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A protocol for interagency collaboration and family participation: Practitioners' perspectives on the Client Network Consultation

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Abstract

Interagency collaboration has many advantages, but seems hard to realise in practice. In Belgium, the need for collaboration between the practitioners in the field of child welfare and child psychiatry, especially for children and adolescents with complex health care needs, was identified. Children with complex health care needs require coordinated care and collaboration between the different sectors in child mental health care (child welfare, child psychiatry, disability care). The authors have developed a standardised protocol based on the wraparound principles, which support interagency collaboration with family participation, named Client Network Consultation (CNC). Focus groups evaluated the CNC by eliciting practitioners' views on the structure, content and impact of collaborative interagency protocols with family involvement. Thematic analysis revealed four core themes: (1) Empowering the child and the family; (2) Utilising the strength of the collective; (3) Being considerate versus constructive a dilemma for participants in CNC; and (4) The structure of a protocol offers opportunities and challenges. Results of the study offer implications for daily practice. Several challenges for interprofessional (IP) practice in the complex field of child and adolescent mental health care are described. The value of the CNC protocol to engage families in a clinical process is also discussed.

Introduction

Children with complex health care needs require support from more than one agency bringing them into contact with a wide range of professionals, services, and sectors (Brooks, Bloomfield, Offredy, & Shaughnessy, 2012; Carter, Cummings, & Cooper, 2007; Watson, Abbott, & Townsley, 2006). Although different interpretations of "complex health care needs" can be found in the literature, children with complex health care needs can broadly be defined as "those children who have or are at increased risk for a chronic physical, developmental, behavioural, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (McPherson et al., 1998, p. 138).

Children's needs in residential care are especially complicated, as they experience a wide range of difficulties including mental health disorders and social, educational, and relationship problems (Callaghan, Young, Pace, & Vostanis, 2004; Lee, Dillon, Dorries, Beech, & McDermott, 2004). These

difficulties are related to early adverse family experiences, as well as secondary effect of their experiences within the care system (Minty, 1999). The different services involved for children with complex health care needs are not likely to be coordinated across key providers and practitioners and/or engaging children and families (McKay & Bannon, 2004). These children's problems persist and fluctuate; in current mental health care this leads to frequent referrals, placement breakdowns, unclear arrangements and consequently not meeting their needs (Arcelus, Bellerby, & Vostanis, 1999; Burns, 1999; Callaghan et al., 2004).

Fragmented care can also have a negative impact on practitioner's performance; services are delayed in quality, and client satisfaction decrease (Glasby & Dickinson, 2008; Kodner & Spreeuwenberg, 2002; Winters, Magalhaes, Kinsella, & Kothari, 2016). Interagency collaboration is described as a key strategy to turn fragmented human services into a system that addresses the multiple needs of children and families in a more comprehensive and efficient way (Cottrell, Lucey, Porter, & Walker, 2000; Patel, Flisher, Hetrick, & McGorry, 2007; Walter & Petr, 2000). Benefits supporting interagency collaboration include faster access to mental health care; better service coordination; shared knowledge; enhancement of creativity and problem solving; and improved children's mental health outcomes (Chuang & Wells, 2010; Dagenais, Nault-Brière, Dupont, & Dutil, 2008; Darlington, Feeney, & Rixon, 2004; McLean, 2012; Osofsky & Lieberman, 2010).

Shared vision and a common value base are essential components of interagency collaboration (Allen & Petr, 1998; Gittel, Godfrey, & Thistlethwaite, 2013; Grace et al., 2017; Walter & Petr, 2000). Several authorities suggest that family-centred values and involvement of consumers in all stages of mental health service delivery offer the best hope to improve outcomes for children and families (Allen & Petr, 1998; Chong, Aslani, & Chen, 2013; Sullivan, Veysey, Hamilton, & Grillo, 2007; Walter & Petr, 2000). The focus is family directed and not program directed. When professional services are placed at the centre of the care system, the focus is often on administrative and organisational processes between agencies rather than on how these processes promote better results for these children and families (Allen & Petr, 1998; Suter et al., 2009; Walter & Petr, 2000).

In Belgium the need for collaboration between the practitioners in the field of child welfare and child psychiatry, especially for children and adolescents with complex health care needs, was identified. Up to that point, client participation was situated at an organisational level. Collaboration between services and sectors was considered case by case and it took place in already existing structures and measures. This need for a more formal and structural collaboration procedure forced us to look for an evidence-based protocol for better interagency collaboration, which also includes family involvement.

