The Collaboration between Early Childhood Intervention and Child Protection Systems: The perspectives of professionals

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Abstract

This qualitative study, conducted in Portugal, aimed to understand professionals' perspectives on the collaborative processes between the Early Childhood Intervention (ECI) and the Child Protection Systems. Participants in this study were 19 professionals from 7 Local Intervention Teams of the ECI system, including 8 professionals with coordinating roles. We conducted content analysis following semi-structured interviews. Participants described collaboration as the cooperation between professionals and services, aiming to improve intervention with children and families. Professionals argued that the main advantage of a collaborative relationship was the promotion of effective interventions. However, collaborative practices were mainly described as limited due to communication problems (e.g., insufficient, untimely). Finally, professionals suggested that limited time and resources were the greatest barriers to collaboration while close contacts and relationships among professionals were viewed as the main facilitators. Implications for practice and policy towards enhancing collaboration processes are discussed.

Keywords: collaboration, early childhood intervention, child protection system, children with disabilities

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Child abuse victims are at increased risk of developing disabilities, while children with disabilities are more likely to be ill-treated (Corr & Santos, 2017; Giangreco, Broer, & Edelman, 2002; Lightfoot, 2014; Lightfoot & LaLiberte, 2006), with higher rates of childhood maltreatment in children with mental, emotional, and behavioural disabilities (Lightfoot, 2014; Manders & Stoneman, 2009). Given the complexity of cases in which disability coexists with maltreatment and the cumulative effect of risk factors, intervention is particularly challenging. Thus, it is often the case that these children and their families, designated as multi-problem families, due to the multiplicity of difficulties experienced (Matos & Sousa, 2006), are multi-assisted by different social services (Anderson, Mcintyre, Rotto, & Robertson, 2002; Hayden & Parr, 2019). Importantly, these services are expected to work in collaboration (Barnes et al., 2017; Canavan, Coen, Dolan, & Whyte, 2009). Indeed, collaboration between organizations and professionals is increasingly recognized as an essential practice for improving service delivery to children (Barnes et al., 2017; Hood, 2014) and their families (Hodges, Hernandez, & Nesman, 2003).

Early childhood is a sensitive period of children's development, which requires nurturing caregiving and supportive environments (Black et al., 2017). Child abuse and neglect have been described as particularly detrimental for children's development during this period (Toth & Manly, 2019). Therefore, interventions are needed to assure adequate early development (Black et al., 2017), protecting young children's right to positive development (Machel, 2017). Conversely, collaboration between the different services intervening in early childhood, such as education and child protection, is also required (Machel, 2017).

Specifically, collaboration between the Early Childhood Intervention (ECI) and Child Protection Systems (CPS) is key to effective and adequate provision of services to young children with disabilities or at risk for developmental delay, who are exposed to violence or are victims of neglect (Friedman et al., 2007; Lightfoot, 2014). In Portugal, both ECI and the CPS involve the assessment of the child and his or her family context. However, while ECI aims to support the development of young children with disabilities or at high risk for developmental delay, and their participation in activities typical for their age, through child- and family-centred support measures, CPS agencies aim to intervene merely with children in danger, protecting their best interests by holding caregivers/parents responsible. Moreover, there are important differences between the Portuguese ECI and CPS legal frameworks regarding collaboration assumptions. The ECI legislation emphasizes the need to coordinate, whenever appropriate, with child protection committees or other entities (Decree-Law No. 281/2009, article 7). In turn, the CPS law, makes no specific reference to the need for collaboration between the two services, referring only to the need for collaboration between different entities or persons whenever the situation so requires (Decree-Law No.142/2015, Article 13).

The national Portuguese ECI system includes 144 local intervention teams, composed of professionals allocated by the Ministries of Education (early childhood education teachers), Health (e.g., general practitioners or paediatricians, nurses), and Welfare (e.g., social workers, psychologists, therapists). These teams identify eligible children and families, design and implement the individualized ECI plan, and work with teachers and other staff from the early childhood education settings that target children attend, among other functions. The Portuguese CPS includes 309 agencies, composed of professionals from different entities (e.g., representatives from health, welfare or

education systems) and diverse backgrounds (Health sciences, Education, Psychology, Social work, Sociology) (CNPDPCJ, 2019). These professionals are responsible for managing the referred cases, namely planning and developing the assessment and defining the best intervention to protect children. This intervention may involve mobilizing community service to work with the family and/or removing children from their home (i.e., foster or residential care). When considering the 9271 children served by the 36 ECI local intervention teams in the Lisbon and Tagus Valley region, in 2018, about two percent were referred by the CPS (Subcomissão Regional de Lisboa e Vale do Tejo, 2019). While two percent reflects the low cooccurrence of disability/high risk for developmental delay and child abuse and neglect in early childhood, the complexity of these cases justifies high-quality collaboration between services and professionals mandated to meet the needs and ensure the rights of these children and families.

