A model for coordination

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This article argues that clear coordination structures are essential if collaboration around the complex needs of a small subcategory of seriously emotionally disturbed children and adolescents requiring multi-agency involvement is to be successful. A model of coordination which evolved out of a project conducted in the western suburbs of Melbourne during 1992-1993 is described. Although expensive to implement this model would be less costly than the current unsatisfactory situation where much time and effort is expended by a number of workers from a range of agencies, often for very little return.

This is the third article in a series. The first one reviewed the literature addressing the complex issues inherent in coordinating services for children and adolescents suffering with emotional, psychological, social and behavioural disorders (Luntz, 1994). The second described a project undertaken in the western suburbs of Melbourne which sought to answer two questions. First, to discover, in an experiential way, why inter-agency collaboration is so difficult and, second, what needs to change in order to overcome the difficulties. (Luntz, 1995). The knowledge gained through managing the project leads this author to take a strong position on issues of collaboration and coordination. The view is that in order to service clients whose complex needs require the collaborative effort of a number of players it is essential to establish clear coordination structures, endorsed and supported by all levels of management of participating facilities. Such structures provide workers with rules, protocols and guidelines on how to work together. There are times when these coordination structures need to take precedence over usual agency practices. It is also necessary to maintain stable staff in the participating agencies. Without such structures, processes and personnel, collaboration may be successful, but on the other hand, it may not.

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From September 1992 to March 1993, she was seconded as a project officer to that Department with the task of developing a model for improved coordination and access to services for emotionally and behaviourally disturbed children and adolescents in the Western Metropolitan Region. This article describes the model developed by the project.

DEFINITIONS

Much confusion surrounds the use of the terms coordination and collaboration. Sometimes they are used as if they were synonymous. On other occasions different meanings are assumed but how they are different is not stated (see, for instance, *Victoria's Mental Health Services: Improved Access through Coordinated Client Care* (1994); and its companion document *Needs for Service Assessment and Review: A Collaborative Approach*). For the purposes of this article the terms can be understood as follows:

> [Mental health] collaboration is an inter-professional method in which a [mental health] specialist establishes a partnership with another professional worker, network, group or team of professionals in a community field or a human service institution. The [mental health] specialist, by agreement with his (sic) colleagues becomes an integrated part of their evaluation and remedial operations, and accepts responsibility for the contribution of his specialist knowledge and for personally using his diagnosis, management and treatment of the clients. He is professionally responsible for the mental health outcome (Caplan and Caplan, 1994 p. 283).

Caplan and Caplan developed this definition in order to distinguish collaboration from mental health consultation. It is useful here because it stresses that a collaborative relationship is non-hierarchical and makes clear that each participant in the interaction takes responsibility and is accountable for his/her own tasks and roles.

> The view is that in order to service clients whose complex needs require the collaborative effort of a number of players it is essential to establish clear coordination structures, endorsed and supported by all levels of management of participating facilities

Harbaugh (1994) defines the term as working together '...with intention, mutual respect and commitment, for the sake of a more adequate response to a human problem' (Harbaugh 1994 p. 1920). He stresses three elements underlying collaboration. These are that the participants share a common objective; that a system of communication exists; and that the relationship is an inter-professional one which

> ...does not blur the distinctiveness of each profession, but does break through the extreme role specialisation that fails to appreciate the kind of balance and integration that a holistic orientation requires (Harbaugh p. 20).

In order to ensure that collaboration is not left to chance it is necessary to

> ... develop co-ordinative mechanisms which clearly detail working relationships which promote communication, consultation, and co-operative decision making between agencies. (Final Report

of the Inter-departmental Committee on Specialist Child and Family Services, August, 1986)

> In order for inter-agency collaboration to be ensured it is necessary to establish a policy framework which ensures the joint planning and management by largely autonomous agencies so as to surmount inter-organisational rivalries, limited resources and policy constraints (Johnson, Bruininks and Thurlow 1987 p. 529).

Thus the two concepts are linked in that '... in order for collaborative work to succeed it needs the support of coordinate structures' (Casto and Julia 1994 p. xiv).

> ...service to clients requiring complex co-ordinative structures in order to meet their needs is part of *core business* and as such must be accorded a high priority. Currently this is not necessarily so and agencies play poison ball...

THE MODEL

The model (see fig. 1) proposes coordination structures at the state level; the regional level; the level of each individual agency involved in the system of care; and the level of working with the individual child/adolescent and his/her family.