Interagency collaboration relies on several factors. First, it should contain procedures to guide the planning, integration, and implementation of a collaborative care trajectory built around the needs of the child and its family. Second, it should be an opportunity to exchange expertise, knowledge, and methods between professionals. Third, it should be relevant, achievable in daily practice and accessible for children, parents, and practitioners from different settings/sectors.

Background

Given the various existing forms of collaboration, the approach that met most of our needs is 'Wraparound', a promising evidence-based practice to organise and realise collaboration (Suter & Bruns, 2008). Wraparound is described as a collaborative planning process that enables the development of an individualised treatment plan (Burchard, Bruns, & Burchard, 2002). The wraparound process ensures that families, service providers, and key members of the family's social support network collaborate as a team. This in order to build a creative plan that responds to the particular need of children and families, monitors the outcomes, and is able to adapt over time (Walker, Bruns, & Penn, 2008). The values inherent to the wraparound process specify that care should be strengths based, culturally competent and organised around the family members' own perceptions of their needs and goals (Burns & Goldman, 1999). These advantages are linked to wraparound: more complete engagement of families in treatment and other decisions; development of self-efficacy, empowerment, and self-determination; a better fit between family needs and services/supports; more frequent problem-solving and continuity of care (Bruns et al., 2010); and improvement of children's day-to-day functioning (Kazi, Pagkos, & Milch, 2011; Painter, 2012). Despite the consensus on the wraparound principles, there is a lack of formal definitions, methods and procedures to translate these principles into practice (Browne, Puente-Duran, Shlonsky, Thabane, & Verticchio, 2014; Bruns et al., 2004). To facilitate the implementation of the wraparound principles in a standardised manner, we have developed a protocol to support inter-agency collaboration with a shared value base, named Client Network Consultation (CNC).

Protocol of the client network consultation

The phases of the CNCs, namely preparation, care plan development and implementation, are based on the process as described by the National Wraparound Initiative Advisory Group (Walker, Bruns, & VanDenBerg et al., 2004). The structure of the CNC also includes strategies to discuss themes (strengths of the adolescent and the family, difficulties of the adolescent and the family, past and current care, support figures, possible solutions and actions), to make conversations between families and practitioners possible and to create a stimulating atmosphere for collaboration. In the end, the goal of the CNC is to develop an individualised care plan and install a care team.

As practitioners in child services in Belgium were not familiar with Wraparound, a script was developed with more information about the CNC and the application procedure.

Practitioners from the different sectors within mental health care for children and adolescents were informed about the project and were able to sign up (complex) cases. These sectors include child welfare, child psychiatry, and disability care. The cases that were presented showed a diversity of needs; for example, child and/or parent psychopathology, difficulties with education, problematic behaviour, family composition, and traumatic experiences. They all had one similarity namely the care was fragmented. There were no further limitations than the geographic catchment area of the province, and the children

not being older than 18 years. As the project had limited funding, participation of practitioners in a CNC was paid for by their own organisations.

The protocol of the CNC follows three subsequent phases. During phase one (i.e. engagement and team preparation), the practitioner, who presented the case, is asked to have a preparatory conversation with the child and his parents to identify strengths, needs, cultural elements, and long-term goals. Formal (e.g. school, practitioners) and informal (e.g. extended family, neighbour) supports are identified and invited to the consultation. Three specialist practitioners from different professions may be invited based on the indicated needs/priorities. In contrast to the other practitioners present during CNC the specialist practitioners don't have an active role in the presented case. They have a supportive and guiding role resulting from their field of expertise. Written consent from the parents and children or adolescents as from the age of 12 years is obtained.

Phase two includes care plan development. During the first CNC, a distinct planning process with a rigid structure is followed to create an initial plan of care. The CNC takes place in a neutral environment, for both practitioners and the families. An independent and trained chairperson moderates the consultation. Before the CNC starts, roles and responsibilities are clarified. The chairman repeats the ground rules, which promote trust and respect with regard to consultation procedures, confidentiality, and legal considerations. The child and his parents' opinions are essential in accordance with the international rights of the child and parental rights ("UN Convention on the Rights of the Child", 2016). The chairman always addresses the child first; secondly the parents and finally the other team members to assure the client's participation. The team members identify the strengths of the child and its family. Next they describe and prioritise the difficulties, safety needs and concerns. They also determine the goals, associated outcomes and progress indicators. The family's perspectives get priority and the team keeps an open mind to develop creative strategies. Finally, action steps are assigned, which clearly specify who will do what and when. A care manager is chosen and the members of the team are identified. The care manager is responsible for the further succession and for maintaining good communication and coordination between the members of the team. All decisions are recorded and checked for clarity and team approval.

