Chapter 8. Professionals and non-professionals collaborating in the provision of psychiatric rehabilitation services. The case of care farms

Abstract

Care farms represent a growing sector in psychiatric rehabilitation. The addition of farmers to mental health care teams raises questions regarding how collaboration between professionals and non-professionals develops. This study is the first to consider the benefits and challenges of collaboration between professionals and non-professionals in psychiatric rehabilitation. It explores collaboration between rehabilitation professionals and care farmers in the Netherlands, based on semi-structured interviews with 17 rehabilitation professionals and 11 care farmers. For rehabilitation professionals, the collaboration helped broaden the range of services they could offer, and provided low-entry work opportunities in green spaces where stigma and discrimination seemed a lesser issue than in other settings. For care farmers, the collaboration formalized referrals to their farms, and helped them establish themselves in a new field. Challenges arose as a result of different perspectives on how care farm services should be provided, and differences of opinion regarding financial arrangements. We conclude with three lessons regarding collaboration on the provision of rehabilitation services between professionals and non-professionals on care farms.
Introduction

People with serious mental disorders encounter complex challenges in their daily lives, for example, in establishing and maintaining social relations, in finding and keeping jobs, or in fully participating in society (Rössler, 2006). Addressing the complex needs of people with mental disorders requires the coordinated efforts of several types of mental health professionals, such as psychiatrists, psychologists, nurses, and rehabilitation professionals, each focusing on different aspects of the same person (Duggan, 1997; Rössler, 2006). Interprofessional collaboration allows for an integrated approach to treatment and rehabilitation, and promote a patient-centred model of care. However, facilitating the integration and participation of people with mental disorders in society often requires that rehabilitation professionals need to reach beyond the realm of mental health care services (Le Boutillier et al., 2011; Rössler, 2006; Slade, 2012; Ware et al., 2007).

In health care, collaboration between care services and non-health care organizations (such as, for example, information technology companies), has been popular since the 1990s because of expectations that collaboration would reduce costs, increase efficiency and improve quality, and allow care services to focus on their core activities (Young, 2008). However, recent studies indicate that expectations might not always be met and that the trend towards collaboration might be in decline (Young & Macinati, 2012). Failed experiments in the field of collaboration are costly. For psychiatric rehabilitation, potential failure might undermine the final goal of facilitating the integration of people with mental disorders in communities. Therefore, a better understanding of benefits and challenges associated with collaboration might help rehabilitation professionals and non-professionals build realistic, well-matched and sustainable collaboration.

The current article aims to provide insights into these issues using the case of care farms in the Netherlands. Care farms represent private farms used “as a base for promoting mental and physical health, through normal farming activity” (Hine et al., 2008). Currently, more than 4000 care farms are providing services to people with disabilities throughout Europe (Di Iacovo & O’Connor, 2009). Among them, the Netherlands hosts the largest number of private care farms (Haubenhofer et al., 2010). In 2005, one third of the private care farms in the Netherlands collaborated with health care organizations (Hassink et al., 2007). This means that both services and care farmers have accumulated sufficient expertise to be able to articulate the benefits and challenges of their collaboration. The exploration of the Dutch experience could yield valuable lessons for other countries, such as Norway, where care farms
Professionals and non-professionals collaborating in the provision of psychiatric rehabilitation services are viewed positively by mental health care providers, and where collaboration is expected to increase (Berget et al., 2008b; Berget & Grepperud, 2011).

This study is part of a larger quantitative and qualitative research that analyses care farm services in relation to rehabilitation services in the Netherlands. The analysis of care farm service characteristics, and the assessment of aspects related to their organization, the rehabilitation process, and the relation with family members and local communities, are reported elsewhere (Iancu et al., under review; Iancu, Zweekhorst, Veltman, van Balkom, & Bunders, in press; Iancu, Zweekhorst, Veltman, van Balkom, & Bunders, submitted).

