

Interagency collaboration

Part B: Does collaboration benefit children and families? Exploring the evidence

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Briefing Paper 21 comprises two papers that focus attention upon how interagency collaborations benefit children and families.¹ Part A looks at what collaboration is, the benefits and risks of involving families in collaborations, when interagency collaborations are likely to be most effective and explores how they can be supported through specific models of governance. Part B investigates the evidence regarding the relationship between collaboration and improved outcomes for children and families.

Terminology

In this paper collaboration is defined as a: “means of producing something joined and new, from the interactions of people or organisations, their knowledge and resources” (ARACY, 2009). This paper focuses upon service level collaboration (rather than policy or research collaboration) amongst agencies (rather than intra-agency and interpersonal collaboration).

Introduction

Interagency collaboration can be a challenging, highly intense process (ARACY, 2009). However, theoretically, the benefit of collaboration is that it has the potential to more effectively address the problems of families with multiple and complex issues, as well as complex, intractable problems such as homelessness and poverty (Bromfield, Lamont, Parker, & Horsfall, 2010; Huxham, 1996; Penner, cited in Foster-Fishman, Salem, Allen, & Fahrback, 2001; Tuma, cited in Foster-Fishman et al., 2001).

In recognition of these potential benefits, interagency collaboration has become a highly regarded way of working, as reflected in government policy both internationally (Dowling, 2004) and in Australia (see Part A). In addition to benefiting participating professionals through, for example, increased skills and knowledge (Flaxman, 2009), parents who participate in interagency collaborations can benefit via, for example, increased self-confidence (El Ansari & Phillips, 2011).

¹ Information on practical strategies to establishing interagency collaboration can be found on the Australian Research Alliance for Children and Youth (ARACY) website <www.aracy.org.au/index.cfm?pageName=advancing_collaboration_practice>



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However, despite the benefits for those professionals and parents directly involved in collaborations, there is limited empirical evidence to clearly demonstrate that collaboration leads to improved outcomes for service users in Australia (Winkworth & Healy, 2009) and internationally (Brown, Tucker, & Domokos, 2003; Dowling, Powell, & Glendinning, 2004; Hayes et al., 2011; Rummery, 2009). A recent systematic review reporting upon the impact of interagency collaborations that target health outcomes and behaviours found that “evidence of health benefit [as a result of collaboration] was extremely weak” (Hayes et al., 2011, p. 19). Furthermore, in a review of research that investigated the impact of partnership working between the health and social service sectors in the UK, Dowling et al. (2004) concluded that:

Knowledge of whether partnerships “work”—in the sense of producing benefits to those who pay for, provide or use services—remains very limited ... If evidence-based policy means more than an empty slogan, then this is surely a large gap in knowledge that needs to be filled. (p. 315)

The increased shift towards inter-agency collaboration in Australia provides a critical opportunity to develop the evidence base regarding the effectiveness of collaboration in bringing about improved outcomes for families. Although undertaking a client outcome evaluation of inter-agency collaboration poses significant challenges (Dowling et al., 2004), there is a need to clearly identify how inter-agency collaborations can most effectively and efficiently contribute to improved outcomes for families.

How does collaboration benefit families?

Five key benefits of collaboration for children and families are commonly cited:

- *Increased use of services*: Those families who require support services are often the least likely to access them (Centre for Community Child Health, 2010). Collaborations between agencies can increase families’ willingness to use services that will benefit them. For

example, collaboration between a health service and an Indigenous organisation may make Indigenous families more likely to use a service (Panaretto et al., 2005). Where particular services are stigmatised within the community (e.g., parenting interventions), agencies can collaborate to provide those services through a less stigmatised venue (Scholte in Rummery, 2009). For example, a program that is stigmatised could be offered in a school or child health clinic—a venue that is recognised within the community as universal (McDonald, 2010a).

