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ORIGINAL CONTRIBUTION

Professionals' views on the development process of a structural collaboration between child and adolescent psychiatry and child welfare: an exploration through the lens of the life cycle model

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Abstract

This study, as a part of a participatory action research project, reports the development process of an innovative collaboration between child and adolescent psychiatry and child welfare, for adolescent girls with multiple and complex needs. The findings emerge from a qualitative descriptive analysis of four focus groups with 30 professionals closely involved in this project, and describe the evolution of the collaborative efforts and outcomes through time. Participants describe large investments and negative consequences of rapid organizational change in the beginning of the collaboration project, while benefits of the intensive collaboration only appeared later. A shared person-centred vision and enhanced professionals' confidence were pointed out as important contributors in the evolution of the collaboration. Findings were compared to the literature and showed significant analogy with the life cycle model for shared service centres that describe the maturation of collaborations from a management perspective. These findings enrich the knowledge about the development process of collaboration in health and social care. In increasingly collaborative services, child and adolescent psychiatrists and policy makers should be aware that gains from a collaboration will possibly only be achieved in the longer term, and benefit from knowing which factors have an influence on the evolution of a collaboration project.

Keywords Collaboration · Mental health · Child and adolescent psychiatry · Life cycle model · Multiple and complex needs · Adolescent girls

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Introduction

For the promotion of health, and delivery of welfare services adapted to the needs of users, models of interorganizational and interprofessional collaboration have been launched for decades, all over the world [1–3]. Collaborative projects have also been at the core of child mental health and social services policy, since overcoming the fragmentation in services for the growing and challenging population of young people with multiple and complex needs (MCN) can only be accomplished through collaboration among child-serving agencies [4, 5]. Existing research identifies potential benefits of collaboration in youth care, for patients, professionals and organizations [6–9].

Professionals in health and social services are increasingly being called to collaborate not only around individual patients but also at the practical and system levels [10]. Increased investment in collaborative working is especially relevant for mental health services, given the changing role of child and adolescent psychiatry (CAP) [10].

However, while a useful and motivating concept, collaboration is challenging and is characterized by a complex development process [9, 11–13]. Earlier research suggests that the manner in which the development towards collaborative working is handled, paying attention to building trusted networks and nurturing relationships, is as important as any of the decisions about goals, governance, or structures [12, 14]. As Kodner states [15], more efficient care is merely a 'hope' when engaging in collaborative projects. Hence, before making pronouncements on the strategy's cost-effectiveness, a thorough calculation and monitoring of all costs is necessary and collaboration projects must be reviewed systematically [16].

Some of the frameworks for collaboration [17] describe stages in the process from initiation through implementation. Kagan [18] describes the development of collaborative relationships in three stages: the beginning stage when the collaboration is forming and making plans; the growth stage when plans are implemented in programs and policies; and the evaluation stage when results are examined and decisions are made about whether or not to make changes. In the related field of interprofessional education, a more recent publication by Khalili et al. [19] describes similar stages in the development of interprofessional collaborative person-centred practice. Other authors concentrate on the planning of interagency development and describe sequential steps in this process [12, 20]. Hodges et al. [21] present stages of collaboration in which agencies develop their capacity to plan and deliver services for a particular population, and emphasize the need for a parallel development of interprofessional and family-professional ties.

However, the health and social literature seems to offer little guidance concerning the development process or the expected timeline of challenges and benefits when engaging in collaboration. Indeed, collaborative projects could benefit from knowledge on what progress should be expected during the process of the collaboration.

Hence, our central research question is: what are CAP and Child Welfare (CW) professionals' perspectives on the development process of cross-sectoral care during an intensive collaboration project? A secondary question is: what are the underlying factors that influence the development process of a collaboration project?

This article aims to describe the perspectives of the different team members regarding the development of an intensive cross-sectorial collaboration between two organizations, but does not have any intention to evaluate that collaboration.

Methods

This study is part of a participatory action research on care delivery for adolescent girls with MCN. In participatory action research, the aim is to enrich both scientific and practical knowledge, in a cyclic reflection process that engages all stakeholders, as the research is done with them, rather that 'on' them [22]. In this project, the professionals participated in every step of the research project: setting goals and choosing methods, discussing intermediate findings and directing further research steps. To describe the development process of the cross-sectoral collaborative care project (CSCC), a collaboration project for adolescent girls with MCN, the perspective of involved professionals was explored in focus groups and analysed with descriptive analysis methods.

Setting

The innovative care delivery project studied in this research is located in Antwerp, Belgium, and started in 2014.

It offers residential care for 17 girls aged 14–21 years, who have MCN. The mean age at entrance is 15.8 years. These girls have a combination of psychiatric problems and a family environment that does not provide safety and stability. A history of (physical, emotional, or sexual) abuse or neglect is very common. Most of these girls have a combination of internalizing (mostly depression) and externalizing (mostly conduct disorder) difficulties. Further group level characteristics are: high-risk behaviour (such as suicide attempts, self-harm, teen prostitution, and substance abuse), physical problems, and school dropout. A large majority of these girls is referred by juvenile court. Each of them has had multiple out-of-home placements.