Interorganizational Relationships: The Collaboration Between Services

Interorganizational relationships can involve several types of collaboration, reflecting different levels of integration (Barnes et al., 2017). Collaboration between services is defined as at least two professionals or services working together with the aim of solving interdependent problems (Friend & Cook, 2013; Hodges et al., 2003; Mendes, Pinto, Abreu-Lima & Almeida, 2018). A collaborative relationship results from the recognition by professionals and organizations that complex and specific problems which led to their relationship cannot be solved only by coordination between the different services (Walker, 2006). In these cases, the relationship between the organizations and the individuals requires a formal, structured relationship with well-defined goals and procedures (Walker, 2006).

The development of collaborative relationships involves three stages (Hodges et al., 2003; Kagan, 1991). In the initial stage, future plans inform and provide the

structure of the collaboration; in the stage of growth, the implementation of objectives and policies occurs; and at the evaluation stage, the results are examined, and decisions are made on future changes. Hodges et al. (2003) add that the process of collaboration can be characterized by five stages of development: (1) individual action - services act individually in relation to the child and family, but recognize the need for collaboration; (2) one-on-one - individuals within one of the services take initiative towards the establishment of a collaborative relationship with members of a different service; (3) new service development - the first steps in collaboration take place; (4) professional collaboration - the collaborative relationship is established at the level of service delivery, at program level, and at system level; and (5) true collaboration - the collaborative process includes the family as a partner.

Collaboration between organizations and professionals has increasingly been recognized as a positive and important practice for professionals and caregivers (Cooper, Evans, & Pybis, 2016), as well as for improving the delivery of services for children (Barnes et al., 2017; Hood, 2014). If the collaborative process occurs effectively and appropriately, it should result in a set of benefits for both the professionals and the client families/individuals (Cooper et al., 2016; Darlington, Feeney, & Rixon, 2005). Specifically, it has been proposed that collaboration results in more holistic professional performance and improved cost-effectiveness (Darlington et al., 2005; Johnson, Wistow, Schulz, & Hardy, 2003; Williamson, 2001), resulting in faster and more effective responses (Darlington et al., 2005; Hetherington, 2002) and consequently, easier access to services (Cottrell, Lucey, Porter, & Walker, 2000; Darlington et al., 2005). Also, a collaborative relationship between professionals from different services, enhances their interventions and continuity of care (Darlington et al.,

2005; Williamson, 2001) as well as positive outcomes of children/families (Cooper et al., 2016).

Despite the potential benefits of collaborative practices for intervention effectiveness, it is important to recognize the barriers to collaborative relationships. In fact, the difficulties and barriers that affect collaboration between organizations are diverse. They can be grouped into three categories (Anderson et al., 2002): (1) professional, such as difficulties in communication (Cooper et al., 2016; Horwath & Morrison, 2007; Walker, 2006) and negative beliefs and attitudes that professionals may have regarding other specialties and organizations with whom they must cooperate (Anderson et al., 2002; Cooper et al., 2016; Darlington et al., 2005; Horwath & Morrison, 2007); (2) systemic, related to the existence of inadequate resources, such as a limited number of professionals, time limits, and the scarcity of monetary and technological resources (Anderson et al., 2002; Cooper et al., 2016); and (3) environmental, related to obstacles at the community, local, or national level (Anderson et al., 2002).

On the other hand, research suggests there are factors which facilitate collaboration between services. They can be grouped into three domains: (1) Organisational and Planning: existence of explicit and clearly defined structures and effective organization and planning, including shared protocols on collaboration between services, that is, formal agreements between professionals or services that identify or coordinate their actions (Barnes et al., 2017; Cooper et al., 2016; Sloper, 2004; Walker, 2006); (2) Communication: the existence of effective communication and information sharing (Atkinson, Doherty, & Kinder, 2005; Cooper et al., 2016); and (3) Objectives and Goals: shared definition of clear objectives and realistic goals (Barnes et al., 2017). Importantly, the positive results of collaboration can only be obtained if there

is a positive relationship between the professionals of both services, that is, a relationship characterized by trust, respect, and openness in communication (Walker, 2006).

Current Study

Despite the complexity of cases involving abused or neglected young children with disabilities and the empirical evidence suggesting the positive role of collaborative intervention practices (Walker, 2006), research on collaboration between services targeting these children is scarce. Therefore, it is important to understand to what extent professionals and different systems collaborate (Matos & Sousa, 2006). Thus, in this study, we proposed to investigate collaborative practices between the Portuguese ECI and CPS, according to the perspectives of professionals involved in both systems. Specifically, we aimed to understand professionals' perspectives regarding: (a) the concept of collaboration; (b) the degree and forms of collaboration between ECI and CPS; (c) barriers and facilitators of the process of collaboration between services; (d) the potential of collaboration between services; and (e) the outcomes of collaboration between services.