**Methods**

Given the scarcity of research on the relationship between mental health care organizations (MHCOs) and care farms (CFs), we have chosen an exploratory, qualitative approach (Babbie, 1989) consisting of semi-structured interviews with rehabilitation professionals and care farmers in the Netherlands.

**Recruitment of study participants**

Rehabilitation professionals were recruited using the online directory of the Professional Association for Mental Health and Addiction (In Dutch: *Vereniging Geestelijke Gezondheidszorg Nederland*) (www.ggznederland.nl). We reviewed the information published on the website of each MHCO, and identified those collaborating with CFs. Among these, we randomly contacted organizations until data saturation was reached. A maximum of two interviews were conducted within each organization, with professionals who fulfilled different roles. Organizations confirmed their involvement in collaboration and provided contact details for the employees most involved in or knowledgeable of the collaboration. These were subsequently invited to participate in the study. We encountered no refusals, and therefore interviewed 15 rehabilitation professionals from 12 MHCOs: 8 managers of day centres / rehabilitation departments, 3 job coaches, 2 day care supervisors, one social nurse and one director. Ten organizations provided psychiatric treatment as well as rehabilitation interventions; one was an addiction centre; and one provided supported housing. In addition, a rehabilitation professional from the Dutch Ministry of Health, and one from the Professional Association for Mental Health and Addiction, were interviewed. This strategy yielded a sample of 17 rehabilitation professionals at 14 organizations.

The recruitment of care farmers followed a similar approach. We used the directory of the Federation for Agriculture and Care (In Dutch: *Federatie Landbouw en Zorg*)
(www.zorgboeren.nl) to identify CFs that provided services to people with mental disorders. CFs were approached randomly for an interview with the person(s) responsible for the provision of services, until data saturation was reached. Five farmers declined participation due to busy schedules, resulting in a sample of 11 private CFs involved in collaboration with one or more MHCOs.

Data collection

Data were collected through face-to-face, semi-structured interviews discussing four major topics: developments that paved the way for collaboration, how MHCOs and CFs collaborated, benefits they derived and challenges they experienced. Interviews lasted between 1 and 1.5 hours. All interviews were digitally recorded after obtaining participants’ approval, and transcribed verbatim.

Data analysis

Unique study IDs were assigned to each participant. Qualitative data analysis was conducted with ATLAS.ti (version 6.2.). A structural analysis was conducted, by exploring, labelling, categorizing and integrating the data using pattern matching and analytic induction. The coding structure was developed through an integrated approach, starting with topics described above. Within each topic, the various concepts were coded inductively as they emerged from the data. Quotes from the interviews were translated from Dutch to English by the second author.

Results

Developments that paved the way for collaboration: rehabilitation professionals

In describing the events that led to the collaborations with CFs, rehabilitation professionals referred to a gradual change in the general understanding of the needs of people with mental disorders which paralleled the development of the policy for rehabilitation services in the Netherlands. Policy for rehabilitation services has been through the following phases: the organization of supported housing facilities for people with mental disorders (1980s), the establishment and growth of day activity centres offering daytime occupations for people with mental disorders (1990s); and the increasing focus on the provision of work opportunities and vocational rehabilitation outside the mental health services during the past decade. The latter development was seen by many rehabilitation professionals as an attempt to address the need
Professionals and non-professionals collaborating in the provision of psychiatric rehabilitation services

for social integration of people with serious mental disorders, not previously central in the provision of mental health care. Currently, mental health care services increasingly aim to assist people with mental disorders in working and living in the community, with as little reliance on professional help as possible. Rehabilitation professionals considered this approach to be an innovative addition to the way they provide services. Interdisciplinary teams of clinicians and rehabilitation professionals aim to ensure the continuity of treatment and integration of a recovery-oriented approach into the rehabilitation strategy. This involves an assessment of users’ needs, abilities and aspirations, and the recommendation of suitable services, within or outside the MHCO. Given the focus on work rather than day care activities, rehabilitation professionals stimulate people with serious mental disorders to consider vocational rehabilitation, preferably outside the MHCO.