All the girls reside in the residential CW facility. From the start of the project until the time of the focus groups, 21 girls were enrolled. Four of them completed their stay before completion of the focus groups in February 2016 and went on to independent living (facilities). Only one of them left prematurely after disciplinary dismissal, but received follow-up on an outpatient basis.

The current collaboration was initiated by the CW and CAP organizations, faced with the challenges brought about by youths with MCN. It received regional funding from the Flemish Government. At the start of the project, all staff members of the CW residential facility were offered the choice of participating in this project. All CW employees spent their entire working time in this CW facility. The CAP staff stayed employed in the CAP hospital and were present in the CW facility at different and flexible times, but ensured 24/7 availability and joint decision making. In the first 8 months, four out of the 32 involved professionals left, because they had other professional opportunities and were replaced to complete the team. All of them were CW staff members and changed to another CW facility. One additional person moved to another function within the project 2 months before the focus groups.

In this project, CAP and CW engage in an equivalent, bidirectional collaboration, wherein all hierarchical levels engage in an intensive collaboration. They take joint responsibility and work simultaneously to optimize care delivery for these vulnerable girls, whose needs could not be met by CAP or CW in isolation. Basic agreements on the input of both partners were made at the beginning of the project, but the collaboration was regularly evaluated and roles and tasks changed according to the needs of the population served. For each of the girls, the final responsibility for intake and treatment planning (including crisis interventions) was shared between CW and CAP. The roles in the implementation are discussed together by CAP and CW professionals on an individual basis depending on the needs of the respective girl.

Table 1 illustrates the roles of both CAP and CW in this collaboration project.

Data collection and sample

In January and February 2016, we conducted four focus groups at the CW centre, with a total of 30 professionals involved in the collaboration project. A literature review on MCN and collaboration assisted in the design of an interview guide. Examples of the starting questions were: how did the collaboration project develop? Did you notice changes when you compare the current situation to the beginning? What underlied those changes? Two researchers conducted the focus groups (moderator and observer taking field notes) and a third one joined them for data analysis. Each focus group lasted for about 150 min, was audiotaped, transcribed verbatim, and anonymized. After four focus groups, the data were rich in details of professionals' descriptions of the development of the collaboration project, referred to as 'thick description' [23].

To achieve an interprofessional in-depth description of the CSCC, we used a purposeful sampling strategy. Potential participants were professionals from CW and CAP closely engaged in the CSCC. Thirty-two persons were approached verbally, of whom 30 gave their written consent for voluntary participation in the focus groups (94% participation rate). The distribution of professions over the focus groups was representative for the collaboration project. As the number of staff members involved was higher in CW than in CAP, focus groups were done separately for both collaborating agencies. This had the additional advantage of limiting (positive) social desirability bias and allowed better insight into the impact of the collaboration on each of the partners. The two persons who did not participate were from CW, and their reason for not participating was time constraints. Table 2 illustrates the composition of the focus groups.

Table 1 Input of CW and CAP in the collaboration project

	Child welfare	Child and adolescent psychiatry
Joint input	Joint *intake*: establishing goals and planning with youths (and relatives) who start the program Joint *team meetings*: decision making and evaluation for all cases: 2.5 h, every 2 weeks *24/7 permanency* of CW supervisors and child and adolescent psychiatrist: dialogue, advice, crisis assessment Communication with *external partners* (schools, adult services, …) *Stakeholder meetings* to evaluate the project together with other partners in youth care or related domains: every 6 months	
Input from each partner	*Safe and stable daily living environment*, group care setting *Independent living* skills *Contextual* working, focus on relationship with relatives, building a social network Focussing on safety, reducing *high-risk behaviours* Focussing on *societal integration* (including administration, school work,…)	For youths Short *consultations:* 2 h every 2 weeks *Diagnostic* testing Ambulatory *therapy* (verbal and nonverbal, individual, group, family) Residential or semi-residential crisis or *treatment* service (including time-outs) *Psychopharmacological* treatment and *medical coordination* For staff Participation in *management meetings*: 1.5 h every month Advice or participation in *case evaluation meetings* *Super- and intervision:* 1.5 h every 2 weeks *Training* on CAP specific topics: 3 h every 2 months
Staff	24 persons investing full working days in the CW facility Administrators: 3 fte Team coordinators (social workers): 3 fte Psychologists: 2 fte Family social workers: 3 fte Social workers: 13 fte	8 persons investing part- time working days in the CW facility but providing 24/7 permanency Coordinating child and adolescent psychiatrist: on-site approximately 2 days a week, ensuring permanency Second child psychiatrist: part time, in the facility on indication, ensuring permanency Psychologists: 4 fte, in the facility on indication Dietician: on indication, working in CAP Social worker: on indication, working in CAP