In phase three, the care plan is implemented into practice. The progress is reviewed and changes can be made to the plan.

The CNC started as a project and is now permanently implemented within the organisations. Therefore, the objective of this study is to evaluate the CNCs by eliciting practitioners' views on the structure, content and impact of the protocol on interagency collaboration with family involvement. If necessary, adjustments can be made to better fit the CNCs to the needs of the children, the parents and the practitioners.

Methods

A qualitative exploratory design with focus groups was used for the study (Sandelowski, 2010). This approach was chosen because it is recognised as a naturalistic research method appropriate for gaining an insight into people's everyday working lives. In focus groups interaction is an important feature (Kitzinger, 1995; Morgan, 1998). We have attempted to create an atmosphere similar to the CNCs meaning that participants are equal and feel comfortable to speak freely (Krueger & Casey, 2000). In addition, focus groups are used to explore each participant's experiences and to allow in- depth group discussions (Van Rijswijk, Van Hout, Van de Lisdonk, Zitman, & Van Weel, 2009).

Participants and sampling

In order to promote discussion, each focus group contained a mix of practitioners (who had signed up a case in one of the CNCs) and specialist practitioners. A letter of the research team, explaining the purpose and the rationale behind their involvement, informed all practitioners involved in CNCs project phase (N = 53). All participants received an invitation with possible data; the focus groups proceeded when we obtained the largest presence. Participation was voluntary. In total a mix of sixteen practitioners and seven members of the specialist practitioner group were involved. Table 1 gives an overview of the main characteristics of the participants for each focus group. During the first focus group it was difficult to get everyone to participate actively, one participant was 15 minutes late. The moderator had to mediate to achieve group discussion. The participation during the second and third focus group went easier; the participants interacted more spontaneously. The atmosphere in all groups was good; the participants gave the impression to be at ease. They listened to each other and respected each other's opinion. In the second focus group one dominant speaker was present and in the third group a participant had the tendency to interrupt. (see Table 1).

Table 1. Main characteristics of the participants for each focus group.

	Group 1	Group 2	Group 3
Mean age	41	45.4	38.8
Mean years of experience	11.3	20.9	13.4
Gender (male/female)	3/4	2/5	3/6
Presenter case/expert	5/2	6/1	5/4
<i>Different sectors within child care</i>			
-Child Welfare	2	5	5
-Flemish agency for disabled persons	3		1
-Child & family		1	1
-Ambulatory mental health centres	2		
-Child and adolescent psychiatric hospital department		1	2

Data collection

Three focus groups were conducted to evaluate the protocol, involving a total of twenty-three participants. The focus groups took place in a neutral environment and lasted about two hours. The

groups were led by the same experienced moderator, who was not involved in further data analysis, and observed by the same psychologist (T.V.D.). A topic guide containing open-ended questions for each of the four themes was at the moderator's disposal to guide the discussion. The themes were: (1) Motivation to participate or to present a case to the project; (2) Expectations prior to the CNC; (3) Structure used during the CNC; and (4) The 'ideal' CNC.

Data analysis

The focus groups were audiotaped with consent of the participants and transcribed verbatim. Two researchers independently analysed the transcripts and discussed differences following systematic text condensation. This approach is a descriptive and explorative method for qualitative analysis. The procedure consists of following steps: First an overview of the data is acquired, looking for preliminary themes—from chaos to themes; second meaning units are systematically identified and classified—from themes to codes; third each code group is further abstracted by condensation of content—from code to meaning; finally the data are synthesised - from condensation to descriptions and concepts (Malterud, 2012). The text was coded using Nvivo10, a qualitative data-analysis program.

Ethical considerations

This study received the approval of the Commission for Medical Ethics of the University of Antwerp (UA A08-28).