- *Increased access to services:* In a siloed service system, children and families may miss out on services because individual agencies within the system are not aware of one another, or what other services can provide, and/or there are rigid organisational boundaries (otherwise known as “gatekeeping”) that restrict an agency’s ability to refer clients on to other services (Foster-Fishman et al., 2001; Scott, 1995). More streamlined approaches within an integrated service delivery model result in clients receiving services in a more timely manner (Brown et al., 2003; Panaretto et al., 2005).
- *Holistic service provision:* When agencies are collaborating it is assumed that they will be more able to respond to the multiple needs of families, whereas in a siloed service system, families’ problems are dealt with in a compartmentalised way (Young & Gardner, 2002). Holistic service provision is likely to be more convenient to families because it reduces the need consult with multiple service providers (which may reduce a family’s need to travel to multiple locations and/or tell the same story multiple times).
- *Concise, consistent information:* Agencies that communicate with one another and share information are able to provide parents with consistent messages. As a result parents are less overwhelmed by information and they will not be faced with competing demands by multiple agencies (Green, Rockhill, & Burrus, 2008).
- *Being heard:* Involving service users is important to the success of collaboration (Winkworth & Healy, 2009). If service users are involved it can benefit them by providing with an opportunity to “be heard”—a central tenet of the Australian Government’s Social Inclusion Agenda (Australian Social Inclusion Board, 2008). Being heard is good for children and families (see McDonald 2010b).

Although these factors are commonly cited as the outcome of interagency collaborations, there is limited empirical evidence to clearly demonstrate that collaboration does lead to these types of improved outcomes for service users in Australia (Winkworth & Healy, 2009) and internationally (Brown et al., 2003; Dowling et al., 2004; Hayes et al., 2011; Rummery, 2009). For example, the evaluation of the Australia-wide Communities for Children (CfC) initiative—that sought to improve outcomes for children aged 0–5 and their families through a range of innovations, including better coordination of services—found that the initiative did lead to a greater degree of collaboration (Flaxman, Muir, & Oprea, 2009; Muir et al., 2009) and did improve some outcomes for children and families (Edwards et al., 2009), however this evaluation did not measure specifically the impact of the former upon the latter.

Edwards et al. (2009) hypothesised that the service coordination aspect of the CfC program most likely did bring about better outcomes for children and families when compared to an initiative that simply increased the number of services. However, they argued that further research is required to support that claim: “Which key ... program elements are most efficacious is a critical question that deserves further empirical inquiry” (Edwards et al., 2009, p. 34).²

2 Hayes et al. (2011) sought to identify which models of collaboration are most effective (e.g., multidisciplinary teams, shared protocols, joint training) however as they found inadequate evidence of any health benefit from the studies they identified, this analysis was not conducted.

There is an abundance of literature regarding the process of collaboration in the child welfare and family support services fields, for example, methods for developing effective collaborative relationships, overcoming obstacles in collaborative relationships and so on (see, for example, the ARACY Advancing Collaborative Practice resources³). Although this information is useful and necessary, especially for agencies that have not had extensive experience with collaboration, the information about process takes the focus away from the fact that collaboration is a “means to an end, not an end in itself” (Bruner, 1991, Conclusion, para 2).

Furthermore, there is evidence to demonstrate the benefits of collaboration to professionals, including enhanced skills, knowledge and confidence of professionals and a more supportive professional environment (Flaxman, 2009). However, whilst these outcomes are clearly positive, a strong evidence base to demonstrate improved outcomes for children through collaboration in Australia is lacking (Winkworth & Healy, 2009).

It is not surprising that this is the case, considering the fact that many of the agencies taking part in interagency collaborations will be relatively small and/or lack the resources to undertake an impact or outcome evaluation of this type. Outcome evaluations of collaborations that seek to measure the outcome for clients are challenging because the effects of collaboration between agencies may take a long time to eventuate among service users and even if changes have occurred it is difficult to attribute those changes solely to the collaboration (Dowling et al., 2004). As a result of these difficulties Winkworth and Healy (2009) noted that process evaluations of collaborations are generally viewed as a “pragmatic, albeit second best solution” (p. 25). However it does raise a critical question; how do we know interagency collaborations *benefit clients*?

Research that seeks to answer this question within the context of child welfare and family support services has a noticeable geographic (i.e., United States and UK based research) and contextual bias (i.e., child protection (US) or health (UK)).⁴ As a result, the extent to which we can confidently answer the question, “does collaboration undertaken by the child welfare and family support services sector in Australia benefit children and families?” is extremely limited. Nevertheless, there are important lessons to be learnt from the evidence that does exist.