fte full time equivalent

Data analysis

The theoretical framework underpinning this research project is descriptive content analysis, as described by Sandelowski [24]. We followed the procedure for systematic text condensation, following Malterud [23]. In this approach of qualitative analysis, four sequential steps are performed: (1) the three researchers read the transcripts multiple times to obtain an overall impression and each of them identified preliminary themes. Discussion between the three researchers led to agreement on the final themes (e.g., 'development process at an organizational level' or 'factors driving the development'); (2) each researcher identified units of meaning that characterize diverse aspects of the development process of the collaboration and coded for these, whereas parts of the transcript not relevant to the research question, were removed from the analysis; (3) after discussion between the researchers, the content of each of the code groups was summarized into a condensate; and (4) data were re-conceptualized, and an analytic text with useful quotations was written. Re-reading the original transcript ensured goodness of fit with the final code groups and themes. These texts and quotations were translated from Dutch to English. Review by a researcher fluent in both languages assured language equivalency. NVivo 11 (QSR International, Doncaster) assisted with coding and management of data.

Verification of findings was increased [25] by different procedures: discussion of the focus group interview guide between researchers; observator taking field notes during the focus groups; debriefing after the focus groups; discussion and negotiation of themes and interpretations until agreement was achieved; member checking by providing the opportunity to check the transcripts; and by feeding themes and interpretations back to participants to ensure that participants' own perspectives are represented and not curtailed by the researchers' background. Researcher triangulation by means of in-depth discussion between researchers occurred right after the focus groups and after coding.

Author reflectivity

Main researchers were a clinical psychologist, a Ph.D. student in CAP training, and an anthropologist. The educational background of the first author is closer to the CAP setting than to CW. However, as a part of the participatory action design, a close contact with the CW setting has taken place since the start of the collaboration project. Participants knew the researchers and the research project, without researchers being involved in the daily practice of the CSCC.

Results

Our findings outline the development process of the collaboration and are structured by describing the changes on the professional, team, and organization levels. Professionals also described what they considered to be the underlying factors driving the maturation of this collaboration.

Description of the development process of the collaboration

Individual professional level

For the professionals, core elements of the change process were: a change in attitudes and the process of getting to know the target population of the collaboration and the professionals in the other agency. Through the first months, an attitude change towards more acceptance of the psychiatric needs and enhanced belief of the value and feasibility of helping this population in a child welfare setting occurred. At the start of the project, CW staff members were not

Table 2 Composition of the focus groups

Focus group number	Focus group 1	Focus group 2	Focus group 3	Focus group 4
Group	CW	CW	CAP	CW
Number of participants	8	8	8	6
Professions	CW administrator ($n=2$) Psychologist ($n=1$) Social worker ($n=5$)	CW administrator ($n=1$) Psychologist ($n=1$) Team coordinator ($n=2$) Social worker ($n=3$) Family social worker ($n=1$)	CAP ($n=2$) Psychologist ($n=4$) Social worker ($n=1$) Dietician ($n=1$)	Team coordinator ($n=1$) Social worker ($n=3$) Family social worker ($n=2$)

This table illustrates the composition of the four focus groups and for each focus group details the number of professionals and their background

familiar with psychiatric problems and considered them as 'not fitting in CW'. These girls were indeed announced as presenting—besides the contextual issues that CW was used to focusing upon—a comprehensive traumatic history, problematic personality development, behavioural problems, self-harm, and suicide attempts. This initial attitude was illustrated as:

> 'That's not for us, she's a girl for psychiatry' (Social worker, focus group 1)

Despite the intent to take joint responsibility in a collaboration project, there was initially much doubt regarding the feasibility of care delivery to this population within a CW setting. At the time of the focus groups, professionals were convinced of the benefit for the girls to stay in CW despite psychiatric problems:

> We have a different feeling compared to when the project started. A team that exudes something like 'that's a tough case here, that's one for psychiatry', the girls feel that immediately. In addition, that attitude does not exist here anymore. There you see the change in attitudes towards these young people, and they feel that, too. (Psychologist, focus group 3)

The changing attitudes due to the evolution of the collaboration project also led to a destigmatization of psychiatry.

> The difference is that now psychiatry is visible, and accessible for the girls. Before this collaboration project, when we previously spoke of psychiatry, their reaction was 'I'm not crazy huh, I just have problems'. Now, that is no longer what they say. Sometimes, the girls say that 'I'm not enthusiastic', but they do not see the contact with psychiatry as adding an additional 'label'. That is thanks to the presence of child psychiatry in our centre. (Family social worker, focus group 4)

A second process that professionals describe at the individual level is getting to know each other. At the start of the project, CW and CAP professionals were not familiar with each other's vision and procedures. Getting to know each other's setting and goals supported the aforementioned change in attitudes and ameliorated the collaboration. The process of getting to know each other and engaging in formal and informal communication facilitated joint working and the development of common routines.

It was the perception of the professionals that, as the investments in the collaboration were so large and all routine was lost due to the large organizational change, the care delivery and client-centeredness were diminished.

