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ANALYSIS OF FACTORS INFLUENCING THE COLLABORATION OF COMMUNITY MENTAL HEALTH PROGRAM IMPLEMENTATION TEAMS IN JEMBER REGENCY

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***Abstrak*:** Interprofessional collaboration (IPC) is a strategy to address the need for integrated community mental health services. In community mental health services, effective interprofessional collaboration practices can increase community participation in carrying out early detection and prevention of mental health problems. In order to create effective IPC practices, it is necessary to identify factors that hinder interprofessional collaboration in community mental health programs. The purpose of this study was to analyze the level of Interprofessional Collaboration (IPC) of community mental health programs in Jember Regency. Methods: This study is a quantitative and qualitative research (mix-method). The level of interprofessional collaboration was measured using the PINCOM (The Perception of Interprofessional Collaboration Model) questionnaire consisting of 32 questions, which included individual factors and team factors. Questionnaire scores were calculated using a 5-point Likert scale. And further descriptive analysis using logistic regression. Then individual factors and team factors were further assessed using the in-depth interview method. The results of quantitative research show that the characteristics of respondents that affect the implementation of interprofessional collaboration are age, education, position, while employment status and length of service have no impact on the implementation of interprofessional collaboration in community mental health programs. The conclusion of this study is that the level of interprofessional collaboration in community mental health programs is running well, government policies are needed so that the handling of community mental health programs can be more comprehensive.

Keywords: collaboration, mental health, implementation team

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INTRODUCTION

Mental health is one of the major health issues globally, including in Indonesia. Worldwide, around 450 million people experience mental and behavioral disorders[1]. The Indonesian Health Survey 2023 showed that 2% of the population aged over 15 years experienced mental health problems. Mental health problems can trigger various social impacts, such as increased cases of domestic violence, crime, suicide, child abuse, divorce, deviant behavior in adolescents, abuse of narcotics, psychotropic substances, and other addictive substances.

Based on the results of the 2018 Basic Health Research (Riskesdas), more than 14% of families have had a family member with psychosis / schizophrenia, with more cases found in families living in rural areas[2]. The Ministry of Health emphasizes that integrating primary care to provide comprehensive, integrated and socially responsive community-based mental health services is one option to improve public health and address care gaps[3].

The Health Profile of the East Java Provincial Health Office, shows data on mental disorders has increased every year, 84% in 2020 increasing to 98.3% in 2024. The same condition also occurs in Jember Regency, the prevalence data of people with mental disorders is 26.4% in 2020 increasing to 88% in 2024 based on the Jember Regency Health Profile[4]. Since 2000, the approach to mental health services in Indonesia has shifted from a referral-focused system to community-based mental health services at the primary care level[5]. Community-based mental health services in primary care are stipulated in Law number 17 of 2023 concerning health[3].

Interprofessional Collaboration (IPC) is a strategy that aims to achieve quality outcomes effectively and efficiently in healthcare. Effective communication in collaboration is an important aspect of improving mental health services. The ability of various disciplines and other professions to work professionally to provide collaborative patient-centered care is considered a key element in interprofessional practice, which requires a specific set of competencies in one institution[6]. Experts state that building a culture of collaboration cannot be done only based on theory, but requires consistent practice and habituation[8].

The researcher focused on analyzing the factors that influence the IPC of the Community Mental Health Program in Jember Regency, because the community mental health program involves various health professions and disciplines from different institutions in the treatment process, so that effective and efficient collaboration between teams is needed.

METHODOLOGY

Research Design

This research method is mixed-method with sequential explanatory design. Quantitative research was conducted first to obtain a description of the characteristics of respondents and the implementation of collaboration using the PINCOM questionnaire. Qualitative research was then conducted to explore the factors influencing the implementation of IPC using in-depth interviews.

Pengambilan Data

The first stage involved proportional sampling of a population of 906 consisting of 50 mental health program managers at community health centers, 248 regional managers, 248 village guidance officers (babinsa), 248 community security and order officers (bhabinkamtibmas), 50 health center heads,

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31 district social welfare officers, and 31 district heads. The second stage continued with proportional random sampling, and 278 samples were obtained with details of 15 mental health program managers at community health centers, 76 regional managers, 76 village supervisory officers, 76 community security and order officers, 15 heads of community health centers, 10 district social welfare workers, and 10 district heads. The qualitative research involved 7 informants who had previously completed a questionnaire. The selected informants represented each population, with the main informants reflecting the ethnographic characteristics of Jember Regency, namely the northern, southern, western, eastern, and central regions. Each informant was interviewed individually by the researcher, and the interview recordings were transcribed.