Results

Four core themes, together with verbatim extracts of the participants' contributions, are outlined in this section (focus group = FG; practitioner = P; specialist practitioner = SP). The themes that will be described are as follows: Empowering the child and the family; utilising the strength of the collective; being considerate versus constructive—a dilemma for participants in CNC; The structure of a protocol offers opportunities and challenges. (See Appendix 1 – online supplementary file – for details on the themes and subthemes generated from the analysis).

Empowering the child and the family

Practitioners mentioned several conditions to facilitate strengthening the family. The first is a strong belief in the clients, their possibilities, strengths, and contributions to a solution. The clients are seen as the experts and their questions should establish the CNC's goals. These goals are seen as demand-driven as opposed to supply-oriented. Practitioners reported that they need to create a positive and constructive environment during CNC where equality and respect for all opinions are essential. As the following data extract indicates:

Moderator: Can you give a concrete example of something you take along from the CNC?

P5: ...the parents experienced that actual work was done in their child's case. They could really participate during the conversation. That was positive.

P6: I think it was the first time that this mother sat at the table as an expert and was supported in that role. She mentioned it afterwards several times, it was the first time that she had the feeling that they listened and took it into account. (FG2)

The clients' dedication is much appreciated by the participants. They emphasised the capability of the children and parents to formulate their needs and questions in front of a large group of people. Next to telling their story, participants said that children and parents are capable to grasp the essence. For the children and adolescents it can be difficult to identify their own strengths:

P6: We think that clients, children cannot express themselves. It was nice to see how parents and children were able to bring their whole story. I think that giving attention to the positive things benefits the process.

SP1: I agree with the importance of this process. In such a short timeframe you cannot grasp the complexity of the situation, but we want to reach a clear description of the questions. (FG3)

These elements of empowerment affect the CNC and clients appreciate when the complexity of their situation is recognised. When practitioners listen to the clients they believe this shows respect, it gives parents and children a voice and can give them a boost. Another outcome mentioned by the participants is that by really listening to the clients other plans with the same goals can be made:

Moderator: The child was present during CNC?

P3: Yes, this was very important I think

P4: This was the same for me; the parents and the child were present. For the family it meant also a recognition of the severity of their difficulties. Just the fact that people listened to them and that they were taken seriously was of value to them. (FG2)

During a CNC practitioners also need to report their limitations and get out of their comfort zone; the participants experience this as a sign of openness. Practitioners consider it their task to help clients with their plans, but clients do not necessarily need to follow the practitioners' ideas. Some even mentioned a veto with the clients concerning decision-making:

SP1: To seek advice from a third party as professional seems to be an important signal to clients; by saying I am not omniscient and I keep on looking.

SP4: I agree with SP1, this contribution from someone who is not involved, this can mean a lot. (FG3)

Being considerate versus constructive – a dilemma for participants in CNC

The participants of the focus groups mentioned different dilemmas during a CNC. Participants seem to want all the best for their clients, but are confronted with practical limitations. The analysis revealed three common dilemmas: (1) Preparation; (2) Presence of the child and parents; and (3). Mindset of practitioners.

First, the preparation of a CNC is seen as very important, but time consuming for the practitioners. However, they also stated that the person who signed up the case had the responsibility to have a preparatory consultation with the parents and the child. All the participants believe that it is essential to prepare the parents and children for the CNC, so they would know who will be present, which questions will be asked, what the goals of the CNC are and what they can expect.

SP1: A huge responsibility lies with the practitioner who signs up the case to properly prepare the consultation with the client. I can imagine that already half of the work has been done. (FG3)

During the preparation extra attention needs to be given to the selection and invitation of participants to the CNC. Participants mentioned that all the practitioners who could help with the implementation of the care plan should be present. In a few cases a certain care system/sector, which could have had a crucial input, was not represented during the first consultation. If that was the case, they were invited to the second CNC, losing crucial time for the child and its family. Participants suggested that the chairperson should take up this task – the selection and invitation of (potential) crucial partners – and question thoroughly who needs to be invited:

P3: Actually, everyone involved needs to be present.

SP1: During the course of the conversation you think of people that should be present ... That is a sore point: not enough different disciplines present.

P4: You start with that expectation. (FG3)

An objection about the meaningfulness of the CNC is made, when there are differences in parents' and practitioners' vision on optimal care for the child. Preliminary work before the CNC is important to anticipate and think through these differences.