> In that first period, we had to invest so much time and energy into making that collaboration work! Making appointments, discussing everything, adapting to all changes—we spent so much more time enabling that collaboration than actually seeing the girls together or having them in therapy sessions. (Child and adolescent psychiatrist, focus group 3)

Team level

Professionals explained that some of their colleagues left in the early stages of the project (see "Methods" section), due to large organizational changes and the challenges set by the new way of working. At the time of the focus groups, the team was constituted of very motivated people who actively chose to work with these adolescents with MCN. Clarity about 'who are we' (identity) and 'what do we do' (approach) further helped the development of a team spirit. 'Taking care of the team', however, is still of great importance:

> Every single professional working here wants to work with these girls. I think that is very bonding. We are more like one team, while not so very long ago that was a different situation. I think we really need attention as a team, because I think a further positive evolution is possible. (CW administrator, focus group 1)

The team appears as an important catalyst of the collaboration project. Truly being one team, crossing CW and CAP boundaries, strengthens and supports professionals in the face of the severity of problems presented by these adolescent girls.

> The togetherness, feeling that you are not alone—that we form one team with CAP and not two separate services. We have a totally different outlook and approach, but we really are one true team, we all feel that now. (CW administrator, focus group 2)

Organizational level

At the level of the organization, after a period of changing procedures and roles, accompanied by a loss of efficiency, an evolution towards more effective communication, clear joint routines and role definition, and a balance between the two complementary ways of working, is described.

> When I see how it evolved, how the crisis situations we are constantly confronted with are handled now—the initial anxiety 'how are we going to tackle that?' compared to what is achieved now—incredible how much progress was made. (CW administrator, focus group 1)

A lot of effort was put into developing an approach that meets the needs of these girls with MCN, and which both partners in the collaboration can endorse. Only after several months and with considerable effort, joint procedures became

clearer, certain routines were streamlined, and the care delivery has shifted from an 'ad hoc' approach to a more proactive action.

> In the beginning you desperately seek answers to 'oh my God, how do we do this?' Back then, we went to the team meeting the same day to find some solutions. But now, we really have a proactive approach as a team. We know how to handle crises and certain behaviours, how to address our population, we have the procedures. (Social worker, focus group 2)

At the start of the collaboration project, professionals' roles were not sufficiently clear, but with time the various tasks and responsibilities were better defined.

> In the beginning it was not really clear who was going to have which role and task. Because we already had psychologists here, I thought—'there are psychologists and [psycho]therapists coming from CAP? Why?' …—On the other hand, the role of the psychiatrist was clear from the start: giving advice and attending team meetings, doing consultations and medication monitoring… But now … the roles are clearer, and we see that the collaboration certainly has benefits. (Family social worker, focus group 4)

From the very start of the project, a lot of effort was put into communication between and within both agencies. At the time of the focus groups, still, much time and energy was spent on dialogue, exchange, and coordination. Initially, a common language and communication pathways had to be developed. According to these professionals, collaboration is most effective when both formal and informal communications are used and face-to-face consultation as well as mail and telephone communication takes place. A lot of communication efforts were invested in conditions that enable the therapy and strengthen the collaboration.

> Everything surrounding it, to enable that contact between you and the girls and to maintain, to nurture this collaboration, you need to spend an incredible amount of time to achieve that. (Child and adolescent psychiatrist, focus group 3)

At the time of the focus groups, there is such a far-reaching integration that a new professional identity, specific to the CSCC project, is being formed.

> So you're creating your own culture, and that culture, I think you can also see it in what we are currently proclaiming. (Social worker, focus group 1)

Factors driving the evolution of this collaboration

In these focus groups, a shared vision and value base seem to anchor the collaborative efforts. The professionals express their motivation to make a difference in these complex cases and relate this to the collaboration.

> These girls have been in many institutions. Because of their problematic behaviour they did not belong in psychiatry; and they cannot stay in a regular institution because of the problematic behaviour and the psychiatric behaviour. So where could they get proper help? Nowhere! Then it's nice to know that some of the girls who previously got stuck, can now be helped here. (Social worker, focus group 1)

From the start of the collaboration project, there was a clear and common goal, guided by the urgent needs in service delivery for adolescents with MCN. The commitment and focus on a common goal increases the willingness of all partners:

> We are no longer looking at each other and waiting—previously everyone had their own agenda—now it is just one shared goal. (Child and adolescent psychiatrist, focus group 3)

Participants describe a person-centred attitude as the core of the shared vision.

> Our girls are the core of this collaboration. And that's what connects us. (CW administrator, focus group 1)

The target population is central in this whole CSCC project and is described as a 'unifying factor' between the professionals. Therefore, they are not only the focus of the collaborative efforts, but the solidarity a person-centred approach entails, is also a facilitating factor for common efforts.

Participants describe how the collaboration project strengthens them by making them feel supported by the collaboration partners when facing the challenges of working with adolescents with MCN, and by enhancing their knowledge and skills. Empowerment, with a focus on enabling professionals to gain confidence, appears as guiding in the evolution of the CSCC project.

