (Pedersen 2002). In contrast to the high-profiled de-institutionalization policies in some other countries – USA and Italy in particular - the Norwegian experience continued without much attention – even in Norway. It was widely regarded as a "silent revolution"; the main explanation being the decentralized structure of Norwegian politics. The nineteen counties, as semi-autonomous political and administrative bodies, reduced hospital beds in incremental processes. State policies played a minor role and national programmes for mental health reforms did not exist.

De-institutionalization in this period reflects, at least partly, a change in mental health knowledge systems. During the 1970s and 80s, the mono-professional domination of the medical profession came under pressure. First of all, new professional groups, such as psychologists, nurses and social workers claimed influence. Second, the growth of local health and social services following the Municipal Act of General Health Care in 1982 specified all citizens' rights to preventive measures, treatment, medical rehabilitation and community care, etc., without mentioning people with mental disorders specifically. In a governmental directive three years later, the municipalities were reminded that people with mental health disorders were also to be granted local services in line with other citizens. Thus, mental health service provision in the municipalities, at least formally, slipped out of the hands of the psychiatrists, as GPs, nurses and social workers ran local services. Finally, through extensive reorganization of the administrative system of health services – in particular by limiting the status and power of the Health Directorate – and during the 1980s, the medical "professional triangle" was broken, and political bodies strengthened their capacity to steer national health policies.

The combined results of these developments, which took place as incremental, uncoordinated processes, were that in the beginning of 1990s psychiatric and mental health services saw a substantial reduction of mental hospital beds numbers. At the same time extramural specialized services – polyclinic services in particular – and municipal general services added to the complexity. Additionally, the medical profession was challenged as new professions were introduced in mental hospitals, but first of all in the municipalities. Thus, biomedical knowledge came under pressure - both from within, as medical knowledge itself became more diversified - and from the outside, as psychological and sociological paradigms presented alternative treatment and work organizations.

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The complexity in knowledge systems and professional ambitions obviously put political reformers in an almost paradoxical situation. On the one hand, professional differentiation gave the politicians an upper hand as they could now attain some professional support for almost any reform proposal. On the other hand, as the political competencies for steering the mental health services during the years of the "professional iron triangle" regime had deteriorated, most politicians gladly would abstain from putting their hands into the turmoil of professional and scientific struggle over how to reform the services. In accordance with this reasoning, and in a Norwegian tradition of pragmatism and compromise, psychiatric and mental health policies were (and still are) officially labelled "eclectic" in its knowledge base, much in accordance with the "integrated model" presented by the WHO.

The Mental Health Action Plan and coordination problems revisited.

In 1998 a Mental Health Action Plan was initiated in Norway. The Action Plan was a comprehensive approach to both specialized services ("psychiatric services") and municipal service provision to "people with mental health problems" in general. The implementation of the Action Plan reflects the combined influences of mental health reform policies and NPM-related modernization of the public sector (i.e. state-municipal relations in particular) (Ramsdal et al. 2002). The Action Plan is a high-profiled, ambitious reform strategy, with high hopes to overcome the present crisis. The modernization strategies of public services in general are, however, embedded in principles of devolution and fragmentation. Representatives of mental health obviously would like to see traditional state steering mechanisms, such as goal setting, detailed claims for service provision structure(s) and

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specified professional groups, imposed upon municipalities as the most efficient reform strategy. The current modernization regime, however, focuses on coordination of results “and nothing else” (Mintzberg 1979).

The evaluations of mental health developments in the wake of the Action Plan indicates that there has been a substantial increase in public expenditures, employees and services since the Action Plan was introduced. On the other hand, the quality of the services has not improved accordingly. In particular, coordination problems are considered just as serious as in the Action Plan White Paper five years ago: The Directorate of Health (which is the central unit responsible for implementing the Action Plan, maintains that: Coordination between local and specialized services “are inadequate”, the distribution of expert knowledge, and cooperation between professionals is inadequate as well (Sosial- og helsedirektoratet 2003: 23). The Council for Mental Health too sums up that services are characterized by “organized discontinuity”, and that users’ perspectives are not taken into consideration in coordinating and delivering services (Rådet for psykisk helse 2003: 4).