Method

Participants

A total of 19 professionals, aged between 29 and 65 years (M = 43.42, SD = 10.96) participated, of which 18 were female. Regarding their academic qualifications, 47.37% had a Bachelors' degree, 31.58% had a master's degree, 10.53% had a Postgraduate Degree, and 5.26% had a PhD. The main areas of training were social work (26.32%) and psychology (26.32%), followed by education (15.75%) and occupational therapy (10.53), in addition to nursing, social policy, physiotherapy and speech therapy (5.26%, each). Thirteen professionals worked full-time and 6 worked

part-time in seven ECI local intervention teams, with 8 professionals working in coordinating roles in local intervention teams serving the Lisbon and Tagus Valley area and in the ECI Regional Coordination Subcommittee. The total number of children served by these seven teams varied between 124 and 530 children (M = 292, SD = 120.58). The number of children who were simultaneously served by ECI and CPS varied between 2 and 15 children (M = 8, SD = 5.15). The maximum number of professionals who served in both systems simultaneously was 2 (M = 1, SD = 0.79).

Instruments

Sociodemographic questionnaire. A questionnaire was used to collect socio-demographic data related to the professionals age, sex, academic qualifications, training field, current professional situation (part-time or full-time), function and length of service in the current institution/organization.

Team questionnaire. A team characterization questionnaire, filled out by coordinators, was used to gather information on the total number of children served, the number of children who were simultaneously served by CPS and an ECI local intervention team, and the number of ECI professionals that were also in the CPS.

Semi-structured interview guide. In order to understand the professionals' perspectives on the collaboration between ECI and CPS, an individual interview script was developed. The guide was composed of 9 questions about (a) professionals' perspectives regarding the concept of collaboration or collaborative work between services, (b) the type of contacts established, (c) the objectives of such contacts, (d) the decision-making process, (e) barriers and facilitators of the collaboration process, and (f) the potential of collaboration between services.

Data Collection Procedure

The recruiting process of participants took place in two phases: first, we contacted the ECI system and, second, we contacted the CPS. The request for collaboration occurred through electronic mail, including information about the study's objectives and procedures.

In the first phase, we requested the collaboration of the Regional Coordination Subcommittee of the Lisbon and the Tagus Valley region. Following authorization, 11 ELI teams were contacted by e-mail, of which seven teams showed interest in participating in the study. Participants were selected based on their primary functions. They were either ECI professionals who served children with a protection measure (i.e., served by CPS), or were professionals with different leadership roles within the regional and local levels of the ECI system. Therefore, the Coordinators of each team were interviewed and, at most, two other professionals serving young children with protection measures (i.e., served by CPS).

The time and place for the interviews was agreed with the Regional Coordination Subcommittee of Lisbon and the Tagus Valley and with the coordinators of each ECI local intervention team. Prior to the collection of data, each participant was given an informed consent form, which ensured anonymity and confidentiality, and provided detailed information about the study and procedures involved. Furthermore, participants were told that their participation was voluntary and that they could withdraw their consent at any time. The average duration of the interviews was 30 minutes, and an audio recording was made. The audio files were transcribed in their entirety, in Portuguese, and only the researchers involved had access to them through an encrypted page with access code. After the transcripts were made, all audio files were destroyed.

For the second phase of the recruitment process, we contacted through email the National Commission of the CPS. Subsequently, aiming to recruit the CPS services that shared cases with the ECI local intervention teams involved in the first stage of data collection, we contacted, by e-mail, seven CPS services of the Lisbon district. All CPS services were contacted at least two times. However, only three teams responded, either refusing to participate due to time restrictions (two teams) or requesting a new invitation at a later stage (one team). Consequently, only ECI professionals were involved in the study.

Data Analysis Procedure

Data analysis was performed using content analysis (Coutinho, 2008). Specifically, categories were constructed inductively from the data, and the process was finalized when theoretical saturation was reached, which happened once the sixteenth interview was analysed. The data obtained was reduced and organized into broad categories, and where necessary, into subcategories. Categories and subcategories were associated with a definition or description. The corpus was segmented into meaning units, based on semantic criteria. The categories were not mutually exclusive, and different categories could be assigned to each meaning unit. In total, 16 categories and 55 subcategories were created. In order to ensure the reliability of the coding process, an independent investigator was asked to code about 33% of the interviews, randomly selected (n = 6), with an average Kappa coefficient of .75 (SD = .19). Only meaning units selected to illustrate each category or subcategory were translated to English by a professional translator and validated by the authors.

