Chapter 27

The Community Clinician And Interagency Collaboration

Mary Ellen Burke, Meredith A. Martin and Garry M. Dezilva

Introduction

Adolescents with an intellectual disability and emotional/behavioural difficulties place complex demands on the service system. In order to achieve effective outcomes for, and with these clients, 'best practice' includes the expectation that all stakeholders will work collaboratively. Collaboration is best expressed as a process of individuals and groups working together for mutual benefit, with an emphasis on building bridges between people and agencies to bring together the needed clinical skills and resources for the benefit of the patient or client (Darlington, Feeney, & Rixon, 2005; Howarth & Morrison, 2007; Padgett, Bekemeier, & Berkowitz, 2004; Sloper 2004).

In practice, the process of working collaboratively is very difficult to establish and maintain. This chapter explores inter-agency collaboration from the perspective of community clinicians or practitioners. Community clinicians are the individuals or teams that provide a service directly to the client and or their family or carer. This could include, for example the case worker, community nurse, psychologist, psychiatrist, social worker, school counsellor, therapist, special educator and other care workers, from different agencies or the same agency. Practical information and strategies are provided to assist community clinicians to decide when to choose a collaborative approach to service delivery and how to effectively participate in collaborative partnerships.

The Need For Collaboration

The high prevalence of mental health disorders for people with an intellectual disability is a major issue for health and welfare service systems in Australia and overseas. Adolescents with an intellectual disability and a possible psychiatric disorder challenge

existing service systems. These adolescents present with complex issues to a range of services that are also complex and include a range of different departments and agencies each of which is responsible for some aspect of the support service. The clinical challenges have been well documented (see Slevin, Truesdale-Kennedy, McConkey, Bar, & Taggart, 2008) and it is generally agreed that to serve this client group there is a need for significant specialised input from a number of sectors including mental health, health, disability, education, families and non-government agencies. Looking through a single lens is not adequate to meet the needs of these individuals. Effective services need to be based on consideration of the broader social context and individual issues confronting the person and their family or carer and the characteristics of the agencies involved in providing services.

People with an intellectual disability and emotional/behavioural difficulties require an integrated, holistic approach to assist in and support adequate assessment and effective treatment interventions. What is needed is collaborative engagement of the person, their family and support network with specialists from a range of professional backgrounds. Collaboration is a term used extensively when describing ways of providing services to people with complex needs. Reviews of ‘good’ service models and those that have proven inadequate reinforce the view that ‘collaboration’ is seen as an essential element of good practice in this area. Often it is assumed that the term ‘collaboration’ is understood and that clinicians are familiar with what constitutes collaborative practice. Clinicians often ‘believe’ that they function in a collaborative framework. This is not necessarily the case.

Focus On Community Clinicians

The purpose of this chapter is to provide some practical information and strategies for community clinicians to assist them to a) decide when it would be appropriate and feasible to establish a collaborative approach to service delivery for clients with complex presentations; and b) effectively participate in a collaborative process of planning, decision making or problem solving.

Collaboration Has Many Faces

Usually the term '*collaboration*' creates an image of a team of people working together all focussed on the same client. The team meets to determine goals, agree on tasks, processes and how to measure outcomes. The team works well together with the assistance of an effective team leader who provides clinical leadership to the members. Often this team consists of the client, family and professionals from different disciplines with different roles in relation to the client. Usually there will be a person identified as the case manager. The membership may change over time as needs or knowledge change; however everyone in the team has equal standing. In practice, the form of collaboration between agencies often does not look like this 'ideal' but incorporates key elements of collaborative processes.

The process of collaboration is about building bridges or connections between people rather than breaking down the agency 'silos' that often exist (Darlington & Feeney, 2007; Howarth & Morrison, 2007; Padgett et al., 2004; Sloper, 2004)**.** This process can look different under a variety of conditions, but generally it describes a range of 'working together' arrangements. Howarth and Morrison (2007) have proposed a way of conceptualising the different ways collaborative relationships may look. They describe a possible continuum of collaborative partnerships identifying the features of

informal local cooperative partnerships *('low level')* to formal whole of agency collaboration *('high level')*. Community clinicians need to consider where on the continuum their current arrangement is placed (refer to Table 27.1).