A key element in the empowerment process is the training by the child and adolescent psychiatrist in the CW setting, which enhances knowledge and expertise among care providers. This cross-sectoral training contributes to understanding the background of certain problems and provides guidelines for addressing them, making the professionals more confident. The need to have a framework to understand behaviour is also related to the gravity of problems presented by these adolescent girls with MCN.

> You have to find a reason for their behaviour, I guess. These girls are very cool ladies, but their behaviour … You get scolded, there is suicidal behaviour, yes it is really hard work. If you don't have an understanding of 'what is this?', 'why is this happening?', then I think you couldn't manage it. While now, thanks to working together with the child and adolescent psychiatrist, you have more background and you know more about, say, self-harm … (Team coordinator, focus group 2)

The child and adolescent psychiatrist also describes these trainings as empowering for the CW professionals:

> The goal is to give the CW team training on CAP topics, to make them strong enough to handle these girls. Therefore, there is a lot of training, but in those weekly meetings, we also give a lot of psychiatric advice. (Child and adolescent psychiatrist, focus group 3)

The working relationship was also strengthened by the joint meetings and training. Having a shared reference frame lowers the threshold to inform each other, facilitates the development of a shared care delivery plan, and increases the possibilities for mutual support.

> During joint meetings or trainings, we speak the same language. That increases the trust we have in each other. In addition, it makes it easier to call each other and ask 'hey, what do you think?' (Social worker, focus group 2)

Besides the training, the relational aspects of the CSCC project also have a positive effect on the (self-) confidence of the professionals, and in this way are also empowering. Thanks to the partnership, the professionals feel supported when confronting problems.

> We now dare to keep a girl in our facility rather than to send her away, because we get support, we are not alone. I think it really makes a difference if you have to evaluate those cases on your own, without psychiatry. Or when it is a psychiatrist who actually doesn't know the setting, the team and the case, who judges it … Here, as we gain confidence, we trust CAP and, therefore, are more confident in ourselves. (Team coordinator, focus group 4)

In addition, not only CAP and CW, but also the rest of the network feels this empowerment and is influenced by it. Thanks to the good basic care and continuity offered, and because CAP is available for advice for partners too, schools, juvenile justice institutions and juvenile court are also strengthened.

> You find yourself pushing back the juvenile court into their position, almost saying please, for once, take your responsibility and do not fear the psychiatric problems. And there we also have a really vital role to get everyone to act normal again, facing young people who make everyone back away. (CW administrator, focus group 1)

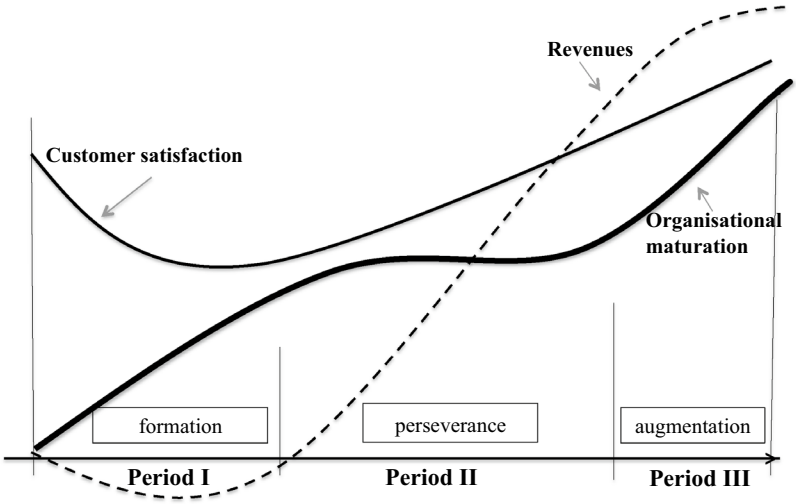
Discussion

Collaborating is an integral, but complex and challenging part of the role of a CAP, both on the case and systems level [10]. Professionals' perspective on the development process and driving factors of CSCC, an intensive collaboration between CAP and CW in care delivery for adolescent girls with MCN, was explored in this research project. As the development path of the CSCC became clear after data analysis, we found it especially striking that after a first phase, characterized by the consequences of rapid organizational change, a second phase was perceived as yielding the benefits of collaboration. After data analysis, a theoretical framework to assist in understanding these findings was sought. We did not find information about the development process of a collaboration in the health and social literature and, therefore, referred to the management literature.

The life cycle model (LCM) describes the development process of a shared service centre (SSC) organization [26]. The first curve in the LCM, depicting sequential evolution of an SSC into a 'mature' organization, is particularly relevant in understanding the process of developing collaborative projects, as its steepness is an indicator for the intensity of change perceived by customers and clients (Fig. 1). The second curve shows the evolution of customer satisfaction, whereas the third one depicts revenues. In the LCM, the collaborative development process occurs in three periods (Fig. 1).