Results

Table 1 presents the categories resulting from the content analysis process, as well as the number and percentage of meaning units coded within each category. In

total, 864 meaning units were coded in 16 categories. Below, we present an in-depth account of categories and subcategories, based on thick description, by using examples of meaning units for subcategories representing at least 25% of the meaning units coded with each category.

Regarding the **Definition of Collaboration** *(n* = 18, *f* = 53)[1], the concept was defined by most participants (*n* = 13, *f* = 20) as *Coordination and/or cooperation* between organizations and professionals: "And there is this whole and correct idea of participation, cooperation, and collaboration" (Participant 2, Social Work). The remaining definitions refer to *Common goals and objectives* (*n* = 5, *f* = 8), *Definition of responsibilities* (*n* = 5, *f* = 6), *Joint intervention* (*n* = 5, *f* = 5), *Information sharing* (*n* = 4, *f* = 5), *Collaboration as a duty* (*n* = 4, *f* = 5), and *Horizontal relationship* (*n* = 4, *f* = 4).

Regarding **Collaboration Objectives** (*n* = 19, *f* = 86), the main objective mentioned by the professionals was *Intervention optimisation* (*n* = 16, *f* = 31), that is, professionals seek to collaborate in order to deliver the most appropriate response to the needs of children and families: "That the response to that child and to that family is the best [possible], most coordinated way for that child to develop his/her skills" (Participant 1, Psychology). Participants then referred, as an objective of collaboration, the *Collection and sharing of information among partners* (*n* = 15, *f* = 31) regarding specific cases of children/families: "When there is a need, we contact [them] too, they contact us and we are always trying to be [open], to not advance with any decision, we always look for the information to be [available], that everyone is aware of the information "(Participant 13, Social policy). Other objectives mentioned by the

[1] *n* = total number of participants, *f* = frequency of meaning units.

participants were *Clarification of roles* (*n* = 7, *f* = 12*), Resource optimization* (*n* = 6, *f* = 9), and *Goal setting* (*n* = 4, *f* = 7).

Regarding **Advantages of collaboration** (*n* = 18, *f* = 70), participants described the *Effective intervention and results* (*n* = 18, *f* = 39) for children and families as the main advantage: "The added value, I think that involving the various professional areas, the success of the intervention will be more appropriate. (…) I think that alone, the successes will not be so desirable, and success will not be so fully achieved" (Participant 13, Social policy). The remaining advantages identified were *Reduction of the overlap of interventions* (*n* = 8, *f* = 12), *Mutual support* (*n* = 8, *f* = 10), and *Optimization of human resources* (*n* = 7, *f* = 9).

Most participants (*n* = 15, *f* = 114) demonstrated a **Negative perception of the current state of collaboration** between the two systems. The participants considered that the collaboration is characterized by *Limited or unilateral communication* (*n* = 11, *f* = 32) among professionals: "I think here there has been a small flaw in the collaboration; because we have given a lot of information and we have not received the information we wanted" (Participant 8, Education). Furthermore, participants refer to the *Low Frequency* (*n* = 12, *f* = 29) of contacts between professionals as a problem: "It is often a process that is not scheduled, [contact] is often urgent in nature or in the moment" (Participant 3, Occupational Therapy). Professionals also reported *General Dissatisfaction* (*n* = 10, *f* = 28) with the collaboration process as it is not yet close to what they consider to be the ideal: "Collaboration is still far, far away" (Participant 2, Social Work). Other negative aspects of the current state of collaboration refer to *Lack of Continuity* (*n* = 7, *f* = 13) and to a *Segmented Intervention* (*n* = 6, *f* = 12).

However, most participants also described aspects that lead to a **Positive Perception of the Current State of Collaboration** (*n* = 15, *f* = 64), although with

about half of the meaning units. Some professionals considered that they are *Working Closely* (*n* = 9, *f* = 24) with the CPCJ: "It is a very close relationship, very open and I think it works" (Participant 12, Education) and reported O*verall Satisfaction* (*n* = 10, *f* = 19) with the collaborative relationship established with the CPCJ: "I think it works very well, I think there is a lot of respect among all the professionals and we try to listen to everyone's opinion" (Participant 13, Social Policy). In some cases, *Frequent Contacts* (*n* = 8, *f* = 15) and *Service Openness* (*n* = 5, *f* = 6) were described as positive aspects of the current state of collaboration.