Instrumen

The questionnaire of Perception of Interprofessional Collaboration Model consists of 32 questions, comprising two factors, namely individual factors and team factors. Individual factors consist of isolation variables (four questions), individual communication (four questions), and personality style (eight questions), while team factors consist of cooperation variables (six questions), team communication (six questions), and social support (four questions). The results of the validity test showed that all questions were valid (Pearson correlation coefficient >0.1173) and had high reliability (Cronbach's alpha = 0.827). A semi-structured questionnaire was used as a guide for interviews to explore collaboration experiences and the factors influencing collaboration.

Analisa Data

Quantitative data analysis procedures were carried out with the following steps: 1) conduct bivariate analysis using Spearman correlation test; 2) select variables that will be included in multivariate analysis, and select variables of age, position, and education that have ρ value <0.25; 3) conduct logistic regression analysis.

Qualitative data analysis procedures are carried out with the following steps: 1) collecting relevant research data through observation, interview, and documentation techniques; 2) summarizing information from general to more specific and focusing on aspects that are relevant to research problems; 3) data that has been reduced by researchers will be presented in a more structured and clear form; 4) taking data that has been presented in various forms and drawing conclusions from the findings found.

The next stage of analysis is a combination by means of integration, connecting quantitative research data with quantitative research data.

RESULTS AND DISCUSSION

Characteristics of respondents

A total of 278 respondents agreed to be involved in this study. Table 1 shows the characteristics of the quantitative stage respondents. Most of the respondents were aged 40-45 years old 105 (37.77%), had positions as regional officers, babinsa and bhabinkamtibmas 76 (27.3%) each, had a Diploma III education 160 (57.6%), Civil service status 254 (91.4%), and length of service >5 years 252 (90.65%).

Table 1. Characteristics of Respondents

Variable	Quantitative n = 278		Variable	Quantitative n = 278	
	Total (n)	Percentage (%)		Total (n)	Percentage (%)
Age			Education		

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<40 years old	89	32,01	Diploma III	160	57,6
40-45 years old	105	37,77	Diplo=ma IV	3	1,1
45-50 years old	50	17,99	S1/Bachelor's degree	64	23,0
>50 years old	34	12,23	Profession (doctor, nurse)	45	16,2
Position			Master's degree	6	2,2
Mental Health Program Manager	15	5,40	Employment Status		
Regional Manager	76	27,34	Civil Service	254	91,4
Babinsa	76	27,34	Non-Civil Service	24	8,6
Bhabinkamtibmas	76	27,34	Length of Service		
Social Welfare Officer	10	3,24	<1 year	4	1,44
Head of Public Health Center	15	5,40	1-3 years	11	3,96
Head of District	10	3,24	3-5 years	11	3,96
			>5 years	252	90,65

The qualitative stage, from all respondents, 7 informants were selected to represent the research population and were willing to be interviewed in-depth, as shown in Table 2.

Table 2: Characteristics of main informants

Code	Gender	Age	Education	Position	Ethnography
IU.1	Male	39	D-3	Mental Health Program Manager	West
IU.2	Female	42	D-3	Regional Manager	Cantral
IU.3	Male	55	S-1	Babinsa	South
IU.4	Male	38	D-3	Bhabinkamtibmas	North
IU.5	Female	56	S-1	Head of Public Health Center	West
IU.6	Female	47	S-1	Social Welfare Officer	Central
IU.7	Male	52	S-1	Head of District	East

PINCOM IPC Implementation Using The PINCOM Questionnaire

The PINCOM questionnaire assesses the implementation of IPC on individual factors and team factors. Table 3 shows that most respondents have implemented collaboration well, except for the personality style variable which has the lowest score as many as 44 respondents (15.83%) implement collaboration well.

Table 3. Implementation of Collaboration based on Individual Factors and Team Factors

NO	VARIABLE	% VALUE AGAINST EXPECTATIONS						N	%
		LESS		ENOUGH		GOOD			
		N	%	N	%	n	%		
	Individual Factors								
1	Isolation	2	0,72	48	17,27	228	82,01	278	100
2	Communication	2	0,72	77	27,70	199	71,58	278	100
3	Personality Style	5	1,80	229	82,37	44	15,83	278	100
	Group Factor								
1	Cooperation	6	2,16	114	41,01	158	56,83	278	100

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2	Communication	0	0,00	87	31,29	191	68,71	278	100
3	Social Support	0	0,00	69	24,82	209	75,18	278	100

Source: Primary Data Processing, 2024

To find out the characteristics of respondents who significantly affect collaboration, bivariate analysis was carried out, shown in table 4. Based on this analysis, it was found that the characteristics of respondents on the variables of age, education and position had a p-value <0.25, namely the age variable 0.008, the education p-value 0.141, the position p-value 0.088, while the p-value of employment status and length of work> 0.25.