[Insert Table 27.1 here]

The team or partnership formed around a specific client also needs to be considered. There will be a core team and possibly secondary support to the core team whose role may be temporary or intermittent. It is acknowledged that often there are many professionals and agencies involved in the support services. The right people need to be identified to enable collaborative work to be effective. These views of collaboration strongly indicate that community clinicians must consider issues of team/partnership working as well as specific client related issues. Membership of teams/partnerships will change over time. Maintaining connections and following agreed ways of working is fundamental to achieving effective outcomes. This means that the two aspects must be addressed – the process involved and the content that must be considered (e.g., clinical issues). In this chapter, the focus is on the low level collaborative processes available to all community clinicians (see Table 27.1). In practice, it is important that all team members understand that there are specific requirements of successful collaboration. These are outlined in Table 27.2.

[Insert Table 27.2 here]

The Experience Of Collaboration

Community clinicians who have worked in collaborative teams or in a collaborative partnership have different experiences and give varied feedback. For some, the collaborative experience is a positive one, e.g., '*Fabulous! Productive! I learned so much; It was so supportive I felt I could add to the success for the person. I found I did have something useful to contribute'* (feedback from a case worker from disability services). For others it is a difficult and frustrating experience, e.g., '*Every time we met I got really anxious that they would blame me; they (other agency) think we're hopeless so it was very upsetting; we got nowhere. Everyone tried to blame everyone else; the meeting was a waste of time- we all talked at cross purposes'* (feedback from a case manager from mental health services).

Community clinicians are often in the frustrating position of trying to make a group of people function in a collaborative way and not succeeding. This sometimes results in blaming the client or their family for being uncooperative, too difficult or just not engaged; blaming the other agencies for not playing the game properly; or feeling bad because the clinician couldn't get it right. To avoid this negative experience and address some of the common difficulties, the following strategies are provided for clinicians to consider when establishing effective collaboration or when diagnosing and managing problems. Decisions made are based on the answers to the questions and the results of reflection on personal practice.

Steps In Using A Collaborative Process

Step 1: Determine If Collaboration Is Required

The community clinician needs to determine whether interagency collaboration is useful or necessary for the client and their family in this case. There are two main reasons for

agencies to collaborate: the needs of the client and the needs of the agencies. These reasons are explained in more detail below.

a) *Needs of the client*

The provision of services to most clients with complex needs will require input from a variety of individual professionals within a number of agencies. Involvement can be at different stages of the intervention process (i.e., assessment, planning, intervention and maintenance) and at primary, secondary or tertiary levels. Often the type, intensity and level of intervention varies throughout the course of the intervention process. This is particularly the case with people with complex needs where the course of intervention is not clear.

b) *Needs of the agencies*

The demands placed upon any one agency to address the varied needs of clients with complex issues usually exceed the capacity of an individual organisation. Sharing of resources across agencies, including expert knowledge, is essential to inform the process of service delivery, creation of new options in response to clients' needs and achievement of outcomes. However, all agencies are cost conscious and therefore it is important to focus on engaging with the minimum number of agencies necessary in the network to meet the needs of the client and family, although which agencies provide this network may be serendipitous.

Answers to the following questions guide decision making about whether to establish a collaborative process or to do something else.

1. Who needs collaboration? You? Client? Family? Agency?
2. What outcome is required? You? Client? Family? Agency?

3. What level of the organisation should be engaged in this process – and is it possible?
4. Are there appropriately qualified people who can be involved?
5. What level of collaboration (low or high) is required and is possible? (See Table 27.1).