Coordination problems and strategies: Some empirical findings.

The case study from the beginning of the 1990’s, indicated that the severe coordination problems that some years later were described in the Action Plan could be identified at all levels in the mental health organization:

At the operational level, the bio-medical approach dominated professional work in a hierachial manner. In specializeed services this was obvious, but even in the municipalities mental health was associated with the specialized knowledge of psychiatrists, and generally being left to specialized services. Other studies indicate that even when specialized agencies designed especially for multi-discipline approaches were set up, (bio-)medical knowledge still dominated (Skærbek 2003). Thus, the uni-professional approach, and hierachial coordination played an important role at the operational level.

At the strategic level, ”fleshing out the superstructure” on the basis of discussions among professional groups about long-term goals, target groups, structure and priorities stranded. In effect, representantives of the professions (in the capacity of agency managers etc.) concluded

their 5-year efforts to agree upon a strategic plan for mental health services in the county by saying that the (despised) top managers and county politicians had to decide how to change the system in a comprehensive way (Ramsdal 1996).

So far, these findings seem to confirm the overall coordination problems of the professional bureaucracy as outlined above. Still, how come that the Action Plan does not seem to improve the coordinating capacities of the system?

First, as mentioned above, the Action Plan not only expands the size of the organization, by adding more money, employees and agencies to the service system. In addition, new target groups have been integrated into the Action Plan, as well as a stronger emphasis upon health and social preventive work in addition to medical treatment and community care. Secondly, the Action Plan's success in achieving less stigma to people with mental problems have also created more pressure upon services. This might easily make the success of the Action Plan look like a failure as waiting lists grow longer and the quality of services do not improve according to plans ("running to stand still" as it might be phrased). The problem here is of course that while the quantitative goals of the Action Plan are getting fulfilled, the coordination problems most likely will continue to haunt the services.

How can these these coordination problems be explained?

Hierarchical medical coordination

As mentioned above, some of the problems are related to the fact that the medical profession acts as if they were running a uni-professional organization, and by hierarchical measures maintaining their powers in spite of the situation the mental health organization is developing into. Here, the complexity of the target groups for the reforms, and the non-medical approaches to the new tasks being imposed upon the system, makes hierarchical coordination on behalf of one profession ever more incompatible with the service system.

Cooperation and collaboration

The main reason for coordination problems in the case study was, however, the way cooperation and collaboration took place. Disagreements within the individual profession (e.g. the psychiatrists), and not least between professional groups, were structured both on scientific, "paradigmatic" differences, but also disagreements over which clients and which

treatment methods should be given priority. Put together, crosscutting cleavages appeared everywhere professionals discussed the design and priorities of the future service system. Accordingly, when coordination and collaboration among professions were imposed upon them, the counter-strategy was "negative coordination", legitimized under the concept of eclectic mental health. This had two implications:

First, debates over e.g. professional treatment methods were transformed into administrative debates, thus avoiding "unproductive" conflicts no one believed might be solved – now or ever. At the administrative level, not only structuring services, but also some questions with a lot of symbolic implications were discussed at length: how many beds do we actually have in specialized services today – how many will be needed in the future? Here, the discussion took the shape of the beneath the table "fight over the bishop's stick" – the symbolic (and to outside observers completely incomprehensible) power struggle described by Bourdieu ().

Second, as a strategy for avoiding professional conflict, negative coordination took the shape of departmentalization and fragmentation: "if you don't intervene in mine/ours' affairs, we won't intervene in yours". Thus the agencies had to find "small-scale" collaboration – rarely formalized – to deal with the obvious needs for coordinated services on behalf of the clients.

While the explanations given here have been based upon the responses of professional actors (as individuals or as groups) the underlying explanation for the coordination problems discussed above are to be found in the characteristics of the mental health service system as described above: The "eclecticism" of mental health work gave all professional approaches legitimacy, and served as a scapegoat for not discussing professional issues in a systematic and open way.

Crosscutting cleavages between paradigmatic approaches (bio-medical, sociological and psychological), between different treatment methods, added to the departmentalization of the service system. In sum, the forces opposing comprehensive coordination based upon professional knowledge were far stronger than the overall need for coordinating the services as seen from the clients', managers' and politicians' perspective.