Table 4. Relationship between Respondent Characteristics and Collaboration Implementation

No.	Characteristics		n	*Interprofessional Collaboration* (IPC)						*p-value*
				Less		Fair		Good		
				N	%	n	%	n	%	
1	AGE	<40 years old	89	0	0,00	25	28,09	64	71,91	0,008
		40-45 years old	105	0	0,00	32	30,48	73	69,52	
		45-50 years old	50	0	0,00	26	52,00	24	48,00	
		>50 years old	34	0	0,00	10	29,41	24	70,59	
2	EDUCATION	Diploma III	160	0	0,00	58	36,25	102	63,75	0,141
		Diploma IV	3	0	0,00	2	66,67	1	33,33	
		S1/Bachelor's degree	64	0	0,00	17	26,56	47	73,44	
		Position (doctor, nurse)	45	0	0,00	14	31,11	31	68,89	
		Master's Degree	6	0	0,00	2	33,33	4	66,67	
3	JOB	Mental Health Program Manager	15	0	0,00	2	13,33	13	86,67	0,088
		Regional Manager	78	0	0,00	26	33,33	52	66,67	
		Babinsa	76	0	0,00	30	39,47	46	60,53	
		Bhabinkamtibmas	76	0	0,00	26	34,21	50	65,79	
		Social Welfare Officer	9	0	0,00	2	22,22	7	77,78	
		Head of Public Health Center	15	0	0,00	4	26,67	11	73,33	
		Head of District	9	0	0,00	3	33,33	6	66,67	
4	EMPLOYMENT STATUS	Civil Service	254	0	0,00	87	34,25	167	65,75	0,523
		Non-Civil Service	24	0	0,00	6	25,00	18	75,00	
5	EMPLOYMENT	<1 year	4	0	0,00	0	0,00	4	100,00	0,634
		1-3 years	11	0	0,00	0	0,00	11	100,00	
		3-5 years	11	0	0,00	5	45,45	6	54,55	
		>5 years	252	0	0,00	88	34,92	164	65,08	

Source: Primary Data Processing, 2024 based on sprearman rho test

Multivariate Analysis

a. Selection of Multivariate Candidate Variables

Tabel 5.Table 5. Multivariate Candidate Variables

No	Variable	P-Value	Multivariate Candidate

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1	Age	**0,008**	**Yes**
2	Profession	**0,088**	**Yes**
3	Education	**0,141**	**Yes**
4	Employment Status	0,523	No
5	Length of Service	0,634	No

Source: Primary Data Processing, 2024, spearman rho test

The variables included in the multivariate analysis were age (p value= 0.008), profession (p value= 0.088), and education (p value = 0.141). Meanwhile, the variables that were not included in the multivariate analysis were employment status and length of service because the p value was >0.25.

The first multivariate modeling is as follows:

Table 6. First Multivariate Modeling

No	Variable	B	P-Value	Exp B	95% CI
1	Age	-1.954	0,001	0.142	0.046-0.435
2	Position	1.495	0,291	4.458	0.468-42.428
3	Education	1.611	**0,311**	5.005	0.275-91.185

Source: Primary Data Processing, 2024

From the results above, the variable with the largest p value is education, which has a p-value = 0.311 (p>0.05), so the first to be removed from the first modeling is the education variable. After removing the education variable from the first modeling, the second modeling results are as follows:

Table 4.7 Second Multivariate Modeling

No	Variable	B	P-Value	Exp B	95% CI
1	Age	-1.789	0,001	0.167	0.057-0.489
2	Position	1.280	0,291	3.598	0.397-32.625

Source: Primary Data Processing, 2024

From the second multivariate modeling analysis, there was a change in OR>10% in the age and profession variables, so the education variable was a confounding variable and was re-entered into multivariate modeling. Meanwhile, based on Table 4.7, the variable with the largest p value is profession, which has a p-value = 0.291 (p>0.05). So the variable that was subsequently excluded from the second modeling was the profession variable. After removing the profession variable from the second modeling, the third modeling results are as follows:

Table 4.8 Third Multivariate Modeling

No	Variable	B	P-Value	Exp B	95% CI
1	Age	-1,336	0,013	0,167	0,057-0,489
2	Education	0,294	0,319	1,342	0,111-16,248

Source: Primary Data Processing, 2024

From the third multivariate modeling analysis, there was a change in OR>10% in the variables of age and education, so the professional variables were confounding variables and were re-entered into multivariate modeling.