Step 2: What The Community Clinician Needs To Know

If it has been decided that a collaborative process is necessary, what does the community clinician need to know? Based on the literature and the authors' experiences of collaborative processes and team work with clients with complex issues, the community clinician will need to consider a number of key elements when attempting to establish effective collaboration partnerships. A checklist of questions to consider is included in Appendix 27A. This outlines what the community clinician needs to know about the person with complex needs, agencies involved, their own agency, themselves and the collaborative process.

Step 3: Analysis Of Information Gathered

The community clinician checklist (see Appendix 27A) can be utilised in a number of ways. Depending on the information gathered in response to the questions, it could used to assist in identifying the skills needed to effectively manage and participate in collaborative processes; clarifying the desirability of engaging multiple agencies in a collaborative process; determining the level of collaboration that is feasible and will result in effective client outcomes; and identifying significant barriers to the delivery of effective service and subsequent remedial strategies.

Step 4: Finding Solutions To Collaboration Problems

The collaborative process is complex when meeting the needs of adolescents with intellectual disability and emotional/behavioural difficulties. Many issues may arise when interagency collaboration is occurring however may be averted if effective and open communication networks are established between all agencies involved. This is easily done with the universal access to email of all community clinicians. It is also essential that the client and family are included in the communication network and that there are agreed criteria for sharing information. This is especially critical in high risk or emergency situations where a clear accountability structure within and across agencies is also necessary.

Unfortunately, even with the best strategies in place, collaboration with multiple agencies does not always go smoothly. Appendix 27B provides some examples of what may happen or go wrong in the collaborative process and provides some indicators for community clinicians that may assist them to identify what may be happening for them and suggested steps on how to manage more effectively. A clear accountability structure is also essential when applying a problem solving approach to the collaborative process.

Firstly, community clinicians are beholden to their professional standards of conduct and process as well as an accountability and management structure within their organisations. There is also peer group accountability between clinicians that works on resolving differences and coming to agreements which are properly documented. However, where there are interagency difficulties or tensions in the collaborative team (e.g., disagreements in action, significant risks to the client), then this should be brought to the attention of the managers of the agencies involved. This is where the high level agreement is essential for low level collaboration to work. The accountability or support

structure of each clinician needs to be public knowledge in the collaborative network. A failure to incorporate this knowledge may lead to formal complaints (especially when one agency feels that another is failing to meet their statutory obligations). These complaints can be costly in time and effort and damage future interagency relationships.

Conclusion

Working in a collaborative partnership to address the complex needs of adolescents with an intellectual disability and emotional/behavioural difficulties is not an easy task. The decision to move toward a collaborative endeavour should be made deliberately, following consideration of the ability of the partners to work and problem solve together effectively. The responsibility of community clinicians is to develop skills in collaborative work, as well as in their specialist or professional area. All agreements or disagreements and outcomes of the collaborative process should be properly documented and circulated within the communication network. Documentation not only provides a formal and legal record, it is also a measure of professional and clinical standards, and ensures the quality of the collaborative work.

The skill in managing the collaborative partnership is being comprehensive in framework and strategic planning, decision making and recommendations. The results of collaborative work can be judged from the evaluation of the outcomes for the clients and the development of networks of specialists prepared to jointly create new options and solutions for people with complex needs.

Appendix 27A

Community Clinician Checklist: Key Elements In Establishing Effective Collaboration

What you need to know about the person with complex needs	What you need to know about the other agencies involved
☐ The reason the person is considered to be complex – is this because there is not enough knowledge/information about the person's issues? Is the context difficult or complex?	☐ What agencies are actually involved?
☐ Has anyone identified the needs holistically or is everyone only looking at their part of picture about the person?	☐ What they are responsible for.
☐ Is the problem about diagnosis or treatment?	☐ What their involvement is – is it current? Is it within their usual client or service framework?
☐ Which agencies agree on the analysis of what the 'clients problem is' and/or what is needed now?	☐ The personnel involved and their role in their agency. Are they representing a service or themselves?
☐ Does the person and family have a relationship with the clinician or agency and how do they experience it?	☐ How the agency usually provides a service.
☐ What are the outcomes expected by the client and their family and carer from a joint intervention?	☐ What is the culture of the service? (Including practices of sharing of information, process of decision making, types of intervention and length of involvement).
	☐ Language used to describe the agencies' service, and/or what is meant by terms usually involved in service delivery (e.g.