In order to be able to offer different types of vocational rehabilitation services, rehabilitation professionals search for work opportunities in the community. In this context, CFs provide interesting opportunities due to several key characteristics that set them apart from the services provided within the MHCOs. As such, CFs are small-scale, real-life settings, in close proximity to communities, where users can do meaningful work, are approached as co-workers (rather than patients) and are socially involved with people with and without disabilities, such as farm workers, family members, and visitors (rather than just with peers).

“It is a different kind of work than what we offer. It involves often very small groups, a business that earns its money from other sources, where clients can just work along.” (Day care supervisor, study ID=3)

“Often, you find yourself in a warm atmosphere, which for these people is very nice. Certainly by a family – some people have had, for a long time, minimal social contacts, and the moment they come in such a farm, their network becomes larger” (Manager, study ID=10)

**Developments that paved the way for collaboration: care farmers**

Care farmers described two developments that led them to start the CF and subsequently to collaborate with MHCOs. The first related to economic problems that were triggered by changes in the agricultural sector, such as decreasing milk prices, increasing land prices, and stricter regulations regarding farming procedures and equipment. These created uncertainties regarding the sustainability of farms, and determined farmers to look for additional income sources. The choice to provide day services was, in most cases, circumstantial. Some farmers had been influenced by their relatives (wives or sisters) who worked in health or social care, and who wanted to combine their profession with income generating activities on the family farm. Other care farmers were health or social workers who wanted to start new careers on
farms and who rented the land and equipment in order to start a new profession (professional reasons).

The second development was concerned with care farmers’ perception of the need to change the general public’s negative image of the agricultural sector, an image linked to the consequences of intensive agriculture. Interviewees argued that the production of organic foods had gone some way to improve public perceptions of farms and farmers. They expected that the provision of services for vulnerable people on farms would also be viewed positively by the community, helping the agricultural sector to further improve its relationship with society.

Whatever their motivation for becoming care farmers, farmers described the provision of services on farms as an extension of a traditional way of life, in which people were sensitive to others’ needs – for example, younger and older generations living together and taking care of each other. The ability to respond to others’ needs made it easy for people with mental disorders to integrate into the farm environment. Here, users were treated not as patients but like any other co-worker, and they could build close relationships with others because care farms tend to accommodate only small groups. Care farmers’ descriptions of CFs were consistent with the rehabilitation professionals’ vision, facilitating collaboration.

**How mental health care organizations and care farms collaborate**

Involvement in collaboration was portrayed as an active choice by both MHCOs and CFs, and was formalized by contracts. Contracts specified roles and responsibilities of each partner, schedules and types of activities provided, possibilities for knowledge transfer (through workshops, information materials, formal communication channels, or joint supervision of users on the CFs) and financial arrangements. Generally, collaboration was established directly between MHCOs and CFs, and contact was initially made through informal networks. However, collaboration could also be mediated by intermediary organizations, which provided additional advantages. For example, intermediary organizations were connected to several MHCOs and CFs. Access to such networks helped rehabilitation professionals to match users’ preferences with the services provided on the farm, and helped care farmers to gain access to users. Moreover, some intermediary organizations were accredited as care providers. For rehabilitation professionals, this accreditation served as a guarantee of the quality of services offered on CFs, and decreased their perception of risk regarding collaboration with non-professionals.
Benefits of collaboration: rehabilitation professionals

Rehabilitation professionals described the benefits of collaboration in the light of the difficulties they encountered in their own field, especially difficulties in finding work opportunities for people with mental disorders in the community. One difficulty related to the fact that people with mental disabilities often lack the commitment, the personal responsibility, or the basic working skills required of workers or interns in regular businesses. For this group, integration into a normal work environment was a step too far. However, most rehabilitation professionals experienced care farmers as sensitive to the difficulties faced by people with mental disorders when starting to work. For example, farmers allowed flexible schedules and created low-entry conditions into a real work environment. As a consequence, users were offered the opportunity to undertake meaningful work, to improve work and social skills, to increase their work motivation, to increase their self-esteem and to develop a sense of personal responsibility.