In the final modeling, the variable that was significantly associated with the level of Interprofessional Collaboration (IPC) in the Community Mental Health program was age, which was

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controlled by the confounding variables of education and profession. The model formed is declared feasible, because it fulfills the meaning of the model seen from the omnibus test value (p = 0.000). Based on Nagelkerke R Square, the value = 0.237 means that the independent variables contained in the model can explain the IPC relationship by 23.7%. The most dominant variable associated with the level of Interprofessional Collaboration (IPC) of the community mental health program is age with OR = 14.2 (95%CI OR: 0.046-0.435) meaning that the age variable has a risk of 14.2 times the level of Interprofessional Collaboration (IPC) of the community mental health program.

Interview Results at the Qualitative Stage

The results of the interviews at the qualitative stage were analyzed thematically to find influencing factors in the implementation of the collaboration of the implementing team in the community mental health program in Jember District. Individual factors include three variables, namely isolation, communication and personality style, while team factors include variables of cooperation, communication and social support.

a. Isolation

Isolation in this study is the lack of willingness of team members to share information, opinions, discuss new things or practices, and respect each other. In general, the main informants stated that they were willing to share opinions and information.

> *"..if there is an people with mental disorders who is angry, I immediately contact Mr R (the person in charge of the public health center mental health program)..yesterday there was an person with a mental disorder who was angry..his mother wanted to be hit..I contacted the village chief..contact pak R.." (IU.3)*

The same thing was conveyed by IU.1, not only information on persons with mental disorders in the area, but new information related to mental health programs or new policies will be conveyed or socialized.

> *"..yes, mrs..if after a meeting at the office, I don't report it first to the head..." (IU.1).*

IU.6 also mentioned that handling persons with mental disorders cases in the field or region requires information disclosure.

> *"..for almost 15 years I have been a district social welfare officer, these 3 pillars must be in contact.*
> *some cases in the field will not be resolved if our information is not open with others" (IU.6).*

Based on table 3, it is known that the isolation variable has an IPC value of 82.01%, which means that the process of implementing interprofessional collaboration for isolation variables is going well.

b. Communication (individual)

In this study, IU.1, IU.3, and IU.4 admitted to communicating well.

> *"... person with a mental disorder matters, I definitely contact with Mr. M (regional supervisor)...actually not only person with a mental disorder...the main health problems call with Mr. M and Mrs. N the midwife..." (IU.4)*

To support effective and efficient communication, the interprofessionals involved in the community mental health program utilize information technology as stated by the following informant.

> *"...we have a wa group, sir...after every activity we report there...bar the people with mental disorders visit I or the village head report there...after the subsidized food assistance program from the Indonesian government distribution also report there...the group contains*

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a mixture...there are me, the midwife, the village head, Mr R (the person in charge of the public health center mental health program)..." (IU.3).

Communication assistance is also needed in community mental health programs when there are language barriers to communicate with targets.

"...when I visit K village, I will definitely invite the village head or Mr Babin...so that I can chat with the people with mental disorders family...because the majority are madurese...but in this area, I go alone..." (IU.1).

Based on table 3, it is known that the communication variable (individual factor) has an IPC value of 71.58%, which means that the process of implementing interprofessional collaboration on communication variables is going well. In this study, according to the results of the interviews, it was found that communication was carried out if there were cases of persons with mental disorders that could not be handled by health workers.

c. Personality style

In this study, in general, all main informants could explain the duties and functions of each profession. As stated by the person in charge of the public health center mental health program as follows

"*...my job as a Mental Health Program manager is to do all the activities in the Mental Health program...starting from mentoring people with mental disorders, visiting person with mental disorder, opening services at the public health center, then reports...this is what I have to learn mrs...now the Mental Health Program report must use the application...*" (IU.1).

The same thing was also conveyed by IU.2 who works as a midwife.