Professionals reported variability in the current state of collaboration between the two systems, depending on the **Specificities of Each Case** (*n* = 8, *f* = 12): "It is quite relative, it depends...it depends on the cases and the situations that appear" (Participant 2, Social Work) and the **Particularities of each service and/or locality** (*n* = 3, *f* = 4): "In general the relationship and coordination between services here in the [omitted] municipality is considered good, taking into account that I have already been in other sites and sometimes there was not even coordination" (Participant 10, Social Work). Finally, it should be noted that only 3 professionals (*f* = 4) referred to the **Common Target Population**: "Therefore, we have here a common [age] range of intervention in the first 6 years of life, while the child is not integrated in an educational system and, then, all the work by the protection committees" (Participant 1, Psychology).

A considerable group of participants identified phases in which a **Collaborative Intervention Process** (*n* = 11, *f* = 28) was observed, including (i) common *Goal Setting* (*n* = 6, *f* = 10) by different professionals/services: "... meetings may also take place in order to define the intervention plan with the family and also the protection agreement" (Participant 19, Social Work); (ii) the initial and/or final *Assessment* (*n* = 4,

f = 7): "It is a joint assessment, the committee does not make a decision based solely on observation and visits, they get in touch to get our feedback" (Participant 10, Social Work); (iii) *Integration of Objectives* (*n* = 4, *f* = 6); and (iv) *Joint Intervention* (*n* = 3, *f* = 5). However, many participants described circumstances in which there is an **Isolated Intervention Process** (*n* = 16, *f* = 32), namely (i) situations in which *Intervention* (*n* = 11, *f* = 15) is conducted individually by each service: "We are all individuals, each one acts on his/her own and deals with it themselves." (Participant 15, Social Work); (ii) reduced collaboration at the *Assessment* level (*n* = 6, *f* = 11): "The assessment is not joint, we work on our own until there is a point [time] for information sharing" (Participant 17, Psychology); and (iii) isolated *Goal Setting* (*n* = 5, *f* = 6).

In relation to the **Type of Contact** (*n* = 18, *f* = 71), we identified two modes of communication between professionals and services: (i) *Distance contacts* (*n* = 16, *f* = 42), through telephone calls (*f*=25) and via e-mail (*f* = 17); (ii) and *In-person contact* (*n* = 15, *f* = 29), including Formal (*f* = 23) and Informal (*f* = 6) contacts.

Regarding the **Participants in the collaborative process** (*n* = 16, *f* = 37), professionals reported that in most contact scenarios, *Professionals from different services were involved* (*n* = 8, *f* = 12): "What is attempted is to always have a moment or several moments together with the all the teams. We have situations with children who, in addition to being served by an early intervention [team], are served by other services." (Participant 2, Social Work). Next, the participants mentioned that, besides the service professionals, the *family of the child* could also be present (*n* = 7, *f* = 10): "The family and the stakeholders in the process" (Participant 10, Social Work). Other stakeholders involved include *Case Managers* (*n* = 6, *f* = 8) and the *Coordinator and Professionals* (*n* = 3, *f* = 7).

The vast majority of participants defined **Success as a Collaborative Process** (*n* = 17, *f* = 33): "I think a successful collaboration process requires that first, people have some personal skills to respond to it, it is necessary to have a record with well-programmed goals in which there is no overlapping of roles, in which people realize that each can effectively have an important part" (Participant 19, Social Work). However, a very significant number of professionals defined **Success in Terms of Results** (*n* = 15, *f* = 38), that is, based on the effectiveness of the intervention: "Without doubt, in this particular case, a successful process of collaboration would be one that rehabilitates the family and the child does not have to be removed" (Participant 16, Psychology).

Regarding **Barriers to collaboration** (*n* = 19, *f* = 109), the majority of participants referred to the *Limited time and resources* of professionals and services (*n* = 13, *f* = 27): "Therefore, I think the difficulties have to do with human resources and if it is not human resources, it is related to time" (Participant 15, Social Work). Participants also considered that *Absence of proximity* (*n* = 9, *f* = 16) between professionals and services makes it difficult to establish a collaborative relationship: "In practice, there is no relationship, they immediately ask for a document and we do not even know each other, or know who is on the other side of the line, to tell the truth" (Participant 16, Psychology). Next, the participants refer to the *Mobility and Work Regime of Professionals* (*n* = 6, *f* = 11) as a barrier: "Even in terms of our team, I am part time in a huge municipality and sometimes this can be a handicap in the effectiveness of the response" (Participant 7, Social Work); "Effectively, we know very little because with the teams, the elements are always changing" (Participant 9, Speech Therapy). *Questions and/or lack of knowledge about services* (*n* = 5, *f* = 10) were also seen by the participants as a constraint to the establishment of a collaborative

relationship: "We lack a lot of notion [regarding] when our responsibility ends and where their begins, despite being complementary" (Participant 16, Psychology). Likewise, the participants identified barriers in the establishment of collaboration related to *Limited communication* (*n* = 5, *f* = 9): "Not sharing information, I consider it a blockage right from the beginning" (Participant 4, Occupational Therapy), the *Existence of few cases in common* (*n* = 7, *f* = 9): "Now we know who we are and we know each other, there is a healthy coordination, but at the moment it is not very regular because, we do not have cases that justify it" (Participant 2, Social Work), and the *Need for demarcation from CPCJs* (*n* = 3, *f* = 9): "But if families could realize that our role is the development of children and not [to act] as policemen. We are not the police, we go there to work with the child and with that family, so that the family learns to work with the child and we do not go there to tell the mother how she is to make the soup and how it is that she will clean the floor." (Participant 2, Social Work).