The second reported dilemma concerns the transparency between clients and practitioners. The presence of the child and the parents is experienced as crucial, but is also a challenge for practitioners. Participants reported that it felt awkward when the clients did not participate in the first part of the CNC. The participants felt that it was intimidating for the clients to enter the room afterwards; they thought it must feel like presenting yourself in front of a jury.

The need for an open agenda between clients and practitioners also seems necessary considering certain expectations or assumptions. The participants reported that some practitioners have a care plan in mind before entering the CNC. Also parents sometimes seem to enter the CNC with certain reservations; namely the fear that the CNC will interfere with their goals:

SP1: It is not correct to divide the CNC. I think that all questions have to be asked with the clients present, even if it means a longer introduction or if it means you never get there at the CNC. But the problem is shared with the clients. During a CNC there has to be an open communication from beginning to end.

P5: Yes, I experienced it during a CNC as a practitioner. The practitioners involved asked me to give information about the family to the chairperson preceding the CNC. (FG3)

The last dilemma concerns the mindset of the practitioner. The balance between being empathic and clearly explaining a difficult topic seems to be delicate. The participants reported the need for a climate of reassurance and a search for the right words. The things said during a CNC can be painful and confronting. However, the participants shared the experience that children and parents can listen to these statements. By putting different opinions together new elements and discussions between practitioners can arise. During a CNC some participants feel that clients can handle these discussions; others experience that this will create tensions and will feel unsafe for the children and the parents. The fact that the specialist practitioners can give their opinion and explicitly define things as an outsider, also means they can be confronting for clients. Practitioners said that this could offer them a new approach for the welfare process with their clients:

P1: And I can still hear him say 'it will only become more difficult given your grandsons handicap'. This was very confronting for the grandparents, but they acknowledged what was said. It gave them more understanding of the problems, and this happened with a great deal of respect.

SP1: I remember that situation; but I also think that it is a pity that we have to wait for it to get complex, to the organisation of a CNC before such effects are reached. (FG2)

The participants expressed the need for a complete story: When things are presented too simplistically, the practitioners report fearing that they may give clients unrealistic expectations. During CNC it seems difficult for practitioners to form a complete image. The practitioners need to have the expertise to let children and parents tell their story:

P5: You have to be very articulate to tell your story as a client. Adolescents sometimes need five, six talks before they tell you something and now they have to do it in front of a lot of people.

Moderator: But has a CNC the intention to bring the whole story or the whole history?

Practitioner: no, but you need some information about the past history to look forward. You can't disconnect these things.

P4: The mother when we have meetings at school she presents herself differently. During CNC she wanted to present herself better and she downplayed the problem a little. (FG1)

The presence of children and parents during a CNC is described as a challenge for the practitioners themselves. The participants indicated that they have to adjust their language and their attitude. The fact that the CNC is demand- driven also seems to be an exercise. When the focus is on the clients,

practitioners report less time for reflecting and more time for reassuring the clients. The participants emphasised that practitioners' experience has to be respected and taken seriously:

SP4: I noticed that with the client present you are so busy comforting the client and that you are really focused on the client. I can only speak for myself, but I felt that you do not have much room to think about possible solutions.

SP5: At that moment you have to take different elements into account, usually we think of possible solutions without the clients present.

SP2: I also experienced it as an exercise to formulate your thoughts in the presence of the clients.
(FG1)

Utilising the strength of the collective

The participants expressed the need to work together; working next to each other is seen as unacceptable for clients. It is very time consuming for clients to meet each practitioner separately and it is sometimes hard to coordinate the schedules of the different practitioners and/or services. By collaborating, parents experience that people are activated for them and their children; both parents and practitioners get recognition for their frustrations.

SP1: As practitioners we often work next to each other, not accessible for our clients.

P1: Yes, I think that is the importance of a CNC; you do it together. Otherwise you start making phone calls, having individual contacts. . .(FG2)

The participants reported that during the CNC new elements and questions arose because a team of people from different professions was assembled. This team approach can help to broaden your view and team members can strengthen each other. It can also provide an opportunity for clients to get more insight into the complexity of the problems and for practitioners to start a new process with their clients:

SP3: It is a process; we are going to try to do some things. We will start and then evaluate what works and what does not work, and what needs to be adjusted.

P4: Yes, as practitioner I got a few emails as a support to check how things were proceeding.