A second difficulty in finding work opportunities outside MHCOs related to the societal stigma facing people with mental disorders. Rehabilitation professionals argued that potential employers on the open labour market were influenced by the “bad reputation” of psychiatric patients and were hesitant to employ them because they expected problems, such as aggression or drug addiction. Therefore, rehabilitation professionals found it difficult to encourage local businesses to collaborate with them which meant that, in the community, work opportunities for people with mental disorders were scarce. However, CFs seemed not to discriminate against between people with mental disorders. Some interviewees argued that care farmers were tolerant of people with mental disorders, accepted them for who they were and welcomed them on the farm, despite occasional deviant behaviour which would not be accepted by other businesses.

“It is really (...) live and let live. A lot of respect is just present there. Really, the guys working there can’t be placed anywhere else. You’re allowed to act weird, be angry, say strange things. The next day, you can still come back, perfect.” (Social nurse, study ID=8)

In addition, several rehabilitation professionals pointed out that some users also expressed a desire to be in green, open environments, and to work with animals and plants. Since MHCOs could not themselves offer services in green environments, they welcomed the collaboration with CFs as a means to better match users’ needs with services, in line with the user-centred approach of rehabilitation.

Benefits of collaboration: care farmers

Care farmers described the benefits of collaboration in the context of the difficulties they encountered in their roles as service providers. One difficulty referred to reaching potential
users of their care farm services, namely people with disabilities looking for opportunities for day activities and work. The marketing strategies care farmers had used (such as advertisement via personal networks, organization of open days or announcements in the print and online media) seemed unreliable. In contrast, contract-based collaboration with MHCOs formalized referral routes, ensured a constant flow of users, and decreased the uncertain sustainability of CF services.

Collaboration also helped some care farmers fulfil their roles as services providers for people with disabilities. This was experienced differently by care farmers with and without prior training in health or social care. Care farmers with no prior training who felt insecure when starting the CF, welcomed collaboration with MHCOs that were searching for work opportunities in communities. Care farmers offered to provide activities for small groups of users, often free of charge, when rehabilitation professionals joined the groups and supervised users. This strategy allowed care farmers to work alongside and learn from supervisors, thus growing into their professional roles. Care farmers with prior training in health or social care felt more comfortable with providing supervision to users with mental disorders on a daily basis, but were apprehensive about the possibility of users becoming aggressive or experiencing episodes of psychosis. For these care farmers, the collaboration with MHCOs provided quick access to professional expertise, and provided a safety net that diminished the perception of risk related to their roles as service providers. The importance of maintaining close contact was confirmed by some rehabilitation professionals who argued that regular telephone consultations allowed them to intervene quickly when needed, sometimes by involving clinicians.

**Challenges in collaboration: rehabilitation professionals**

Challenges in collaboration were, according to the interviews, mostly related to the fact that rehabilitation professionals and care farmers have different frames of references on CFs and have different backgrounds.

For rehabilitation professionals, the goal was to stimulate users in becoming active, to support them in acquiring basic work and communication skills, and to guide them in finding jobs on the labour market. Therefore, they viewed care farm services as beneficial as long as they helped users in achieving similar goals. However, some rehabilitation professionals wondered if care farmers, as newcomers in the field of rehabilitation, were sufficiently equipped to monitor users' progress and to inspire them to envision new goals. Other rehabilitation professionals argued that care farmers, as entrepreneurs in search of additional income, might not have a rehabilitation agenda but, rather, act from a commercial
perspective that endangered the qualities of CFs. For example, increases in service capacity to maximize income might be justified from a commercial perspective but could endanger the small-scale quality of CFs. Therefore, rehabilitation professionals are concerned to orchestrate the collaboration, and impose conditions to safeguarded users’ interests and to ensure a certain quality of CF services.