"*...my job so far is to open the integrated health service post, to be responsible for the targets of toddlers and pregnant women...visits to risti bumil, toddlers who do not come to the integrated health service post..."* (IU.2).

The same condition was also conveyed by IU.6 who served as a District Social Welfare Officer.

"*...my duties in the field are very numerous...what* I *take care of is not only people with mental disorders...all social problems I have to respond to I report to be followed up whether given assistance or basic necessities...but all social problems must be recorded..."* (IU.6).

A slightly different thing was conveyed by IU.3 who works as a babinsa who does not have specific main tasks and functions, especially in community mental health programs, but rather secures government programs to run well through superior orders.

"*...I depend on the leadership...the superior orders a I work a...the superior orders b I do b...most recently I took care of stunting...waduuh"* (IU.3).

Based on table 3, it is known that the personality style variable has an IPC value of 15.83% which is the smallest value among other variables. This shows that the process of implementing interprofessional collaboration for personality style variables has not gone well. In this study, it was revealed from the interview results that participants focused on their respective duties and functions, on the other hand, some participants had different organizations.

d. Cooperation

Community mental health programs require interprofessional cooperation across sectors in handling people with mental disorders, as the following informant said.

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"*...if it's just a regular home visit...usually alone...contact Mr Babin or hamlet head if the people with mental disorders is angry and troubling...or doesn't want to be referred, then contact them...*" (IU.1)

"*...just as long as I get a call from mbak A (the person in charge of the mental health program at the public health center)...I will definitely go...*" (IU.4)

Based on table 3, it is known that the cooperation variable has an IPC value of 56.83%, which means that the process of implementing interprofessional collaboration in the Mental Health Program in Jember Regency for the cooperation variable is going well.

The above is not in accordance with the results of the interview with IU.5 as follows.

"*...if you think about it, yes..it seems that so far the cooperation has been mental health manager, babinsa, bhabinkamtibmas who are perceptive ...*

...I was once invited to a home visit...but that was a long time ago..when what was it..oo the people with mental disorders did not want to take medicine" (IU.5)

The results of in-depth interviews do not match the results of the questionnaire, indicating that cooperation in interprofessional collaboration rarely occurs, this is because cooperation is still carried out by implementers, in this case the person in charge of the public health center of mental health program, babinsa, bhabinkamtibmas and District Social Welfare Officer. The person in charge of the area is rarely involved because they feel that the community's mental health problems have their own responsibilities. The cooperation carried out so far is more caseistic, if a problem is found in the process of handling mental health, the personnel involved will coordinate and cooperate.

e. Communication (team)

The interview data shows a slightly different situation as stated by the following main informant.

"*...communication with the district head is under the authority of the head of the sub-district...the important thing is that I report to the public health center...*" (IU.1)

"*...means of communication with the district...we have an external lokmin every three months...we invite the linsek on behalf of the district...usually we present the achievements of the health program...the achievements of the mental health program are also presented...but since last year health has focused on AKI, AKB, stunting...*" (IU.5)

"*...here there are two public health center...public health center A and public health center B...both of them routinely hold meetings...usually the two capitals are exposed...*" (IU.7)

"*...basically I personally follow the public health center...what themes are raised are discussed with the linsek...this year it seems that the trend is stunting and maternal mortality...*" (IU.7)

Based on table 3, it is known that the communication variable has an IPC value of 68.71%, which means that the process of implementing interprofessional collaboration for the cooperation variable is going well. The results of the interview showed that team communication had been carried out regularly but never discussed mental health because it focused on a predetermined theme. At the time of the study, the priority program of the Jember Regency Health Office was to reduce MMR, IMR, and stunting, so every time the public health center held an external mini-workshop, the theme of community mental health received less attention.

f. Social support

Social support from cross-sectors, in this case bhabinkamtibmas and babinsa, can be seen from the following interview results.

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"*...social support...if mr Babin mr Kamtibmas responds well...they are good...*" (IU.1)

Social support from the family, in this case the people with mental disorders's family, can be seen from the following interview.

"*..my obstacle is usually from the people with mental disorders' family...there are those who are not cooperative, asked to take medicine, they don't take it.*" (IU.1)

"*...there is even one north of Krajan...the people with mental disorders were expelled from the family...*" (IU.3)

"*..there is a housing near the mushola...the family is in Patrang...the house is rented...yes he lives alone...his family comes once a week to send food...*" (IU.4)

The support of superiors or leaders to subordinates for program sustainability can be seen from the following interview results.