With lower percentages, the participants also mentioned as barriers to collaboration the *Undefined Responsibilities* (*n* = 3, *f* = 6), *Differences in Understanding about the Role of the Family* (*n* = 3, *f* = 5), *Absence of Organizational Regulation and Orientation* (*n* = 3, *f* = 4), and *Absence of a Common Language* (*n* = 1, *f* = 3).

Regarding **Collaboration Facilitators** (*n* = 19, *f* = 108), most of the participants referred to *Contacts and Relationships among Professionals* (*n* = 16, *f* = 47), characterized by proximity: "The fact that communication is very open, gives us an advantage of being more objective" (Participant 14, Nursing). Participants also describe the *Competence and Motivation of the Professionals* (*n* = 8, *f* = 20), that is, factors inherent to the professionals involved that allow a greater and better involvement in the collaborative relationship: "I think it is the will of people [professionals] in fact (…) it is

their awareness regarding the practices (…)" (Participant 11, Psychology). *Accessibility* (*n* = 9, *f* = 17): "The facilitators, the accessibility, that is, if we want, if we take the initiative, we can easily contact the various services, if we want to take the initiative we can contact" (Participant 4, Occupational Therapy); *the Existence of Legal or Organizational Guidelines* (*n* = 6, *f* = 11) that promote collaboration between professionals or services: "I think that there were even higher orientations in the sense of how we can coordinate, only I think we all begin to feel that the best way is to work this way" (Participant 19, Social Work); and *Knowledge of the Specificities of the Partner Service* (*n* = 5, *f* = 10): "There was a concern here to know exactly the services which should be referred to the families and not simply to delegate tasks that are not within the scope of intervention of that service" (Participant 10, Social Work) were identified as facilitators. Finally, the establishment of *Common Objectives* (*n* = 2, *f* = 3) was also mentioned by the participants as a facilitator: "We all speak the same language and I think this is very important, we are all rowing to the same place" (Participant 12, Education).

Discussion

This study aimed to understand professionals' perspectives on the collaborative processes between ECI and CPS. Specifically, we aimed to understand the ECI and CPS professionals' perspectives on (1) the concept of collaboration, (2) the potential of collaboration between services, (3) the degree and form of collaboration between services, and (4) barriers and facilitators of the collaboration process.

Definition of Collaboration

Most participants used the concepts of coordination and cooperation to define collaboration. These definitions are consistent with the assumption that cooperation and collaboration imply a more formal and structured level of interorganizational

relationships, contrary to the mere informal sharing of information (Darlington et al., 2005; Fletcher et al., 2009; Konrad, 1996). However, theoretically, the concepts of cooperation and collaboration seem to diverge in that cooperation implies a high degree of independence of each service (Fletcher et al., 2009; Frost, 2005; Konrad, 1996), and collaboration involves the sharing of information systems, formalized procedures, joint financing, and joint training of professionals (Fletcher et al., 2009; Frost, 2005; Konrad, 1993). Note that participants identified role clarification, common goal setting, and information gathering and sharing as objectives of the collaborative process. These objectives may arise from the recognition that effective solutions to the complex problems experienced by young children with disabilities exposed to abuse and neglect require the establishment of a more structured, formal relationship characterized by a set of clear objectives and procedures (Walker, 2006).

Potential of Collaboration between Services

The participants in this study identified as the main objective of a collaborative relationship the increment of the intervention effectiveness among children and families. These data are consistent with a conceptualization of collaboration as a problem-solving process (Hodges et al., 2003). The optimization of resources was also identified by the participants both as an objective of collaboration and as one of its main advantages, suggesting that collaboration allows services to work together, but also prevents duplication and gaps in service delivery (Frost, 2005). The literature does suggest that collaboration allows professionals and services to provide more resources to the family, improve time management, use available resources, and monitor cases more accurately (Green, Rockhill, & Burrus, 2008).