THE STATE LEVEL

The article does not address the State's role in detail since the project was not asked to make recommendations on this area. However, because the structures which are set in place at the other levels depend on State leadership, some comment is necessary.

In order to ensure that collaboration occurs, the State needs to establish the policy which provides the framework and direction for the regions to follow. It must back up such policy by allocating financial and other resources for the regions to use flexibly and sensitively in order to meet the unique needs of each client. It must ensure that the full range of services required to meet clients' needs exists; and that the quality of service delivered is monitored (Luntz 1994 p. 29). A recent draft document on child and adolescent mental health services (CAMHS) lends hope that the State is accepting leadership responsibility. The document makes a recommendation which could well have its origins in the project. The recommendation is for senior regional management to establish inter-service linkages. The main focus of these linkages known as Child and Adolescent Taskforce(s) (CAST)

> ...is to monitor and plan improvements in service delivery for those clients whose service delivery has not been satisfactory, to identify where service developments are required, to recommend or pilot new cross-service initiatives, and resolve inter-departmental conflicts. It is anticipated that regional management will be empowered to expedite assessments, identify responsible services and case management structures, and support case management planning for particular clients (draft document on *Victoria's Child and Adolescent Mental Health Services: Future Directions for Service Delivery* January, 1995 pp. 17-18).

This recommendation is to be applauded and it will hopefully be implemented, although the view of this author is that the responsibilities of the CASTS (or regional coordinating panels) need to be