The first period, 'formation of an SSC', revolves around concentrating resources and developing the customer relationship. This is reflected in a combined internal and external focus, as the collaborating professionals focus on their own and the partner's organization. In this first period, the maturation curve is steep, indicating important changes, as the whole organizational culture shifts. During these large organizational changes, service delivery is perceived as declining, as reflected by the customer satisfaction curve. In this initial period, very large personnel and financial investments must be made, but the financial revenue balance should not be expected to be positive. Most collaborations go through difficult times during this phase and many organizations would consider withdrawing from the collaboration as the efforts don't seem to weigh up against the benefits.

The second period, 'perseverance', is aimed at obtaining efficiency and operational excellence. Protocols and organization functioning are further developed; new roles are accepted and routine created. This means a strong



	Period I	Period II	Period III
activity	Investment; concentrating resources, developing client relationships	Obtaining efficiency and operational excellence; new roles and routines accepted	Exploring growth possibilities
focus	Internal and external	Strong internal	Shift towards external
process	Change > improvement	Improvement >> change	Change and growth

Fig. 1 Life cycle model for shared service centres. The life cycle model for shared service centres after Struik and Brugman [26] illustrates the progress of a collaboration project. The *x*-axis depicts the three consecutive periods of the development process of a collaboration. Three curves describe different aspects of the progression of a shared service centre: the thick, full line shows the organizational maturation, the thin, full line shows costumer satisfaction, whereas the thin, interrupted line describes the revenues produced by the shared service centre

internal focus resulting in more improvement than change. It is in this second period, where the revenue curve is steeper, that efficiency and revenues should appear, and user satisfaction increases. In the third period, 'augmentation', the focus once again starts to shift externally towards looking at further growth possibilities.

To our knowledge, the LCM has not yet been used to describe the development of collaboration projects in mental health and social services. We describe our findings using the lens of the LCM. When comparing the emerging themes, we found that the perspectives of participating professionals are coherent with the periods described in the LCM.

First of all, although a common goal was clear from the start, the first period of the collaboration was characterized by the need for large personnel and financial investments and the feeling of chaos and uncertainty. On the individual level, professionals had to handle a radical change in their work habits, population served, and communication procedures. They had to invest in new expertise and skills, but also in the relationships with new partners. The team composition changed, and tensions were described. Complementary skills and communication pathways had to be developed, and important financial investments were made. Difficulties existed where 'two different worlds' met, at the level of organization specific procedures and language. In this first period, the perception of professionals was that there was a lot of uncertainty, for themselves and for youth served. In summary, this fits well in the first period of the LCM, where the change is very rapidly occurring and felt by all concerned, corresponding to a steep maturation curve.

When reporting about the current situation, professionals describe a different picture. On the individual level, a change in attitudes has occurred and professionals have come to know each other's setting. They feel empowered and supported by each other. The team is now composed of people who explicitly chose this population and work arrangement. On the organizational level, a shared vision and global plan of action has been developed. Some issues are still incompletely resolved. For example, some redundant communication still occurs due to a lack of agreed-upon procedures and protocols.

The situation at the time of the focus groups corresponds to the end of the second and beginning of the third period in the LCM, where collaboration has been established and different routines are set. The maturational curve is less steep, reflecting there is less change and more amelioration. The yield curve is now positive, reflected in the better care delivery described by the professionals. Looking out for further growth possibilities in terms of parent support and networking could be the first glimpse of the third period, while unresolved communication and procedure issues are remnants of the first period.

The LCM does not describe underlying factors that influence the maturation of the collaboration project. However, in our findings, such themes appeared. Important driving factors in the development of the collaborative project were: a common person-centred vision, and the empowerment felt by professionals on different levels, thanks to this collaboration. Freeth [27] identified (1) a continued need to collaborate and (2) empowerment to do so, as favourable conditions for maintaining collaboration by describing a collaboration

project between a medical and a nursing school in the UK. Our finding that a common vision is driving the development of collaboration could be related to Freeth's [27] description of 'continued need', as a prerequisite for sustaining collaborative efforts. Likewise, our participants indicated empowerment as the underlying evolution of the collaboration project. Our findings are also in line with the literature pointing out that successful interagency collaboration requires value clarification and the development of a shared philosophy and goals [28, 29] and that, conversely, having different understandings of children's problems and having different goals, is identified as a major barrier to good collaborative care for children and youth [30]. The literature confirms the importance of a person-centred perspective [31] and its role in staff working. In an integrated structure, focusing on improving patient care helps to overcome professional boundaries [15, 32].

The concept of empowerment has been used in a variety of ways, and different conceptual approaches exist [33, 34]. From the organizational and management point of view, empowerment is most often described as a process, and is correlated with staff well-being and commitment to their work [35], as well as increased productiveness [34]. According to our participants, the new organization and the training and experiences seem indeed to lead to more efficiency at the organizational level, and a sense of confidence in daily practice.