“We found a way, how to professionalize together with that care farmer. Because we took the lead, by stating that day activities are a permanent part of treatment. The rehabilitation professional together with the user set the goals and we [rehabilitation professionals] provide care together with the farmer. I think you need to do that in this order, also to appreciate the farmer’s skills. A farm is a commercial business. He would benefit from having ten clients now and twenty next week, to increase the income. However, as care institute, you need to take precautions, and indicate: ‘we don’t want that’. Provide the farmers with enough space to be a commercial entrepreneur and let us then say: ‘you can have two [users], this is how care needs to be provided, this is the mission and that’s it’.” (Manager, study ID=9)

Furthermore, rehabilitation professionals indicated that, even when they could safeguard the quality of services provided on the collaborating CFs, they sometimes encountered difficulties in recovering the related costs from health insurance organizations. These organizations sometimes refused to cover the costs of CF services because of the perceived lack of scientific evidence of their effectiveness. Some rehabilitation professionals felt that such refusals weakened their position among other mental health professionals (such as psychiatrists, psychologists and nurses), whose practices followed the lines of evidence-based research.

Challenges in collaboration: care farmers

For care farmers, the main challenge related to establishing or maintaining their farming practice in relative independence from MHCOs. This was described in the context of a power struggle between partners during the negotiation phase, when MHCOs tried to impose their conditions regarding how farm services would be organized. Many care farmers argued that, in the interaction with users, they tended to rely on common sense and intuition, and to plan activities on a day-to-day basis, thus distinguishing themselves from the goals-and-plans approach used by rehabilitation professionals. In the words of a care farmer:

“At the care farm, it is just the farmer who guides the people with his common sense. I did some courses, but in principle, you do this from your heart, your gut feeling. And not from a theoretical book telling you how to deal with somebody with Down syndrome or borderline [personality disorder]. (…) In principle it is a kind of day activity, but what goals
you need to set for someone, well, that’s something you sometimes just don’t know.” (Care farmer, study ID=15)

The second challenge experienced by some care farmers in collaboration with MHCOs related to the mismatch between provision of employment and provision of care. Rehabilitation professionals sometimes considered the work of users as contributing to the agricultural production of CFs, and therefore to the income of the care farmers. From this perspective, they argued that users should be remunerated for their work. However, care farmers indicated that users required intensive, time-consuming guidance and do not contribute sufficiently to the agricultural production. Moreover, care farmers indicated that they needed to hire others to do the farm-related work because they were providing supervision and did not have time to do this work themselves. Therefore, they felt that they should be paid for CF services.

Discussion

In this study, we explore different aspects of the collaboration between rehabilitation professionals and care farmers in the Netherlands. Our results demonstrate an increased focus on work and social integration of people with mental disorders, as well as the economic developments in the agricultural sector, as essential developments that had paved the way for collaboration between rehabilitation professionals and care farmers. For rehabilitation professionals, such collaboration makes it possible to offer users low-entry work opportunities in green spaces, where stigma and discrimination seem less of a problem than in other settings. For care farmers, collaboration makes it possible to formalize referral routes, learn competencies relevant for the new field and provides a safety net in service provision. However, collaboration is not always without difficulties. Challenges arise as a result of the different perspectives of rehabilitation professionals and care farmers: the former view care farmers as newcomers whose lack of professional knowledge and skills, as well as perhaps an economically motivated agenda, jeopardize the goal of rehabilitation, whereas care farmers consider that rehabilitation professionals intrude into their practices.

Collaboration, whether direct or mediated by intermediary organizations, was an active choice of both rehabilitation professionals and care farmers. In 2006, the World Health Organization proposed that “non-professional workers can help meet some of the demand for care as long as they are competent and supervised, and can draw upon professional staff when necessary to deal with complex cases” (World Health Organization, 2006). Indeed, the current study suggests that collaboration with non-professionals, such as care farmers, might help
Professionals and non-professionals collaborating in the provision of psychiatric rehabilitation services

rehabilitation professionals with some of the difficulties they experience in their work, broadening the range of interventions available for people with mental disorders and bringing users closer to communities, thus facilitating their social integration. Furthermore, the current study specifies some of the conditions under which professionals and non-professionals in mental health collaborate, and draws three major lessons.