The body of research

The literature reviewed for this publication focused upon interagency collaborations within the child welfare and family support services fields. Much of this literature is descriptive rather than evaluative (Horwarth & Morrison, 2007) and those evaluations that do exist are overwhelmingly process evaluations (Dowling et al., 2004; Brown, Glasby, & Dickinson, cited in Ball, Forbes, Parris, & Forsyth, 2010).⁵ Process evaluations focus upon how an intervention works (Parker, 2010). A process evaluation of an inter-agency collaboration will address issues such as whether the collaboration is functioning in the way that was intended and what factors are hindering the functioning of the collaboration.⁶

3 ARACY Advancing Collaborative Practice resources <www.aracy.org.au/index.cfm?pageName=advancing_collaboration_practice>

4 UK evaluations of partnership focus upon partnerships between health and social care rather than a specific population group (e.g., children), US evaluations focus on partnerships between services in statutory care.

5 Dowling et al. (2004) also noted that, “most of the available tools, audits and benchmarks that have been suggested to assess the effectiveness of partnership working appear to focus largely on process” (p. 311).

6 These questions are based upon those listed in Parker (2010) which refer to programs rather than collaborations specifically.

Some research has focused on the outcome of collaborations for professionals and agencies (Gulliver, Peck, & Towell, 2000, 2002). However, very little research has evaluated the outcome of collaborations for service users (Brown et al., 2003; Dowling et al., 2004; Rummery, 2009; Winkworth & Healy, 2009).⁷ Brown et al. concluded that: “although it is perceived wisdom that joint working must be beneficial, even at this stage, there is little evidence to support that notion” (2003, p. 87).

Overall, the evidence that does exist regarding the benefits of collaboration for children and families shows that collaboration is beneficial; however some caveats emerge from the research. Some researchers argue that collaboration does bring about improved outcomes for children (Bai, Wells, & Hillemeier, 2007; Selden, Sowa, & Sandfront, 2006; Panaretto et al., 2005), and that the more intense the collaboration, the better the outcomes (Bai et al., 2007, Selden et al., 2006). Other researchers argue that some components of collaboration work better than others (Chuang & Wells, 2010), and that the success of collaborations in bringing about improved outcomes depends upon the strategies that are utilised (Jayaratne, Kelaher, & Dunt, 2010). Further research suggests that collaboration works for some clients but not for others (Hurlburt et al., 2007).⁸ In the following discussion, this body of research about collaboration is “unpacked” in order to identify exactly what it says about the benefits of collaboration.

What components of collaboration work?

In practice, collaboration can comprise many different types of activities. As described in Part A (*Interagency Collaboration. Part A: What is it, What Does it Look Like, When is it Needed and What Supports it?*), interagency collaboration could include: cross-training of staff, multi-agency working group, common financial arrangements, sharing of administrative data and joint case management. It is useful to consider, therefore, whether some collaborative activities are more effective at improving outcomes for clients than others.

Chuang and Wells (2010) investigated the impact of inter-agency collaboration between child welfare and juvenile justice systems upon access to behavioural health services for children and young people involved with both systems. This research is especially useful because it takes account of the potential for collaboration to be multifaceted, investigating three components of collaboration:

- *jurisdiction*: the development of rules about who is eligible to make decisions, which actions are allowed or constrained, and what information needs to be provided;
- *shared information systems*: allow participating agencies to communicate and monitor each others’ activities; and
- *connectivity*: inter-organisational arrangements such as joint decision-making, cross-training of staff and joint budgeting.

Chuang and Wells (2010) found that while jurisdiction and sharing information did lead to improved outcomes for children, connectivity did not.

⁷ The situation is similar in the field of public health (Smith et al, 2009). In their systematic review of research relating to the impact of partnerships on public health, Smith et al. found that “there is not yet any clear evidence of the effects of public health partnerships on health outcomes” (p. 210).

⁸ These mixed findings regarding the impact of collaboration are not confined to the child and family services sector; research that investigates the impact for clients in the health sector (Schmeid et al., 2010) and aged care sector (Brown et al., 2003) also appear to be mixed.