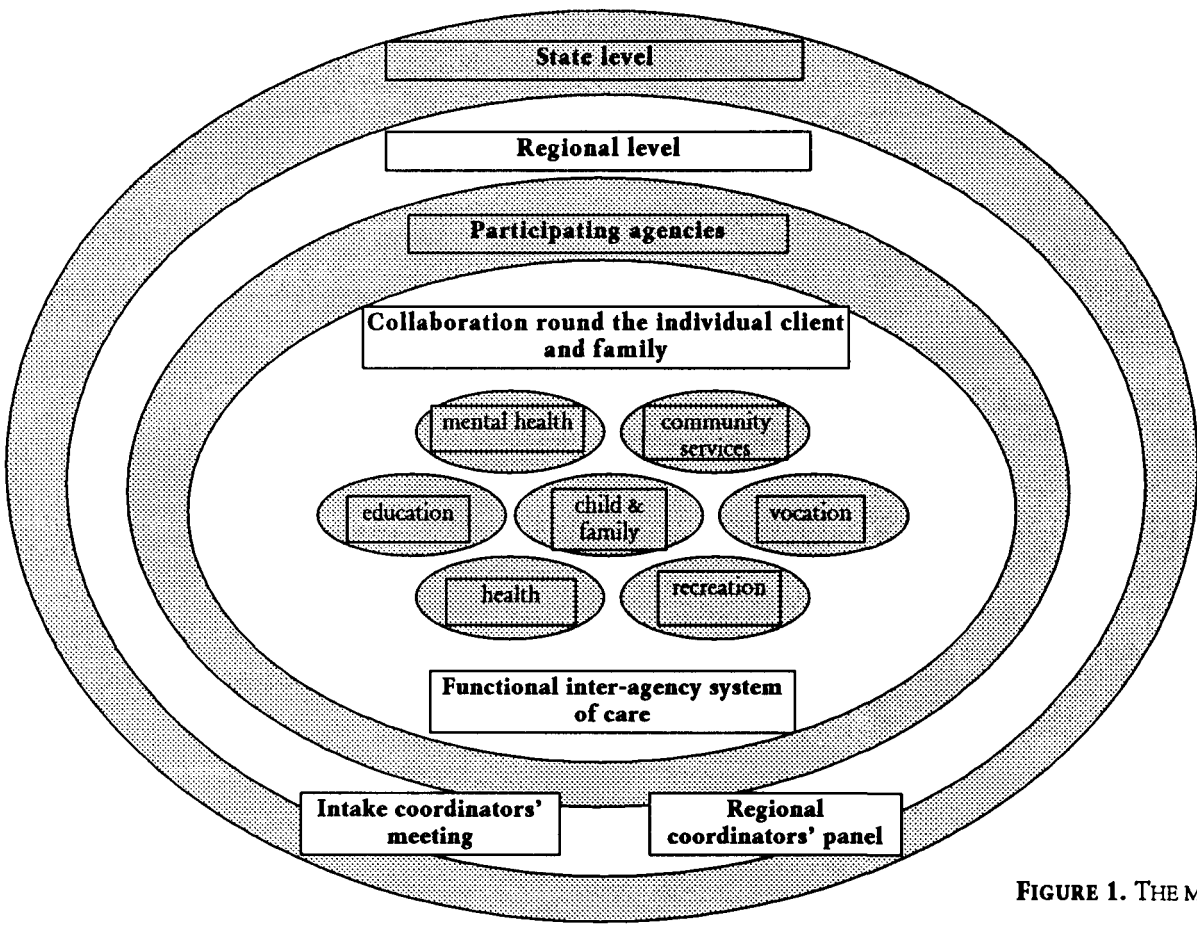

FIGURE 1. THE MODEL

more wide-ranging than those listed above.

THE REGIONAL LEVEL

Principles underpinning the coordinating structure

Acceptance of, and commitment by, management of both government and non-government agencies (NGOs) that service to clients requiring complex co-ordinative structures in order to meet their needs is part of *core business* and as such must be accorded a high priority. Currently this is not necessarily so and agencies play poison ball by disposing of the high risk case '...going through the motions of dealing with the case in order to ensure that their back(s) is protected from the accusation that they failed to act when all the while the family's problems are not addressed' (Scott 1994 pp. 6-7).

An important step in preventing the playing of poison ball is for management in both government and NGOs to acknowledge the following:

That work with the target group is highly complex both to the kinds of problems which these young people present and with respect to the range of services and disciplines needed in the *system of care* if the response is to be adequate; that because of the complexity, working arrangements must be supported by administrative rules and procedures often not part of current practice.

These include:

- active participation by key staff of the core regional agencies in the development, implementation and management of the coordination model;
- acceptance of the *no reject no eject* principle. Once a commitment has been made to service a client such service cannot be terminated unless the client's problem is solved, the system is discharged by the client, or it withdraws from treatment by making a proper or timely referral (Bope and Jost, 1994 p. 66);
- that positions directed to perform this work be classified at senior levels so as to attract staff skilled in working with clients and families, as well as being proficient in interdisciplinary and inter-agency teamwork;
- that as far as practicable, the same staff from the different agencies be allocated to work together with a number of these highly complex cases in order that they have the opportunity to

  > ...develop the trust and respect; overcome the obstacles to communication rooted in mutually disparaging stereotypes; ...develop a common language and ...understanding of the social systems, the patterns of communication, leadership authority and decision-making mechanisms in the other agencies in the network (Caplan and Caplan 1994 pp. 282-283);

- that management acknowledge that the difficulty and complexity of such cases requires much more time than is usually spent round an individual client. Staff who carry a disproportionate number of such cases need to have their caseloads monitored and adjusted accordingly.

Aims of the regional coordinating structure

The complex response aims to ensure that: the clients are able to gain access to the range of services required; that staff from the participating agencies form a collaborative, co-operative system of care able to develop an individualised service plan which addresses the unique needs and potential of each client; and that the system of care delivers the services in accordance with the service plan. The regional coordination structure has two tiers: a regional coordinating panel comprising representatives of senior management from the government and NGOs in the region who work with children and families and chaired by the regional director; and a regular meeting of intake workers at which the participating agencies make cross-agency referrals of clients who meet the criteria of this level of service delivery response.

> ...provision of a forum for dialogue is particularly important in times of budget constraint because it will ensure that individual agencies do not retreat to core business without consultation about the implication of cuts within their respective services on the capacity of the system of care to deliver...

The regional coordinating panel

The role of the regional coordinating panel is pivotal in the coordination process. Tasks include: the development of common definitions of key concepts as a priority. Responses to the questionnaire distributed in the project highlighted some stark differences in the understanding of terms such as emotional and behavioural disturbance, therapy, case management and consultation, amongst others (Luntz, 1995). Agreement about such fundamental issues as who is the target group is an essential pre-requisite to providing an adequate service. Also essential is the articulation and accommodation of philosophical differences and mandates of the participating agencies within the region. It is the regional Coordinating panel's responsibility to ensure that all workers at all levels understand these differences. This is especially important where mandates are determined by Acts of Parliament. Responses to questions raised in the project highlighted much confusion about the Children and Young Persons' Act (Luntz, 1995). Scott's insightful comments about this Act set out some of the reasons why the confusion is so profound (Scott, 1993 p. 6).