In addition, cross-training of staff has been described as an important strategy for building relationships between staff at different agencies, and helping staff to understand how other organizations operate and ultimately reduce service fragmentation [29, 36]. In this project, effort is put in providing ongoing education on relevant themes in a very concrete way, through training and by discussing cases from different perspectives in team meetings. Professionals state that this helped them to have enough background to understand certain behaviours and to enhance skills in coping with crisis situations.

Our findings have theoretical as well as practical relevance. On the theoretical level, it is interesting to see that a model originating in the management literature, can give valuable information to describe the evolution of a collaboration project in social and mental health sectors. Our findings add a dimension to this model, describing not only the sequential phases, but also the factors that appear to have driven the evolution. Further research, ideally combining qualitative (interviews or focus groups and observations) with quantitative data (e.g., questionnaires about the perception of collaboration, a measure of 'efficacy',…), will determine if the framework needs adjustment for the health or social care contexts and could investigate the time line of the phases described in the LCM, in a collaboration between child-serving agencies.

On the practical level, knowing what developmental course to expect when starting a collaboration project is very useful for policy makers and clinicians working in an increasingly collaborative care delivery system. The LCM describes that a difficult start, when the consequences of large organizational change ask for large investments that may not seem to yield enough benefits, is to be expected. Knowing this can assist in the planning and allocation of resources, and can motivate professionals to persist in the collaborative efforts, in spite of the challenges they meet.

A strength of this study was that we described the collaboration process in the service delivery to adolescent girls with MCN as seen from the perspective of an interprofessional team closely involved in the project. This study also has a high participation rate (94%) and a representative distribution of the professions involved in care delivery. A limitation of this study is the fact that we only gathered perceptions of professionals, rather than combining them with observations of the collaboration. It would be interesting to consider the perspective of the professionals who left the CSCC project in an early stage, or to question those who do not participate in the collaboration project, but do take part in the delivery of care to these girls with MCN. It would be valuable that future research includes the view of the adolescent girls and other professionals working with these girls (e.g., schools, juvenile court). In addition, the timing of focus groups can have an impact on the findings [37]. However, collecting 'real time' perceptions of professionals who are still in the evolution process of a collaboration is valuable to make sense of the organizational change [38].

Concluding comments

Perspectives of professionals involved in an innovative collaboration project for adolescent girls with MCN on the process of this organizational change were explored through focus groups. The evolution of benefits and investments that follow the pattern depicted in the LCM for SCC was described. This is useful knowledge for those starting a collaborative project and could motivate them to maintain their efforts even when a first period is characterized by the impact of large investment and change. Developing a shared person-centred vision as well as empowerment are important aspects in the development process towards more satisfaction and efficiency in the collaborative care.

On a theoretical level, it is interesting to notice that a collaboration project between child-serving agencies appears to follow the predictions of a model from the management literature. On a practical level, knowing that large investments in collaboration projects may not pay off immediately, could inform policy makers planning collaborations in CAP, and

could motivate those engaged in such collaboration projects to maintain their efforts.

Compliance with ethical standards

Ethical standards All human and animal studies have been approved by the ethics committee of the University of Antwerp/University Hospital of Antwerp and have, therefore, been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments. All persons gave their informed consent prior to their inclusion in the study.

Conflict of interest The authors declare that they have no conflict of interest.