"*...even my manager formed a community association for people with mental disorders..the contents are the families of people with mental disorders patients....* " (IU.5)

Official support was also shown by the sub-district by making a decree on mental Integrated Health Service Post as stated by IU.7

"*...ooo that decree (decree on mental health services)...the one who made it came from the district head before me...yes...maybe district head is very concerned with people with mental disorders...I have only been here for the beginning of 2024, not yet a year...*" (IU.7)

The interview results show the social support factor for interprofessional collaboration according to table 3 with a value of 75.18%.

Good practice of social support emerged from an interview with IU3.

"*..some time ago we were able to get help to buy medicine..from Mr L, a good person who owns a shop in the market...*" (IU.3)

Social support is very much needed in running a community mental health program, not only the support of the family as the closest person to people with mental disorders, but cross-sector support is also very helpful, and it will be even more helpful if it is supported by regional policy makers.

Discussion

The Effect of Age on Collaboration of the Implementation Team of the Community Mental Health Program in Jember Regency

Age is one of the factors that can influence the effectiveness of interprofessional collaboration in the work environment, especially in the health sector. Age is a predisposing factor that motivates or provides reasons for interprofessional[24]. This study had respondents with a wide age range, from 30 to 50 years old. Younger health workers have generally been familiar with the concept of collaboration since their education, as modern curricula emphasize the importance of teamwork and effective communication. They tend to be more adaptive to change and more open to receiving input from other positions. On the other hand, more senior health workers usually have rich clinical experience, but may be used to a more hierarchical work pattern. The results of in-depth interviews illustrate that implementing level team members such as the person in charge of the keswa program, babinsa, and babinkamtibmas will report the results of activities to their respective superiors.

The practice model of interprofessional collaboration in Indonesia is similar to the hierarchical or traditional model, where the final decision regarding the handling of mental health problems rests with the leader of the organization, in this study, the doctor as the head of the public health center. Based on in-

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depth observations and interviews, the handling of community mental health problems is still curative, thus requiring validation and verification from superiors for handling[30].

However, the age difference is not an absolute barrier to IPC. If managed wisely, age diversity can be a strength within the team. Younger generations can bring a spirit of innovation and openness, while older generations contribute depth of experience and stability in decision-making. The key is respectful communication, joint training, and the establishment of an inclusive work culture, so that every team member feels heard and valued regardless of their age. Older individuals usually have more experience in their roles, which often means they have a deeper understanding of work challenges and dynamics. This experience can enhance their collaborative skills in cross-functional teams. Older or more experienced team members can contribute to IPC by providing richer insights, sharing knowledge, and helping guide younger team members. They usually have more skills in handling conflict and managing team dynamics[28].

The results of in-depth interviews of the main informants or participants in handling conflicts and managing dynamics, trying to create a work environment that supports the community mental health program, by creating a people with mental disorders association, and creating a mental Integrated Health Service Post which is strengthened by a decree issued by the sub-district head. It is hoped that the creation of the association and mental Integrated Health Service Post will make it easier for the implementation team to implement the mental health program. Research conducted at The London School of Medicine and Dentistry Universty is in line with the results of this study that the causes of work stress include high work demands from management, lack of social support, unfair treatment, lack of appreciation, lack of transparency and poor communication. Organizational interventions are considered effective by making activity decrees as conveyed by informants can minimize gaps or problems that arise in mental health programs[23].

Age is often associated with experience, hence more respect in terms of authority or leadership. Older individuals may be more likely to hold leadership positions or be decision-makers in the team, especially if they have been in the role longer. Team leaders must be able to strive for two-way communication or information exchange, discussion, and complementary actions. In this study, individual communication variables and communication variables have no common thread, not well coordinated. Communication that exists at the level of implementers (responsible for the mental healt program, babinsa, babinkamtibmas, Subdistrict Social Welfare Workers) is not conveyed to their respective leaders. Leadership that comes from older and more experienced individuals can provide clear direction, increase confidence in the team, and facilitate more thoughtful decision-making.

The Effect of Position on Collaboration of the Implementation Team of the Community Mental Health Program in Jember District.

A position is a certain position, role or responsibility given to someone in an organization, company or institution, while in KBBI a position can be interpreted as a job or task in government. The results of in-depth interviews with informants illustrate that collaboration goes well on the teamwork factor at the implementing level, in this case the person in charge of the program, babinsa, bhabinkamtibmas and district social welfare workers. The cooperation carried out so far is more caseistic, if a problem is found in the process of handling mental health, the personnel involved will coordinate and cooperate.