Participants' perceptions of the advantages of collaboration allow a better understanding of the potential of collaboration between services and illustrate the

favourable attitudes of ECI professionals towards collaboration with CPS. In general, the identified advantages relate to the fulfilment or pursuit of the main objectives of the collaboration. Thus, according to the participants, the main advantage of establishing a collaborative relationship is the improvement of service provision based on a more effective intervention with children and families. According to Barnes and collaborators (2017), the main impacts of collaboration are related to improving the quality of service delivery. Establishing a positive collaborative relationship results in benefits for children and families through faster and more effective responses (Darlington et al., 2005; Hetherington, 2002), which also benefits professionals and services (Darlington et al., 2005).

Degree and Methods of Collaboration between Services

Regarding the current state of collaboration between these services, the participants mostly used negative descriptions, highlighting the fact that the collaborative process does not correspond to their expectations and needs. This negative perception comes, essentially, from communication difficulties. Participants reported that the exchange of information is scarce or occurs unilaterally. According to Green et al. (2008), communication and information sharing appear to be key elements for more effective results. Participants also referred to the reduced frequency of contacts as well as to the lack of continuity of the collaborative relationship. These results suggest that the pattern of collaboration is not recurrent and continuous, resulting in a segmented intervention. However, the establishment of a collaborative relationship allows professionals to work in a team more effectively, according to the specificities of the family (Green et al., 2008). The perspectives of professionals about the current state of collaboration support the proposition that these two systems are in the one-on-one stage of collaborative processes, in which there are only ad-hoc initiatives by the services

towards the establishment of a collaborative relationship, based on a given child and family (Hodges et al., 2003). As discussed by our participants, the reduced number of common cases may help explain the current one to-one stage of the collaboration between ECI and CPS in Portugal. However, the complexity of these cases justifies effective collaboration at the practice level (Hodges et al., 2003), as mandated by the Portuguese ECI legal framework.

Note, however, that not all descriptions of the current state of collaboration between services were negative. A considerable proportion of professionals (79%) also reported positive aspects of the coordination between professionals and services, considering that this occurs whenever necessary, in a context of institutional openness, and there are reports of close working relationships, with frequent cooperation. This finding reinforces the idea that effective collaboration stems from the existence of positive relationships among professionals, characterized by trust, respect, and open communication (Walker, 2006). As acknowledged by the participants, the differences in perspectives regarding the current state of collaboration may be related to the specificities of each case and to differences between services and localities, suggesting that different phases of the collaborative process can coexist in the same region of the country and that lessons might be learned from the local teams involved in higher-quality collaboration processes.

Regarding the intervention process, most participants (84%) described parallel interventions of the two systems, without the joint work that is characteristic of the collaboration between services (Frost, 2005). The stages of assessment, goal setting, and intervention tend to occur separately, with joint work only at certain stages and without continuity. However, about half of the participants (58%) described circumstances of a

collaborative intervention process, characterized essentially by working together at the stages of assessment and definition and/or integration of objectives.

Regarding the degree and form of collaboration between services, the data obtained suggest some preponderance of moments of distance contacts, based on telephone and electronic mail. In addition, face-to-face contacts are mostly formal. Participants described a greater frequency of meetings and moments of case discussion than informal dialogues between professionals. In fact, the literature demonstrates that collaboration is characterized by formalized structure and procedures (Fletcher et al., 2009; Frost, 2005; Konrad, 1993). In relation to these face-to-face contacts, professionals reported that in most cases there are professionals from two services, as well as other services that are involved in the specific cases, suggesting the potential for development towards an intervention centred on family participation in decision-making processes (Boavida, Aguiar, & McWilliam, 2018) or true collaboration, as proposed by Hodges et al. (2003).

Regarding the professionals' perspectives of the success of the collaboration, a group of participants identified the success of the collaborative relationship based on the results achieved. Specifically, these professionals considered that a collaboration is successful if the results are favourable to the life of the child and his/her family. However, consistent with the idea that the main objective of collaboration is to develop a process for problem solving (Hodges et al., 2003), another group of participants defined the success of the intervention according to the characteristics of the process of collaboration itself.

Barriers and Facilitators of the Collaboration Process

Regarding the barriers to collaboration identified by the participants, these can be grouped, according to the model of Anderson and collaborators (2002) into three

categories: professional, systemic, and environmental. In this study, systemic barriers were the most common, including limited time and resources, also identified by Anderson et al. (2002), as well as the mobility and work regime of professionals. The focus on systemic barriers seems consistent with the one-on-one stage of development of collaborative processes (Hodges et al., 2003), seemingly in place, based on our findings. According to Sloper (2004), the reorganization of teams and the mobility of professionals are obstacles to collaboration, as professionals and services may find it more difficult to establish and maintain collaborative relationships in the context of unstable teams (Darlington et al., 2005). The participants in this study also recognized the lack of regulations and organizational guidelines. This is consistent with the literature suggesting that guidelines are essential to promote collaborative practices (Darlington et al., 2005). Finally, the participants also mentioned the lack of face-to-face meetings between services as an obstacle. Note that, according to Walker (2006), the results of the collaboration are dependent on the existence of a positive relationship between the professionals of both services.