P2: I did not notice that, no. (FG3)

Practitioners mentioned that working alone can cause one to lose perspective on a case. A CNC offers the possibility to start with a 'tabula rasa', to look at the situation from a greater distance and to have a more objective look. A CNC can mean a new approach in current care relations.

The participants mentioned the presence of specialist practitioners during CNC as much appreciated by practitioners and clients. They said that some specialist practitioners, like physicians or child psychiatrists, are unreachable in other situations. The role of the specialist practitioners is very specific, as they assess the situation from their particular field of expertise. The specialist practitioners have to keep an independent, unattached position. Practitioners reported the advantage that the specialist

practitioners still see the positive things. When a specialist practitioner decides during a CNC to take on an active role in the care process for the child and/or its family, he loses his neutral position in future CNCs. During the focus groups practitioners suggested to invite another specialist practitioner in these cases.

Next to sharing information and giving advice a CNC is seen as an occasion to get more commitment. Participants reported that after a collective search alternative ideas and new starting points were assembled and different perspectives were offered:

SP1: We need to find more believers for this family. By focusing on the strengths clients convince at that moment.

SP4: Otherwise, those strengths could soon decrease. (FG3)

The structure of the protocol offers opportunities and challenges

Practitioners discussed that expectations and tasks need to be clear. Practitioners who entered a CNC knowing what to expect, rarely reported being disappointed or overwhelmed by the tasks that came along with the job. Clear expectations were also mentioned as being important to the clients and positively influenced by preparation.

The participants questioned which information needs to be shared before the CNC. To pass on more information than filled out on the registration form is against the agreements.

The participants perceived the protocol of the CNC as constructive; it provides a clearly structured planning process. Stating the strengths at the beginning of a CNC slows down the process, but it also seems necessary as a starting point. Participants expressed the need to hear positive things about the child. This was beneficial for the child, parents and for the practitioners:

SP3: The first CNC, I had the feeling: This has a slow beginning. First all the qualities of the child and then the difficulties. . . and you stay very vague while a complex situation has to be presented.

P1: I personally also felt that it took a long time and I thought: is this really necessary? But when you see the reactions of the people, they start laughing and get a bit of courage. . . (FG3)

The role of the chairperson is crucial. Practitioners described different tasks. Initially, the chairperson needs to reassure the participants, so everyone can feel comfortable and contribute equally. The chairperson also needs to get a clear focus on the present situation and on the goals. The chairperson notes the things said; this visualisation on paper gives recognition. In a short time a lot of information is shared. However, some participants wondered if they were able to grasp the full complexity of the situation.

By using the protocol of the CNC the chairperson can also stay consistent. The CNC has a tight timeframe; this needs to be better guarded by the chairperson. Furthermore, he needs to connect the different

participants in order to get full support for the care plan and to get someone responsible for the follow-up of the agreements.

During the planning process different solutions are suggested before deciding and looking for proper care. Participants said that practitioners need to mention their limitations to formulate a realistic plan. The participants also mentioned the lack of motivation with clients as a reason for practitioners to not initiate support.

The result of the CNC is a specific plan. This is something tangible and makes succession possible and necessary. Participants did not reach a consensus about the fact whether a CNC leads to a solution but they reached a consensus about the fact that a CNC has an influence on the welfare process:

SP1: If you can make free associations concerning the question, maybe you get creative answers. Not yet the solutions, but things are beginning to move. So clients themselves can say 'this is something different.'

SP4: I also think it is a way to slow down the process and reflect on present concerns. (FG3)

Discussion

There are significant challenges to IP and interagency practice in the complex field of child and adolescent mental health.. One of the challenges is advancing child and family empowerment. Another is practitioners' ability to report their own limitations and to think 'out of the box' by searching for uncommon solutions. During CNC practitioners state, it is their task to help the clients with their plan, but clients should not necessarily follow their ideas. A thorough preparation with the child and his parents is necessary to ensure that they can state their opinions and desires without this interfering with current care ("UN Convention on the Rights of the Child", 2016). Evidence indicates that a sense of personal control, empowerment, and self-determination are associated with positive mental health and enhanced quality of life (Prilleltensky, Nelson, & Peirson, 2001). Shared professional values and a supportive work environment influence the level of client participation (Kemp, Marcenko, Hoagwood, & Vesneski, 2009; Mizrahi, Humphreys, & Torres, 2009).