References

1. World Health Organization (1986) The Ottawa charter for health promotion: first international conference on health promotion, Ottawa, 21 November 1986. WHO, Geneva
2. Rivard JC, Morrissey JP (2003) Factors associated with interagency coordination in a child mental health service system demonstration. Adm Policy Ment Health 30:397–415. https://doi.org/10.1023/a:1024641630430
3. Department of Health & NHS England (2015) Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing. Department of Health & NHS England, London
4. Keene J (2001) Understanding complex needs: a multidisciplinary approach. Blackwell Science Ltd, London
5. Rankin J, Regan S (2004) Meeting complex needs in social care. Hous Care Support 7(3):4–8
6. Hurlburt MS, Leslie LK, Landsverk J, Barth RP, Burns BJ, Gibbons RD, Slymen DJ, Zhang J (2004) Contextual predictors of mental health service use among children open to child welfare. Arch Gen Psychiatry 61(12):1217–1224. https://doi.org/10.1001/archpsyc.61.12.1217
7. Bai Y, Wells R, Hillemeier MM (2009) Coordination between child welfare agencies and mental health service providers, children's service use, and outcomes. Child Abuse Negl 33:372–381. https://doi.org/10.1016/j.chiabu.2008.10.004
8. Rowlandson PH, Smith C (2009) An interagency service delivery model for autistic spectrum disorders and attention deficit hyperactivity disorder. Child Care Health Dev 35:681–690. https://doi.org/10.1111/j.1365-2214.2009.00956.x
9. Oliver C, Mooney A, Statham J (2010) Integrated working: a review of the evidence. Institute of Education, London
10. Fritsch SL, Schlesinger A, Habeger AD, Sarvet B, Harrison JN (2016) Collaborative care and integration: changing roles and changing identity of the child and adolescent psychiatrist? J Am Acad Child Adolesc Psychiatry 55(9):743–745
11. Hughes M (2006) Multi-agency teams: why should working together make everything better? Educ Child Psychol 23:60–71
12. Horwath J, Morrison T (2007) Collaboration, integration and change in children's services: critical issues and key ingredients. Child Abuse Negl 31(1):55–69. https://doi.org/10.1016/j.chiabu.2006.01.007
13. Smith BD, Mogro-Wilson C (2007) Multi-level influences on the practice of inter-agency collaboration in child welfare and substance abuse treatment. Child Youth Serv Rev 29:545–556. https://doi.org/10.1016/j.childyouth.2006.06.002
14. Hamblin B, Keep J, Ask K (2001) Organisational change and development. Fi, Harlow
15. Kodner DL, Spreeuwenberg C (2002) Integrated care: meaning, logic, applications, and implications—a discussion paper. Int J Integr Care 2(11):12
16. Wong S, Sumsion J (2013) Integrated early years services: a thematic literature review. Early Years Int Res J 33:341–353. https://doi.org/10.1080/09575146.2013.841129
17. D'Amour D, Ferrada-Videla M, San Martin Rodriguez L, Beaulieu MD (2005) The conceptual basis for interprofessional collaboration: core concepts and theoretical frameworks. J Interprof Care 19(sup1):116–131. https://doi.org/10.1080/13561820500082529
18. Kagan SL (1991) United we stand: collaboration for child care and early education services. Teachers College Press, New York
19. Khalili H, Orchard C, Laschinger HKS, Farah R (2013) An interprofessional socialization framework for developing an interprofessional identity among health professions students. J Interprof Care 27(6):448–453. https://doi.org/10.3109/13561820.2013.804042
20. Smale G (1996) Mapping change and innovation. HM Stationery Office, London
21. Hodges S, Hernandez M, Nesman T (2003) A developmental framework for collaboration in child-serving agencies. J Child Fam Stud 12(3):291–305. https://doi.org/10.1023/A:1023987710611
22. McTaggart R (1994) Participatory action research: issues in theory and practice. Educ Action Res 2(3):313–337. https://doi.org/10.1080/0965079940020302
23. Malterud K (2012) Systematic text condensation: a strategy for qualitative analysis. Scand J Public Health 40(8):795–805. https://doi.org/10.1177/1403494812465030
24. Sandelowski M (2000) Focus on research methods whatever happened to qualitative description? Nurs Health 23:334–340
25. Creswell JW, Poth CN (2017) Qualitative inquiry and research design: choosing among five approaches. Sage Publications, London
26. Struik P, Brugman M (2008) Life cycle model voor shared service center. Facil Manag Mag 21(165):63
27. Freeth D (2001) Sustaining interprofessional collaboration. J Interprof Care 15(1):37–46. https://doi.org/10.1080/13561820020022864
28. Hunter T (2004) Child welfare and alcohol and other drug treatment (aod): bridging the gap to comprehensive services. J Fam Soc Work (Taylor & Francis Group) 7(4):63–67
29. Drabble L (2007) Pathways to collaboration: exploring values and collaborative practice between child welfare and substance abuse treatment fields. Child Maltreat 12(1):31–42. https://doi.org/10.1177/1077559506296721
30. Cooper M, Evans Y, Pybis J (2016) Interagency collaboration in children and young people's mental health: a systematic review of outcomes, facilitating factors and inhibiting factors. Child Care Health Dev 42(3):325–342. https://doi.org/10.1111/cch.12322
31. Gondek D, Edbrooke-Childs J, Velikonja T, Chapman L, Saunders F, Hayes D, Wolpert M (2016) Facilitators and barriers to person-centred care in child and young people mental health services: a systematic review. Clin Psychol Psychother. https://doi.org/10.1002/cpp.2052
32. Armitage GD, Suter E, Oelke ND, Adair CE (2009) Health systems integration: state of the evidence. Int J Integr Care 9(6):82. https://doi.org/10.5334/ijic.316
33. Gibson CH (1991) A concept analysis of empowerment. J Adv Nurs 6(3):354–361
34. Kuokkanen L, Leino-Kilpi H (2000) Power and empowerment in nursing: three theoretical approaches. J Adv Nurs 31(1):235–241. https://doi.org/10.1046/j.1365-2648.2000.01241.x

35. Chandler G (1991) Creating an environment to empower nurses. Nurs Manag 22:20–23
36. Salmon G (2004) Multi-agency collaboration: the challenges for CAMHS. Child Adolesc Mental Health 9(4):156–161. https://doi.org/10.1111/j.1475-3588.2004.00099.x
37. Whiteley A, McCabe M, Buoy L, Howie F, Klass D, Latham J, Bickley M, Luckeenarain L (1998) Planning the qualitative research interview. Graduate School of Business, Curtin University of Technology. Working paper series 98.01
38. Balogun J, Johnson G (2005) From intended strategies to unintended outcomes: the impact of change recipient sensemaking. Organ Stud 26(11):1573–1601