They pointed out, however, that their findings could be specific to the child welfare and juvenile justice systems, as research on collaborations between other types of systems (e.g., child welfare and behavioural health agencies) has shown that connectivity does lead to improved outcomes for clients (Bai et al., 2009; Hulburt et al., 2004). Indeed, whilst Chuang and Wells' research suggests that some components of collaboration are more effective than others, Bai et al.'s (2009) investigation of collaboration between child welfare and mental health service providers, showed that: "the more ways child welfare agencies coordinate with mental health service providers, the better" (p. 378).

One of the messages from across the research by Chuang and Wells (2010), Bai et al. (2009) and Hulburt et al. (2004) is that in some contexts collaboration will benefit clients, whilst in other contexts some types of collaborative activities will work and others will not. Further research is required that investigates which components work in which contexts.

It is important to note also that the differences between Chuang and Wells' (2010) and Bai et al.'s (2009) findings could be attributed to the quality of the relationships between the agencies. Selden et al. (2006) argued:

Scholars should examine and model variations within the collaborative relationship to capture any differential effects of the diverse complexities [of collaboration] to truly capture the impact of collaboration. (p. 416)

Taking a slightly different approach to Chuang and Wells (2010), Jayarante et al. (2010) identified the characteristics of child health partnerships (e.g., Sure Start, Toronto First Duty, Stronger Families and Communities Strategy) that have led to significant improvements in child outcomes. Focusing more on strategies rather than broad components Jayarante et al. (2010) concluded that the partnerships that demonstrated better impacts had the following characteristics. They:

- targeted disadvantaged families;
- focused on outreach service provision;
- paid attention to the process of partnership; and
- had a high quality evaluation design.

The differences between the effectiveness of collaborations could be attributed to the relationships between the participating partners (as mentioned) and also the strategies those collaborations use to improve outcomes, as Jayarante's research suggested.⁹

Overall, this research shows that the success of collaboration is highly dependent upon context—the quality of the relationship between the agencies, the sectors involved (e.g., child welfare, mental health, child health) and the strategies utilised by the agencies. Because of the importance of context, process and outcome evaluations of collaborations are important. Process evaluations can demonstrate whether and how the collaboration has worked. As Bruner's (1991) work suggested, *the outcomes for children and families will not improve if the collaboration itself is not operating effectively*.¹⁰

9 In other words, as relationships are central to collaborations, it could be that some agencies can more easily develop relationships with one another than others thereby bringing about more positive outcomes for clients. One of the factors that can facilitate collaborative relationships between agencies is pre-existing networks (Muir et al., 2009). As developing relationships of trust takes time, agencies with pre-existing relationships will be able to advance more quickly to enhance service systems (Muir et al., 2009).

10 ARACY (2010f) has produced a checklist to assist in assessing the functioning of a collaboration <www.aracy.org.au/cmsdocuments/ACP%20FS10%20Evaluating%20collaborations%2029_061.pdf>

Do some clients benefit from collaboration more than others?

Researchers and advocates in Australia commonly argue that collaboration is most effective for vulnerable and at risk families. The logic behind this claim is sound—where families have multiple and complex problems, collaboration between agencies can provide more seamless access to the full range of services that those families need. But is there any evidence to demonstrate that collaboration benefits some clients more than others?

Hurlburt et al. (2007) looked at whether links between child welfare and mental health agencies increased the likelihood of specialty mental health service use for children involved with child welfare system. Interestingly, they found that as linkage levels increase, the likelihood of specialist mental health service use increases for children above the clinical cut-off point (i.e., those with significant emotional and behavioural problems) and *decreases* for children below the cut-off point (i.e., those with less significant emotional and behavioural problems).

Hurlburt et al.'s (2007) findings support the claim that collaboration is most effective for children with multiple and complex needs but adds a new dimension to this claim, that is, that collaboration can have a *negative impact* on those children whose needs are not as complex. However, further research is needed to support Hurlburt et al.'s (2007) findings and to identify exactly *how* increased collaboration leads to poorer outcomes for some clients.¹¹

There is also evidence to suggest that children with mental health problems and learning disabilities benefit especially from inter-disciplinary, multi-agency and collaborative teams of health and social care. For example, research conducted in the UK demonstrated that the involvement of social workers in mental health teams resulted in improved outcomes for children (Rummery, 2009).