Regarding the strength of the collective, the preparation of a CNC is seen as very important, but time consuming. A barrier to collaboration mentioned in literature is the burden faced by child welfare workers, in terms of high caseloads. As a consequence they may not have the additional time, authority or resources needed to collaborate (Ehrle, Scarcella, & Geen, 2004). The participants mention that extra attention needs to be given to the selection and invitation of participants to the CNC. Is the priority that the CNC is organised as soon as possible? Or is the priority the presence of certain people?

In most cases health care services are well represented, but an important source of support for parents is missing; for example, extended family, neighbours, friends. This needs to be questioned explicitly. These families are often isolated and have a limited social network. International literature reports that

identifying and inviting greater numbers of natural support is an ongoing challenge (Walker, Koroloff, & Schutte, 2003; Walter & Petr, 2011). When certain specialist practitioners' presence was promised, this creates high expectations: enough specialist practitioners need to be present and the required expertise needs to be introduced.

Confidentiality and information sharing is another challenge to the CNC. Participants questioned which information need to be shared before the CNC. They discuss the balance between sharing enough information to start a CNC and the amount of information that is really necessary. A balance between restraint and release of information needs to be considered, especially with the presence of informal support who are not bound by confidentiality. A certain degree of information-sharing facilitates care coordination, while sharing too much information threatens patients' privacy rights and violates professional ethics of confidentiality (Van Liew, 2012). When a limited amount of information is shared, this also has the advantage that practitioners enter the CNC objectively. A thorough preparation between practitioner and clients is therefore required; they discuss which information needs to be shared, thereby considering the relevance of the information and handling this information carefully (Liégeois, Haekens, & Eneman, 2006). In some cases practitioners wanted to inform the chairperson about crucial information without the knowledge of the clients. Some practitioners seem to need someone else to bring up these delicate issues.

The next theme that emerged from the focus groups was the value of the CNC protocol to engage families in a clinical process. The participants all agree that the clients should be present. The presence of the child and the parents throughout the whole process is experienced as crucial, but is also a challenge for practitioners. Transparency and joining together appear to be the main principles to motivate the presence of the child and the parents. It seems a plea for more client involvement in care programs.

The role of the chairperson during a CNC is mentioned as crucial through this process. Practitioners describe the task of the chairperson to be important to reassure the participants, to get a clear focus, to be consistent and to connect the different participants.

During a CNC practitioners want to be empathic, but also want to bring a clear message to their clients. In a safe atmosphere clients seem to be able to manage this duality. However, some conditions need to be present to create such a safe environment. Listing the strengths of the child and the parents at the start seems to be an important condition setting an environment in which information can be shared and difficult conversations can take place. The fact that the clients are actively involved during the process appears to be beneficial for them, as it shows respect and trust (Chong et al., 2013). Other factors identified for effective collaboration are: a shared recognition of the need for collaboration; clear rules, responsibilities and procedures; open, frequent and clear communication; outlined goals and objectives (Horwath & Morrison, 2011; Marek, Brock, & Savla, 2014). The protocol of the CNC includes these factors.

The structure of a CNC offers opportunities and challenges. The participants perceive the protocol of the CNC as constructive; it provides a clearly structured planning process. However, the protocol is also

experienced as time consuming and having a slow start. When practitioners perceive the advantages for the child and the parents they do not seem to have a problem with the restrictions of the CNC. The following elements contribute to family empowerment (Saleebey, 1996; Walker & Schutte, 2005): Active participation by the child and parents; and attention to child and family strengths.

The goal of a CNC to bring people from different sectors with different expertise together succeeded. Different mental health professionals were present during CNC: Child welfare, child protection services, agency for persons with disabilities, pupil guidance centre, child and adolescent psychiatry, juvenile justice, child and adolescent mental health services. 'An effective team embraces a broad range of expertise' (McGinty et al., 2013). Combining these perspectives during CNC resulted in a feeling of shared responsibility among the different practitioners. Children with complex mental health care needs require the coordination of different agencies; combining primary mental health workers and specialist posts, each on bringing their own skills and expertise (Callaghan et al., 2004).