Cooperation occurs when team members work together and share knowledge and skills. In the cooperation variable, there is an application of the authority and competence of each position, which is then agreed within the team and creates a division of tasks. Various studies have shown that mutual respect in

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interprofessional teams may be hindered by a lack of understanding of the roles of team members, rather than by power struggles or competition[31]. A culture of cooperation can also be built by respecting each other's values, namely interprofessional ethics[29].

Position is related to the practice of interprofessional collaboration in inpatient services. Position background is a significant factor in the practice of interprofessional collaboration, because initially the concept was created as a profession center, so that health workers were accustomed to working independently. Doctors (head of health centers) are still considered more independent and superior to other health workers so that the relationship between positions becomes unequal and creates stereotypes[33].

Each position has a different approach to problem solving, and this difference in perspective may affect how they collaborate with people in other positions. For example, a doctor as the head of a public health center may focus more on the management of the public health center, while a person in charge of the mental health program focuses more on the management of person with a mental disorder patients, or a babinsa and bhabinkamtibmas focus more on community security and order issues. This difference in approach or perspective can also cause tension or misunderstanding, especially if team members are not open to understanding the roles or workings of other positions. If these differences are not managed well, they can hinder collaboration. Differences in ways of thinking and approaches to decision-making can cause tension or conflict within the team.

In carrying out tasks according to the position held by the implementing team in the mental health program, coordination is needed so that collaboration runs well. The coordination domain requires good leadership, selection of team leaders and setting clear common goals (Findyartini, 2019). In this study, all respondents except the head of the public health center and sub-district head, had their respective superiors or leaders. If the person in charge of the keswa program, babinsa, babinkamtibmas, District Social Welfare Workers do not communicate mental health problems in the community to their respective superiors or leaders, then the mental health program cannot run well.

The implementation of tasks according to the positions held by participants requires openness of information or data on patients with mental disorders, the more open the information, the easier the coordination process because in its implementation not only health workers are involved but also involve elements of society and across sectors. Another study states that isolation affects the implementation of interprofessional collaboration with the assumption that if isolation decreases, the implementation of interprofessional collaboration can be improved[24].

Mental health problems often occur in the middle to lower class community, aggravated by economic problems, usually people with mental disorders will be eliminated by the family. If community mental health problems can be communicated to people who have positions that can determine policies, it is hoped that mental health problems can be handled properly and prevention can be done early. Each position usually has a different code of ethics or professional standards, which can affect how they interact with other positions. If there is a mismatch between the code of ethics or professional standards held by team members, this can lead to role confusion or a lack of understanding of ethical boundaries, which can create barriers to collaboration.

The Effect of Education on Collaboration of the Implementation Team of the Community Mental Health Program in Jember District

The basic concept of education is a learning process, which means that in education there is a process of growth, development, or change towards a more mature, better, more mature individual, group /

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society. The concept of health education is also the process of learning in individuals, groups or communities from not knowing about health values to knowing, from not being able to overcome health problems to being able to overcome health problems[32].

The education completed by the majority of research respondents is Diploma III which has expertise, ability, teamwork and good communication, that Diploma III education has expertise and skills in the practice of interprofessional collaboration. These health workers are educated and trained to communicate, work together, and collaborate casually, not for community health which demands comprehensive treatment, especially in community mental health[7].

Educational programs that include interprofessional training, communication skills, understanding the roles of other positions, and practical experience can improve the ability of individuals to work effectively in interprofessional teams. Therefore, it is important for educational institutions to develop curricula that introduce and develop IPC skills early on, and support continuing education for professionals already working in the field. Thus, good education will create individuals who are better equipped to collaborate and work effectively in interprofessional teams[24].

The results of in-depth interviews with participants who have a high level of education, illustrate that the collaboration of team communication variables is going well, according to the informant's or participant's statement that the public health center has conducted regular cross-sector communication through External Mini Workshops (external lokmin) every 3 months, for coordination related to public health efforts that require the active role of cross-sectors, as mandated by the Minister of Health Regulation number 44 of 2016 concerning Public health center Management Guidelines. However, the community mental health program is not a priority program. At the time of the research, the priority program of the Jember District Health Office was the reduction of MMR, IMR, and stunting, so every time the public health center held an external mini-workshop, the theme of community mental health received less attention.