In addition to benefiting children and families with complex needs and children with mental health problems and disabilities, there is some evidence to suggest that collaboration benefits families who are disengaged from the service system. In relation to Indigenous families, Flaxman et al. (2009) noted:

Many Indigenous families and children are disengaged from the service network. In many cases, a family's engagement with a child-care service is the only connection they have to service networks and for this reason, referrals between early childhood service providers and other support services are crucial. (p. 13)

Whilst referral in itself is not “collaboration”, research undertaken in the health sector indicates a strong link between “meaningful” collaboration and “meaningful” referral (Lockhart, 2006). Lockhart's research on collaboration between general practitioner and mental health services in rural and remote Australian shows that poor collaboration leads to mistrust and conflict around referrals (Lockhart, 2006). It is reasonable to assume that, as a result, patients may experience poorer outcomes. When a service provider has an existing relationship with an agency they are referring a client to, they can reassure the client that they know the agency and that it is safe and welcoming (otherwise known as a “warm referral”). Also, when service providers are aware

¹¹ Cottrell, Lucey, Porter, and Walker (2000) described how inter-agency collaboration between child and adolescent mental health services and the Department of Social Services in Leeds (UK) led to a change in referral practices, resulting in priority cases being seen more quickly. Faster referrals for high priority cases could result in the phenomenon Hurlburt et al. explained—whereby those children with the most clinically significant problems benefited the most from increased links between services. However, Hurlburt et al. (2007) did not identify whether referral practices were part of the service system changes they investigated, therefore it is not possible to use Cottrell et al.'s (2000) findings to explain Hurlburt et al.'s findings. In any case, changes in referral practices where children with high needs are seen more quickly does not explain why children with “moderate” needs would experience *poorer* outcomes.

of what other agencies provide they are more likely to refer to services that will best meet the client's needs.

Does collaboration pose risks for children and families?

Apart from the aforementioned research regarding the fact that collaboration can have negative impacts for children with “moderate” needs, there is very little research or even discussion of the risks that collaboration may pose for children and families. The majority of the drawbacks of collaboration pertain to the professionals involved, such as feeling overwhelmed as a result of an increased workload brought about by their involvement in collaboration (Bruner, 1991) or “partnership fatigue” (i.e., with professionals attending regular meetings for a range of different collaboration initiatives) (Huxham & Vangen, 2004), feelings of resentment if one party is not pulling their weight in a collaborative relationship (Flaxman et al., 2009) and feeling threatened or uncomfortable if professionals boundaries are challenged (Bruner, 1991).

Parton (2009) suggested that one of the drawbacks of collaboration for children and young people could be a reduced sense of trust as a result of information sharing between agencies.¹² Arguing that one of the fundamental reasons why children and young people trust service providers is their assurance of confidentiality, Parton's claim suggests that increased information sharing may lead to children and young people not accessing services. Although Parton focused upon the impact of information sharing on children and young people, it is reasonable to assume that for parents who are wary or distrustful of service providers, this may also be a concern. However Parton (2009) does not refer to any specific research findings in order to back his claims about the relationship between collaboration and a reduced sense of trust.

CALD families, service use and inter-agency collaboration

One surprising issue emerging from the research is that the stronger the ties between agencies, the more likely families from some culturally and linguistically diverse (CALD) backgrounds are to use services (known as “racial disparity” in the US based literature) (Hurlburt et al., 2007)

Under-utilisation of services by families from CALD backgrounds exists in both the United States and Australia. In Australia, for example, Indigenous children are under-represented in early childhood services and many Indigenous Australians are not accessing mainstream human services (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2007, cited in Flaxman et al., 2009; Department of Family and Community Services, 2005, cited in Flaxman et al., 2009). Parents from a non-English speaking background in Australia are more likely than other parents to have an unmet early childhood health service, primarily because of the inflexible operating hours of these services (Ou, Chen, Garrett, & Hillman, 2011). Other reasons why families from CALD backgrounds may not utilise services are multiple and include: a lack of knowledge that services exist or that they are eligible to use them, or a reluctance to use services because they or their families have had a negative experience of them (Carbone, Fraser, Ramburuth, & Nelms, 2004).