A CNC does not always result in solutions. Practitioners report feelings of frustration that even this type of meeting cannot remove certain obstacles. The monitoring of the agreements made during CNC is crucial and needs consistent emphasis (Kingsnorth, Lacombe-Duncan, Keilty, Bruce-Barrett, & Cohen, 2013). To achieve a high-fidelity wraparound process an intensive care coordinator needs to be appointed. This care manager helps the youth and the family with the preparation; facilitates the meetings; helps to develop an individualised, strengths-based care plan; and ensures appropriate follow-up (McGinty et al., 2013). To provide continuity in current care seems difficult. The different agencies are not coordinated, which can lead to cracks in a care trajectory or the maintaining of an inappropriate level of care. Mutual trust and clear agreements are required (Horwath & Morrison, 2011; Marek et al., 2014) for the whole team to support the care plan.

Participant in the study reported that wraparound principles are positive, but difficult to achieve. The principles concerning "active involvement of natural support", "community based services and supports" and "being persistent as a team" need more attention. During CNC the team listens to the preferences of the child and the family, but the practitioners did not address the principle "culturally competent". This principle assumes that practitioners have an understanding of cultural backgrounds, such as health beliefs, language and customs. Furthermore, decisions made by families and youth that reflect a cultural perspective, can be in conflict with mainstream clinical practices and support interventions (Lazear, 2015). Although participants reported the participation of families from different origins during CNC, they did not mention any considerations of taking a cultural perspective. The protocol of the CNC did not provide guidelines for practitioners to make a cultural sensitive care plan.

The creation of standards for child and parent involvement in child mental health care is important (Kemp et al., 2009; Prilleltensky et al., 2001). Implications of this study translate into educational needs for practitioners on translating IP principles and client- and family-centred care into real world practice.

Client involvement requires the skills to communicate and to listen actively as a practitioner. The practitioner needs to verify the things being said and has to be able to reflect on one's own behaviour to really connect with the client's goals.

Future education and training needs to emphasise collaboration skills, intervention techniques that respect and strengthen families, multicultural competence and understanding of child growth and development in a broad sense (Friedman, 1993; Tracy & Pine, 2000). Practitioners' competences within a broad range of agencies need to be kept up-to-date, with supervision and wide organisational support (Secker & Hill, 2002). The establishment of a trusting and respectful relationship is also an important factor for IP collaboration. Professionals need to know each other and to reach a shared understanding of their expertise and roles (Andvig, Syse, & Severinsson, 2014; Rousseau, Laurin-Lamothe, Nadeau, Deshaies, & Measham, 2012). Furthermore, training programs need to pay more attention to the ethical dilemmas that are a part of IP collaboration and the manner in which to handle these as a practitioner in daily practice (Van Liew, 2012).

A general recommendation in line with the IP literature is the need to train all practitioners in IP collaboration; including open communication skills, shared decision making, dealing with different views on power and hierarchy of relationships among professions, and conflict resolution (Baker, Egan-Lee, Martimianakis, & Reeves, 2011; Hillier, Civetta, & Pridham, 2010; Winters et al., 2016). These educational opportunities can promote collaborative working (Freeth & Reeves, 2004) and enhance patient-centred care (D'Amour & Oandasan, 2005). A shared framework exceeds CNCs, as it is a way of thinking and acting for children with complex health care needs.

In relation to study limitations, the results of the study were gleaned from a small number of practitioners and specialist practitioners and thus it remains difficult to generalise the findings. A more general limitation of the study stems from the reliance on the perceptions of the service providers alone. A need for collaboration perceived by the practitioners in the field of child welfare and child psychiatry initiated this project. We enquired the experiences of the practitioners first to keep the protocol of the CNC adjusted to these needs from the field. Future research should be conducted with children and families, who participated in CNCs to gain their perspectives. This study is also limited to self-report of practitioners who were actively involved in a CNC; no data was collected on protocol fidelity. Observational data could be an added value in further research. Despite the study limitations, important information was gathered about the benefits of the CNC and wraparound principles in daily practice.

Concluding comments

The power of the CNC protocol includes the clear value base, the fixed structure that can be implemented into practice, the focus on strengths, the presence of families, the contribution

from different sectors with different expertise and the shared responsibilities. The CNC is a useful way for practitioners to organise and realise collaboration. Subsequently, practitioners, children and families can

benefit from the advantages linked with family participation and interagency collaboration. Further research is needed on the achievement of the wrap-around principles in daily practice. The question remains how to move these evidence-based principles into every aspect of routine mental health care.

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