The panel needs to develop principles to accommodate the dilemmas inherent in such issues as confidentiality. The services to be represented on each regional coordinating panel requires some thought. For example, in regions where there are a large number of NGOs it may be necessary to develop some mechanism for deciding who sits on the panel and how these representatives communicate with the other NGOs in the region. If there is to be consumer/carer involvement this needs to be genuinely representative, not just token, and so requires the establishment of a consumer/advocacy group. With devolution of financial and other resources to the regional level the panels will be in a strong position to plan the range of services required by each region. This control and provision of a forum for dialogue is particularly important in times of budget constraint because it will ensure that individual agencies do not retreat to core business without consultation about the implication of cuts within their respective services on the capacity of the system of care to deliver high quality service to the clients. The provision of joint funding arrangements will allow the flexibility of providing those clients whose particular needs are such as to require services not regularly available, for example, individualised therapeutic foster care or enhanced adolescent community placements. It is important to remember that

this coordinating structure is experimental and will need to be fine-tuned over time. The regional coordinating panel is responsible for monitoring and altering its various components as required. Addressing the above-mentioned tasks will provide the foundation upon which those tasks listed in the draft document (see above) can be built. The draft document suggests that quarterly meetings will be adequate. This may be correct but frequency does depend on the amount of business to be covered and, in the early stages at least, quarterly meetings may be insufficient.

Intake coordinators' meeting

The second regional structure essential for ensuring a coordinated response is a regular meeting of those workers responsible for organising intake in the participating agencies. At this meeting clients requiring multi-agency involvement are presented and cross-referrals (Baglow, 1990 p.390) made as appropriate. At the Intake Coordinators' Meeting, decisions as to which agencies are to be involved in any individual case and the roles which each will play are clarified.

PARTICIPATING AGENCIES

All direct service workers in the participating agencies need to be knowledgeable about a range of matters which will enable the smooth running of the inter-agency coordination approach even though only a small number of staff will actually participate in the functional inter-agency systems of care. These matters include an understanding of the mandates and practices of the other services in the network and of the concepts of shared responsibility and joint management when working with emotionally and behaviourally disturbed children and adolescents in general. Specifically with respect to the clients who fit into this small sub-category, there is a need for all who participate in the intake process to be sensitive to the possibility that clients being referred may require more intensive multi-agency collaboration than is usually necessary.

If appropriate, such clients can be flagged for special allocation to collect information about the agencies currently involved and the roles being played by these agencies with respect to the client. In those participating agencies providing a range of programs, clients may be involved with an intra-agency service team as well as the inter-agency system of care. For example, the larger CAMHS are resourced to address learning problems as well as emotional and behavioural ones.

Many clients will have contact with a special education teacher, an occupational therapist who provides a sensory-motor program and/or a speech therapist who works with the child's language. These specialists may not need to be actively involved in the inter-agency system of care but will certainly need to have periodic contact.

Most CAMHS use an internal case manager to orchestrate the response for such clients and it appears to be an efficient use of resources for this person to be the CAMHS representative on the inter-agency system of care.

COLLABORATION ROUND THE INDIVIDUAL CLIENT AND FAMILY

The functional inter-agency system of care

> A functional system of care would be conversant with the language and culture of different agencies, it would have mechanisms for integrating work involving multiple providers, it would have a means for making decisions involving multiple decision makers and working out funding of care involving multiple sources; it would have a mechanism for defining standards against which to program and evaluate comprehensive interventions; and it would have a means for holding the community and its families in primary focus even as the administrative rigmarole demands near-total attention (Platt, 1994 p. 8).

Once it becomes apparent that a client fits the criterion of requiring the support of a functional inter-agency system of care the following steps need to be taken (see fig. 2).

> The ongoing collaboration involves all members of the system of care participating in the development and implementation of an individualised service plan for the client as appropriate...

The client's problems are presented at the intake coordinators' meeting and cross-agency referrals are made as required. The meeting decides which of the agencies to be involved will take responsibility for calling the first inter-agency case conference. Each intake worker from the separate agencies allocates the case internally to workers with an appropriate level of skill and experience. The inter-agency case conference is called as soon as possible. At this first-case conference, a case manager/case coordinator is appointed and a date set by which workers will have completed their separate assessments in preparation for the development of an individualised service plan. Also, the roles and responsibilities of all workers are negotiated, documented and communicated to relevant parties including the client (and parents, carers as appropriate); regular review meeting dates are set; and plans made for contingencies when crises occur. The ongoing collaboration involves all members of the system of care participating in the development and implementation of an individualised service plan for the client as appropriate; providing their specialised service for the client; and participating in the ongoing monitoring of the progress of the client as required. It is important to acknowledge that conflict is endemic to inter-agency collaboration. The issue is discussed by Scott (1993 pp. 4-5) amongst others. It is to be hoped that the coordination structures proposed in this model are sufficiently strong to ensure that such conflict can be resolved in the best interests of the client within the system of care. Where such resolution is not possible the regional coordination panel is responsible for resolving such conflict.