	assessment, individual plan)? ☐ If a formal management plan exists, does it incorporate collaborative work with other agencies or identify them as being 'needed'? ☐ What response does the agency provide in high risk or emergency situations?
What you need to know about your own agency	**What you need to know about yourself**
☐ The reason your agency is involved. ☐ Whether the client falls within your agency's usual client group. ☐ Whether there is another reason for this client's high profile. ☐ If your agency supports interagency work, do a Memorandum of Understanding (MOU) between agencies or specific policies exist? ☐ Identify who has decision making responsibility.	☐ Your role with this case. ☐ Limitations to your involvement. ☐ Your role in the process of collaboration. ☐ Whether you have the skills required to manage this case i.e. substantive knowledge as a professional. ☐ Whether you have the experience and procedural knowledge of the agencies involved in the collaborative team.

- ☐ Whether your view of what should be implemented is supported by your agency.
- ☐ The philosophy of service delivery.
- ☐ Terminology that may need to be interpreted for other agency clinicians.
- ☐ The history of collaboration between agencies or individual clinicians (effective or ineffective?).
- ☐ Whether you have case management responsibility.
- ☐ The support you have from your manager or agency to participate in the collaborative process.
- ☐ Where you fit in terms of 'power/authority' in the collaborative team.

What you need to know about the collaborative process

- ☐ Has the actual process of partnership has been agreed?
- ☐ Have goals have been set for the client, for stakeholders and agreed upon by all agencies?
- ☐ Has agreement has been reached about accountability and commitment by all parties?
- ☐ Has a process for communication been agreed for the Primary team and for higher level communication by all agencies?
- ☐ Is there commitment by both senior and direct staff to the process?
- ☐ Is there strong leadership or a multi-agency steering group for this process?

☐	Does an agreement exist about implementation timeframes?

(Adapted from Carnaby, 2007; Darlington & Feeney, 2007; Howarth & Morrison, 2007; Kvarnstrom, 2008; Mohr, Curran, Coutts & Dennis, 2002; NSW Department of Ageing Disability and Home Care, 2004; Sloper, 2004; Simpson, 2007; Xyrichis & Lowton, 2008).

Appendix 27B

Common Experiences Of Collaboration

What's happening	Indicators	Where do I go?
Pseudo Collaboration	▪ Agencies are either unable or unwilling to share information. There may be different understandings and policies related to privacy and confidentiality. ▪ Statements by team members such as: 'we have our own plans'; 'it's really *your* problem'; 'you will need to sort out our management problems if you want us to help'; or, inability to move beyond repeated descriptions or declarations of 'the problem'. ▪ A feeling that an agency is showing 'all care but no responsibility'. ▪ No time being spent establishing 'common ground' for all those involved.	▪ Focus on establishing or re-establishing the collaborative process including agreements and common ground about goals, processes, roles and expectations. ▪ Clarify privacy provisions. ▪ If necessary, engage the hierarchy of both (all) agencies involved to address systemic issues e.g., the sharing of information. ▪ Understand the limitations and strengths of each agency or service and then looking at ways to be more innovative and creative to achieve the desired outcomes.

Just sort it out!	▪ Interagency Collaboration is often seen as a 'fix it' solution to a 'crisis'. Higher levels of management can direct this to happen, particularly when there is a crisis or there is some 'political pressure' to solve the problem quickly.	▪ Pressure to 'solve' problems does **not** always create an environment of cooperation and collaboration between agencies and clinicians. While the identification of a 'team' to address problems may be seen as an answer it is really the first step only. ▪ The team needs to develop a joint understanding and agreement of what is actually required. ▪ Examine and prioritise short term, medium and long term options. ▪ Raise the strategies and analysis with senior roles in each organisation.
Who's in charge of this 'team'?	▪ A person or agency appears to have greater authority than others which does not match agreed roles and responsibilities. Often this is an informal arrangement that can undermine collaborative case work.	▪ The 'team leader's role needs to be clarified and assigned. ▪ Decision making processes agreed, including an escalation process for issues of concern.