The first lesson is that a shared vision of the scope of their collaboration represents the basis for collaboration between professionals and non-professionals. In our study, both rehabilitation professionals and care farmers viewed CFs as small-scale, community based settings offering meaningful work and socialization opportunities in non-care environments. Furthermore, our study shows that, despite a shared vision on CFs, professionals and non-professionals differed in their backgrounds and hold different frames of reference. These frames of reference are learned during professional training (rehabilitation professionals) or during participating in a traditional way of life (farmers), and therefore might be difficult to change. Care farmers are focused on the current, day-to-day organization of tasks and activities, guided by common sense and intuition, whereas rehabilitation professionals appreciated CFs because of their potential contribution to current, as well as long term rehabilitation. Therefore, collaboration requires that both partners need to make the effort to consider, understand and integrate the view of the other. This is the second lesson to be derived from this study.

The first two lessons are in line with the results of a systematic review of the literature on determinants of successful interprofessional collaboration. Among determinants, authors identified the ability of partners to acquire a common vision and to develop mutually-relevant goals, the establishment of trust and mutual respect (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005). These seem to be ingredients of good interpersonal relationships that can help service providers, professionals and non-professionals alike to transcend their own frames of reference and engage in successful collaboration that can benefit users.

The final lesson refers to the potential of CFs in the rehabilitation of people with mental disorders. CFs seem to combine the sheltered character of dedicated services with the real-life setting of productive business. Not surprisingly, many rehabilitation professionals depicted CFs as transitional work places where users who wanted to work, but lacked needed competencies and motivation, could explore and train generic work and social skills that would further help them pursue vocational goals. This view on the role of CFs as prevocational services is supported by a systematic review of the literature, which showed that basic work and social skills could be the very ingredients needed for advancing vocational rehabilitation of people with mental disorders (Michon et al., 2005). However, the literature on CFs has still to explore the vocational outcomes of CF users. Qualitative studies suggest that CF users experience the occupational dimension of CFs as beneficial (Hassink, Elings, et al., 2010;
Pedersen, Ihlebaek, et al., 2012), but a quantitative analysis failed to reveal significant improvements in users’ work functioning (Berget et al., 2007), possibly due to methodological limitations. Therefore, our final lesson is also an invitation for further research on whether or not CFs can facilitate the transition of people with mental disorders towards employment, and under which conditions.

To the best of our knowledge, the current study is the first to explore the benefits and challenges in the collaboration between professionals in psychiatric rehabilitation and non-professionals on CFs. The potential benefits of involving authentic, pragmatic and empathetic farmers as service providers have been discussed before (Endlers-Slegers, 2008; Hassink, Elings, et al., 2010; Pedersen, Ihlebaek, et al., 2012). The current study contributes to these accounts by providing information on potential challenges facing interaction with care farmers, thus contributing to a better understanding of the factors that rehabilitation professionals need to consider when collaborating with CFs. Among limitations, we acknowledge that, due to the scope of the study, we did not explore the reasons why rehabilitation professionals or care farmers might choose not to collaborate. This might have provided different, possibly more negative, insights. Furthermore, despite data saturation, we need to be cautious with generalizing findings to the entire care farming sector, or to other non-professionals whose relationship with professionals for mental health care might be of a different nature.

We conclude that collaboration between rehabilitation professionals and care farmers is beneficial for both partners, but not without difficulties. Three lessons can be derived from our study: professionals and non-professionals need to share a similar vision on the scope of their collaboration, and need to allow for the articulation and mutual understanding of own frames of reference in order to create collaboration that has the potential to help users further pursue vocational goals. Further research could assess the degree to which CF users make the transition to the labour market, and under which circumstances.