Role of the case manager/case coordinator

The case manager plays a critical role in ensuring that the multi-agency system of care delivers the required services to the client. Tasks include ensuring that participating agencies together provide a comprehensive assessment of the client's need, that an individualised service plan which addresses these needs is developed out of the joint assessment; that the participating agencies each implement their part of the plan. In such circumstance where the client's needs fall outside the services offered by the participating agencies, it is the case manager's responsibility to negotiate with the regional coordinating panel in order to gain access to financial and other resources which will enable the development of an innovative response to meet the client's needs. The case manager must keep in regular and frequent contact with the members of the system of care as well as the client and where appropriate with the client's family and other significant others. The case manager regularly monitors the level of continuity, adequacy and appropriateness of the services being provided, and ensures that the plan is altered when it is no longer

ACTION	RESPONSIBILITY
• Client referred for service	GP, school, self, etc.
• Complete intake form • Ascertain if client requires system of care • Clarify other agencies already involved • Ascertain roles of these agencies • Present client for cross referral at meeting	Intake worker
• Flag for special allocation to worker on inter-agency system of care	Intake worker
• Call case conference of members of inter-agency system of care	Worker designated to call meeting
• Select case manager • Set dates for completion of assessments • Roles and responsibilities negotiated and communicated to relevant parties • Regular review dates set • Contingency plans made	Members of the inter-agency system of care and case manager
• Link system with client and family • Advocate on behalf of client and family • Negotiate with regional panel if client requires services needing additional finances and special arrangements	Case manager
• Develop individualised service plan • Implement same	Case manager and inter-agency system of care
• Keep in touch with system of care and client system • Monitor adequacy and appropriateness of service • Ensure continuity of service provision	Case manager
• Monitor on-going progress • Review at regular intervals • Alter plan to address changing needs • Terminate as dictated by client's needs	Case manager and inter-agency system of care

FIGURE 2: PROCEDURE TO BE FOLLOWED WITH CLIENTS REQUIRING THE SUPPORT OF THE FUNCTIONAL INTER-AGENCY SYSTEM OF CARE

meeting the client's needs. The role includes advocating for the client and family as required and bringing in new players as they become necessary. For example, if the client needs to be transferred to the adult psychiatric services, the case manager makes the links and oversees a smooth transition. The first article in this series (Luntz, 1994 pp. 30-31), provides definitions and discusses in some detail the structural complexities of the inter-agency case management role including such matters as whether the position requires mental health expertise, whether it is essential that it be located within the mental health system or not and whether the role should include some direct service responsibilities or not. The Corporate Client Services Model (CCSM, Community Services Victoria, 1992), is the prototype on which case management arrangements in Victoria have been based. This model includes direct service as one of the essential tasks of the case manager.

This author is convinced by her own experiences which concord with the eloquent arguments of authors experienced in policy implementation with seriously emotionally disturbed children and adolescents, such as Stroul and Friedman, 1986 p. 95 and Behar, 1985 p. 194, that because of the conflict of interests inherent in the case management/direct service role, it is necessary to separate these roles in order to enable the model to work. Thus the case manager should not provide any direct service to the client. The issue of to what system the case manager is primarily responsible appears less clear-cut. Common sense would suggest that since the fundamental issues are those of the clients' mental health, the worker should be both sophisticated on mental health issues and accountable to the local CAMHS, but it may be necessary to trial different alternatives in order to ascertain which works more effectively.