		▪ Joint training and supervision to maintain agreed focus and roles.
Contact is not collaboration	▪ Team members have no contact of any kind between meetings. ▪ Partners may feel that 'we meet because we have to'. ▪ Little or no progress is made on agreed tasks from meeting to meeting.	▪ Team leader to assess lines of functional communication and monitor compliance. ▪ Team leader to actively manage the interaction focussed on attaining goals and agreed actions.
Agency ambush!	▪ Disagreements or concerns within an agency may result in additional people attending the team meeting or bringing internal issues to this forum. ▪ Raising issues unrelated to the intervention and support plan.	▪ Establish who attends the meetings and what role they fulfil. ▪ New attendees need to be introduced with a purpose that relates to implementing the agreed plan or to inform the understanding of the clients needs and issues. ▪ Shared understanding of how meetings will be conducted.

		▪ Identify team leader to manage the meetings.
Blame the others	▪ The 'unstated' views of some team members or partners are that others are not working competently with the client. Individuals or agencies presume that they have the 'right' view and/or attempt to direct others to do 'their jobs properly'. ▪ There is a presumption that one agency is better or more professional than another.	▪ Participants need to take time to listen and learn about each service or agency and the context in which the clinicians operate. Also see section above in Pseudo collaboration. ▪ Acknowledge the specialised knowledge and contribution of others. ▪ Focus on a strengths based approach
Passing the hot potato	▪ Despite attempts to address issues, no progress has been made. ▪ Comments such as - 'What more can we do, this client is beyond our resources.' - 'Lucky you're here – we have done all we can so	▪ Work through the requirements for collaboration. ▪ Stick with the agreed process of how you will operate and escalate issues of concern. ▪ Applying the escalation process to more senior levels in agencies to assist in resolving areas of concern (see Table 27.1).

now it’s up to you!’

- There may be a sense of the client being ‘dumped’.

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Table 27.1

The Features Of Collaborative Endeavours

Communication	Co-operation	Co-ordination	Coalition	Integration
➔	➔	➔		

Low level collaboration	**High level collaboration**
Limited or no formal agreements	Formal agreements
Agencies remain autonomous	Agencies sacrifice autonomy
Work towards different targets and goals	Work to shared goals & targets
Agency maintains control of resources& funding	Joint responsibility for resources& funding
Staff managed by individual service	Staff managed by partnership
Focus on individual case	Focus on whole service
Decision-making responsibility of agency	Joint decision-making
Collaboration likely to be voluntary or within guidance	Clear mandate for collaboration at government or state level
Variable practice dependent on individual	Specific focus of activity outlined in strategic plans
Affiliation to own agency and/or discipline	Affiliation to partnership
Accountable to agency	Accountable to partnership

Reproduced with permission from Howarth and Morrison (2007, p.57).

Table 27.2

Requirements For Collaboration

Collaboration requires:

- Inclusion and involvement of the client and significant family or carers throughout the process;
- Recognising and respecting each person's expertise;
- Trusting other team members or partners;
- Sharing knowledge and understanding of the client;
- Having a shared understanding of how services will be provided;
- Having a shared understanding of the client's context;
- Having one plan that sets the direction;
- Having equal ownership of the plan;
- Jointly defining needs and priorities;
- Sharing responsibility for the outcomes;
- Using a solution focussed problem solving approach; and,
- Being active team members.

It does not mean:

- Each person having their own plan and set of goals;
- A competition between stakeholders;
- Individuals doing their own thing and occasionally meeting to tell others what they are doing;
- Having an expert who directs the process;
- Ignoring the needs of the person and their family or carers;
- Ignoring the agreed ways of working; attending lots of meetings;

- Conducting the meeting in such away that contributions are excluded; and,
- Everyone doing the same thing.