Trans-professional cooperation.

It seems obvious that neither political authorities, managers nor the public at large will tolerate the consequences of inadequate coordination of professional work in mental health services in the long run. Several policy documents indicate an increasing impatience with the service provision in this respect. Truly, several coordinating measures have been initiated. Some of these represent a fundamental change in the organization of health services in general, e.g. the Health Reform of 2000 and the "modern" municipal administrative models embracing mental health services as well. Here, the "divisionalized form" described as one organizational "archetype" by Minzberg is putting the mental health services – and all other public services likewise – under a "carpet" of the New Public management regime. One aspect is that here, professional power at the operational level is regarded as a steering problem, and professional knowledge has to adapt to the overall goals and values of the organization. The prime coordination mechanism is output (generally this means a formal structure with result units) and professional knowledge is "reduced" to one among many ways to obtain the organization's goals. Within the "coordination by output" rationale, several coordinating devices and tools are at hand. The common denominator for these instruments is that they are "profession-blind" – meaning that the instruments are based upon a "de-differentiated" knowledge base. This is reflected in both ways: These instruments have no conceptualization or understanding of mental health (or any other "substantial") problems as such. And curricula from profession schools and universities hardly mention these "new" ways of coordination.

Still, several coordination instruments are designed to accommodate mental health services (KPA: "Coordination of Psycho-social Work", CCM: "Clinical Case Management" (Onyett 1998)). These instruments relate to the overall making of Individual Plans which is now mandatory for all clients with longterm and complex problems in need for health and social services. Behind these there were efforts to create better trans-professional coordination "hardcore" coordination instruments where "Business Process Reengineering" tools are at work. Here the focus is solely on the "production process". In private production, models to reorganize production lines to make them "lean and flat", fast and efficient, are increasingly changing not only organizational design, but recruitment and employees' competencies as well (Hammer and Champy 1985). The focus on "logistics" in these models has already been

adapted to several somatic hospitals, in order to improve the patients' flow through the "production line". Probably, mental hospital managers very soon will jump on the patient flow coordination train as well. When the international research about new and even increasing coordination problems in the divisionalized/result unit-structures of "modern" organization is confirmed by experience in Norway as well, "process perspectives" briefly outlined here represent the next step in adapting models and perspectives from the private sector (Ramsdal and Skorstad 2004).

To the extent that trans-professional coordination takes place by means of BPR-related instruments, this will profoundly change the strategic power of the health professions. Organization theorists and experts on logistics in particular will intervene into the organization of work at the operational level, thus breaking through the idea that there is a division between "neo-bureaucratization" at the managerial/strategic level and continuous professional autonomy at the operational level, even under the modernization regime of our days. This idea, which is held by many political scientists, that modernization programs generally do not influence professional work at the operational level (see Brunsson 1989, DiMaggio and Powell 1991), seems to be even less relevant in the future.

Coordination - from professional deadlock to "technocratic fallacy"?

Based upon research of the coordination problems in service provision in mental health, I have argued that the problems facing mental health in this respect to a large extent reflect coordination problems in professional bureaucracies generally: pigeonholing is a key word. These problems generate, however, also from peculiarities in the mental health service organization: Here, conflicting professional perspectives and knowledge systems add to the fragmented organization structure. Paradoxically, the expansion of the services – triggered by the Action Plan for Mental Health – might easily add to the coordination problems. Obviously, the continuous coordination problems are not acceptable to policy makers and the general public– and probably not even for the professionals themselves. Consequently, new coordination strategies are initiated. Some of these strategies are adapted from private production theories, in which trans-professional coordination instruments are at hand. In the future to come, these approaches may well influence profoundly the role of professionals. A "production line" approach most probably will be adequate to just a few clients in mental

health, given the complexity of mental health problems. Here, the lack of "substantial" knowledge can easily make trans-professional coordination instruments fall into the trap of a "technocratic fallacy". Standardization of outputs and the belief in social engineering that these new perspectives represent, must be met with new questions about what is lost and what is gained by these developments. That's another story.

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