Interprofessional team collaboration is most effective when there is good communication and respect for diverse opinions among interprofessionals. The team factor that has the most significant effect on the implementation of interprofessional collaboration is team communication24. Team communication is the interaction between team members face-to-face with agreed goals such as sharing information, discussing problem solving and so on. Interprofessional collaboration is better if community mental health services are integrated, if there is an increase in communication then the interprofessional relationship is getting better[22].

Literature identifies that 70-80% of errors in health care are caused by poor communication and understanding within the team; good teamwork can help minimize the emergence of public health problems. Community mental health implementation teams are needed to solve complex patient problems, as well as improve efficiency and continuity of care. The process of collaboration will have a positive impact and improve the quality of service to patients or person with a mental disorder, through complementary tasks, responsibilities and skills.

Effect of Employment Status on Collaboration of the Implementation Team of the Community Mental Health Program in Jember Regency

Interprofessional collaboration can be hindered if there are significant status differences, lack of access to resources, or imbalances in decision-making. Conversely, if the organizational structure supports inclusiveness, values contributions from all professions regardless of employment status, and if higher

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status team leaders actively support interprofessional collaboration, then IPC will increase. Creating an equitable work environment that supports interprofessional collaboration is critical to improving team outcomes and quality of work.

Team leaders or individuals with higher employment status have a key role in directing and facilitating interprofessional collaboration. Leaders who are higher up in the organization have more responsibility for ensuring that interprofessional collaboration works, and they can create policies or cultures that support IPC.

In organizations with clearly defined employment status, differences in power and authority can affect who is involved in decision-making. Key decisions in interprofessional collaboration often involve leaders or individuals with higher status, which can lead to decisions that are less inclusive or less considerate of perspectives from different professions.

Inequalities in employment status can create gaps in interprofessional communication and interaction. If someone feels undervalued or unappreciated, they may be reluctant to share ideas or actively participate in team discussions. Nonetheless, if team members with higher status actively encourage openness and value input from all parties, this may mitigate the negative impact of employment status on IPC.

The Effect of Length of Teamwork on Collaboration of the Implementation Team of the Community Mental Health Program in Jember District.

Length of work is the period of time that a person has passed since pursuing work, which is determined by the time of starting work until now working, and is usually associated with work experience[28]. The results of this study indicate that there is no significant influence between length of work and the level of collaboration of the mental health program implementation team in Jember Regency. This can be explained from the results of in-depth interviews, the duration of working together does not guarantee effective interaction. The mental health program implementation team that has been working together for a long period of time does not necessarily reflect on their respective roles or develop a good communication mechanism, as evidenced by their collaboration and coordination if there is a case of person with a mental disorder that is considered troubling to the surrounding community. In line with Nurul's research (2020) that the length of time working with the team had no influence on the implementation of interprofessional collaboration at RSUD R. Syamsudin Sukabumi City, coordination and communication were carried out indirectly through medical records.

The results of subsequent research from the results of in-depth interviews, mental health programs receive less attention from superiors or leaders of each organization because they are more focused on the problems of MMR, IMR and stunting, which can reduce the morale of the mental health program implementation team. Increasing information and monitoring the evaluation of community mental health programs must be carried out regularly, that the performance of the team actually becomes stagnant and does not develop because there is no renewal of work approaches or joint training. The same situation at Ngudi Waluyo Hospital in Blitar City, that length of work has a negative influence on the implementation of interprofessional collaboratio[27]. The longer they work together in a team, the more understanding of personal characteristics between team members, so they tend to avoid rather than negotiate when resolving conflicts that occur[26].

The longer team members work together, the more experience they gain in collaborating. They are more familiar with how each profession works, as well as the strengths and limitations of each

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profession. Teams that have worked together for a long time tend to have a better understanding of the role and contribution of each profession in the team, thus ignoring the opinions of other teams. This is consistent with the results of this study, where the implementation team focused on their respective tasks and functions, and even the babinsa and babinkamtibmas would prioritize orders from their direct superiors. At the policy-making level, the head of the public health center and the sub-district head pay more attention to the priority programs set by the local government, while the mental health program is an indicator of district SPM assessment. A person who has worked for a long time has broader insights and more experience that will play a role in workforce behavior. Psychologically, workers with a long work period feel experienced with their work and consider their work a daily routine[25].

CONCLUSION

Factors that influence the implementation of the collaboration of the community mental health program implementation team in Jember Regency are age, position and education. To support this, it is hoped that the local government can make Regent Regulations or Regent Decrees related to the district-level community mental health implementation team.

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