Hurlburt et al. (2007) found that increased interagency links between child welfare and mental health services decreased service use disparity for African American children but not for children

¹² It is interesting to note that in the mental health sector in the UK, where inter-agency and inter-disciplinary collaborations are common, users also express concern about the lack of privacy as a result of collaborative approaches (Freeman & Peck in Rummery, p. 1799).

from other ethnic minorities. They did not offer an explanation as to why this might be the case, concluding only that:

Efforts by child welfare and mental health agencies to coordinate around the mental health needs of children may be able to prevent disparities in mental health care use among African American children, who are heavily over-represented in the child welfare system. (Hulburt et al., 2007, p. 1223)

Australian-based research has also demonstrated that collaborative approaches can increase service use by Indigenous Australians. For example, a collaborative antenatal care program delivered by a team of health professionals in an Aboriginal and Torres Strait Islander community controlled health service led to increased use by Aboriginal women and improved perinatal outcomes (Panoretto et al., 2005).¹³ Anecdotal evidence suggests that the Communities for Children initiative, which had a strong collaborative component, also led to increased participation of Indigenous families in early childhood programs and activities (Flaxman et al., 2009).¹⁴

Although Hulburt's (2007) findings regarding African American's increased use of mental health services as a result of collaboration is perplexing (especially when considering service use by other ethnic groups did not increase), Panaretto's (2005) findings clearly articulated the importance of collaboration between Indigenous and non-Indigenous agencies in creating a "safe" environment for Indigenous clients. This supports other research that highlights the importance of collaboration between Indigenous and non-Indigenous agencies for Indigenous clients. This is demonstrated in the following quote from a service provider cited in Flaxman et al.'s (2009):

The funding has strengthened linkage and developed partnerships [between mainstream services and] Aboriginal organisations. I can see it working. The fact that there can be crossover [between Indigenous and mainstream organisations] opens it up a lot. Indigenous families are becoming more comfortable using mainstream services. Aboriginal families are comfortable as long as it's a partnership. (p. 14)

Discussion

The research undertaken thus far suggests that collaboration does benefit children and families, although there are some caveats relating to that claim. In the Australian context the evidence pertaining to the relationship between improved client outcomes and interagency collaboration is extremely limited. Methodologically rigorous evaluations that measure process and outcome indicators are required in order to develop this evidence base. This evidence is critical in order to justify the intensive resources that are required for the purpose of inter-agency collaborations and to demonstrate which collaborations work (e.g., which sectors, what components) for which clients and under what circumstances.

Research regarding which clients do not benefit from collaborations is especially limited, perhaps as a result of an overwhelmingly "pro-collaboration" environment. Although on the surface it would appear that collaborations benefit everyone, there is some evidence to suggest that for some clients collaboration has a neutral or even negative impact (see Hurlburt et al., 2007). This

¹³ The collaborative health care team comprised Aboriginal health workers, other health professionals (e.g., doctors, nurses, obstetricians) and an Aboriginal outreach health worker (Panoretto et al., 2005).

¹⁴ In remote areas collaboration can also be more cost and time effective; as multiple service providers can fly in fly out at the same time (Flaxman et al., 2009, p. 14).

hypothesis needs to be tested in the Australian context and if this is the case the implications of this need to be carefully considered.

Key messages

- Although research has demonstrated that interagency collaboration benefits the professionals and agencies involved (e.g., increased skills and knowledge) there is limited empirical evidence to clearly demonstrate that collaboration does lead to improved outcomes for service users.
- Research that seeks to determine whether interagency collaboration leads to improved client outcomes has a noticeable geographic (i.e., United States and UK based research) and contextual bias (i.e., child protection (US) or health (UK)).
- The success of collaboration is highly dependent upon context—the quality of the relationship between the agencies, the sectors involve (e.g., child welfare, mental health, child health) and the strategies utilised by the agencies.
- Collaboration is most effective for children with multiple and complex needs, however there is some evidence to suggest that collaboration may have a negative impact on those children whose needs are not as complex.
- The stronger the ties between agencies, the more likely families from some CALD backgrounds are to use services. In Australia, there is some evidence of a link between interagency collaboration and increased Indigenous engagement in antenatal services.

Further resources

For additional information about interagency collaboration that is specific to Indigenous communities, please refer to the forthcoming publication by the Closing the Gap Clearinghouse:

Effective Practices for Service Delivery Coordination in Indigenous Communities (Resource Sheet No. 9)
<www.aihw.gov.au/closingthegap/publications/>

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