> The case manager plays a critical role in ensuring that the multi-agency system of care delivers the required services to the client

CONCLUSION

The model presented in this article could be criticised for being too expensive to implement, especially in times of fiscal restraint. This criticism can be answered in two ways. First, the current arrangements are also very expensive, and in fact the full extent of the cost is hidden within the haphazard nature of the process as practised. What is worse, despite much effort, and often a great deal of goodwill, the results are regularly unsuccessful, so the money is actually being wasted. Secondly, the number of clients who do require the arrangements proposed is not very large, about 5% of the 11.8% of children and adolescents with clinical maladjustment difficulties (Stroul and Friedman, 1986 pp. iv-v). This statistic is born out by impressions of the Victorian scene (see Project Plan, 1992) and the difficulty experienced in obtaining a full sample of cases which went wrong for the project to analyse (Luntz, 1995). Because the model was developed in a particular region it represents a solution to a particular set of problems. These may or may not require adaptation for other regions of Victoria. Close monitoring is certainly necessary to ascertain whether this model requires modification. ☼

REFERENCES

Baglow, L.J. 1990, 'A Multi-dimensional Model for Treatment of Child Abuse: A Framework for Cooperation' in *Child Abuse and Neglect* 14(3), pp. 387-395.

Behar, L., 1985, 'Changing Patterns of State Responsibility: A Case Study of North Carolina' in *Journal of Clinical Child Psychology*, 14(3), pp. 188-195.

Bope, E.T. and Jost, J.D. 1994, 'Inter-professional Collaboration: Factors that Affect Form, Function and Structure' in *Inter-professional Care and Collaborative Practice, Commission on Inter-professional Education and Practice*, eds Casto and Julia, Brooks/Cole Publishing Co., Pacific Grove, California, pp. 61-69.

Community Services Victoria 1992, *Corporate Client Services Model, A New Approach in Delivering Services to Clients.*

Caplan, G., and Caplan, R.B. 1994, *Mental Health Consultation and Collaboration* Jossey Bass Publishers, San Fransisco.

Casto, R.M., and Julia, M.C. 1994, *Inter-professional Care and Collaborative Practice, Commission on Inter-professional Education and Practice,* Brooks/Cole Publishing Co., Pacific Grove, California.

Department of Health and Community Services, Psychiatric Services, *Victoria's Child and Adolescent Mental Health Services: Future Directions for Service Delivery* 1995, draft, January.

Harbaugh, G.L., 1994, 'Assumptions of Inter-professional Collaboration: Interrelatedness and Wholeness' in *Inter-professional Care and Collaborative Practice, Commission on Interprofessional Education and Practice,* eds Casto and Julia, Brooks/Cole Publishing Co., Pacific Grove, California, pp. 11-31.

Johnson, D.R., Bruiniks, R.H. and Thurlow, M.L. 1987, 'Meeting the Challenge of Transition Service Planning Through Improved Inter-agency Co-operation' in *Exceptional Children* 53(6), pp. 522-530.

Luntz, J.J. 1994, 'Coordination of Services for Children Suffering with Emotional, Psychological, Behavioural and Social Disorders', *Children Australia* 19(3), pp. 26-32.

Luntz, J.J. 1995, 'Collaboration in the Service of Coordination' in *Children Australia* 20(4) pp. 9-14

Platt, L.J. 1994, 'Why Bother with Teams? An Overview' in *Inter-professional Care and Collaborative Practice, Commission on Interprofessional Education and Practice,* eds Casto and Julia, Brooks/Cole Publishing Co., Pacific Grove, California, pp. 3-10.

Scott, D. 1993, 'Inter-agency Collaboration: Why is it so Difficult? Can we do it Better?' in *Children Australia,* 18(4), pp. 2-9.

Stroul, B. and Friedman, R.M. 1986, *A System of Care for Severely Emotionally Disturbed Children and Youth,* Washington D. C. CASSP Publication.

Victorian Department of Health – Office of Psychiatric Services 1992, *Project Plan on the Coordination of Services for Emotionally and Behaviourally Disturbed Children and Adolescents,* March.

Victorian Inter-departmental Committee on Specialist Child and Family Services 1986, *Final Report,* August.

Victoria's Mental Health Services *Improved Access through Coordinated Client Care* 1994, and its companion document, *Needs for Service Assessment and Review: A Collaborative Approach,* 1994, Training Notes, Psychiatric Services Branch, November.

SOCIETIES FOR THE PREVENTION OF CRUELTY TO CHILDREN

Dr Dorothy Scott and Dr Shurlee Swain of the University of Melbourne are currently engaged in researching a history of the detection and treatment of child abuse in Australia drawing primarily on the records of the Children's Protection Society (Victoria). The Society was previously known as the Victorian Society for the Prevention of Cruelty to Children and always believed that it was the only such society established in Australia. Our research, however, has indicated that there may have been similar, if shorter lasting, societies in other states. We would be interested to hear from anyone with information about such societies as we are keen to expand our research beyond its Victorian base.

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