At the professional level, questions and/or lack of knowledge about services were important barriers. For collaboration to be effective and positive, professionals need to have a positive view of the work of colleagues in the other service (Darlington et al., 2005). To do this, it is necessary to have knowledge about the functions of the service with which one is collaborating, since according to the specificities of the service, professionals can act or intervene in different ways (Anderson et al., 2002; Darlington et al., 2005; Horwath & Morrison, 2007; Morrison, 1996; Walker, 2006). In this case, differences in understanding about the role of the family may make it difficult to establish a collaborative relationship. It should be noted that some professionals discussed the need to demarcate their actions from the professionals of the CPS in order

to build and maintain a positive relationship with families, without them fearing the removal of their children. Limited communication was also identified by participants as an obstacle to establishing a collaborative relationship (Horwath & Morrison, 2007; Walker, 2006). Finally, the lack of clearly defined responsibilities was also referred to as a barrier. It should be noted that the existence of well-defined roles and responsibilities allows all professionals to understand where their work begins and ends; avoiding service overlaps (Cameron & Lart, 2003). However, we should also consider whether the strong focus on role definition and delimitation may reflect a veiled resistance to the integration of service provision, based on specialization arguments, with potential risks for delivering comprehensive interventions.

The existence of few cases in common was perceived by the participants as a barrier to the establishment of collaborative relationships and it may result in the perception that a more structured and intentional collaboration is not necessary. Given the characteristics of this barrier, namely the fact that it is not directly related to the collaborative effort, it can be classified as environmental (Anderson et al., 2002). Importantly, this barrier needs careful consideration as the young children targeted by both systems are likely the most vulnerable (i.e., low prevalence but highly complex needs).

Regarding factors that facilitate collaboration, findings suggest the value of explicit and clearly defined structures associated with formal agreements that identify or coordinate actions between professionals or services (Barnes et al., 2017; Cooper et al., 2016; Sloper, 2004; Walker, 2006). The participants identified the existence of legal or organizational guidelines as a facilitator to collaboration. At the same time, the participants described the competencies and motivations of professionals as promoters of establishing a collaborative relationship. According to Sloper (2004), the

development of collaborative practices is associated with leadership and supervision of teams, as well as with the recruitment of professionals with adequate knowledge and skills. On the other hand, a significant number of professionals identify effective communication and information sharing as a collaboration facilitator (Barnes et al., 2017). The existence of close and positive communication strengthens collaborative relationships, in addition to having colleagues in the other service who can promote these close ties. At the same time, accessibility, which the professionals often associate with the use of communication technologies (i.e., telephone and e-mail) is a facilitator. In fact, the literature suggests adopting the use of new technologies is a factor that facilitates and eases communication (Barnes et al., 2017; Cooper et al., 2016; Sloper, 2004).

According to Barnes and colleagues (2017), the joint and shared definition of clear objectives and realistic goals is one of the main facilitators of establishing a collaborative relationship. To the same extent, the participants in this study say that the establishment of common objectives, that is, collaboration for the same purpose, facilitates the establishment and maintenance of the collaborative relationship. Finally, the literature reports that the understanding of the different functions, policies, and responsibilities of services generates a greater understanding and empathy among professionals (Atkinson et al., 2005, Cooper et al., 2016). In fact, the participants in this study said that knowledge of the specificities that characterize each service facilitates the development of the collaboration relationship.

Limitations and Implications for Future Research

The limitations of this work are essentially methodological and associated with the characteristics of the sample. First and foremost, we did not include the perspectives of professionals from CPS, resulting in a one-sided picture of the collaboration

processes among ECI and CPS systems. This limitation resulted from the lack of response or time restrictions of the seven CPS services that were invited to participate. We specifically targeted CPS services that shared cases with the ECI local intervention teams that participated in this study, so that professionals could report on shared experiences. However, the recruitment strategies that were effective for recruiting ECI professionals were not effective in targeting CPS services and should be reconsidered. Nevertheless, considering the nature of the study, it would be important to guarantee the triangulation principle, in order to obtain a broader and more complete understanding, based on the analysis and integration of multiple perspectives (Coutinho, 2008). Since we only included ECI professionals' perspectives, it was not possible to triangulate data sources (Flick, 2014). Second, this work provided insights regarding professionals' perspectives and did not generate data on actual collaboration practices or data on the results of the collaborative process. In order to gain a broader understanding of the results of the collaboration, it would be necessary to include the perspective of the families served by these services (Cameron & Lart, 2003) and to assess children's outcomes. Finally, the study was conducted in the Lisbon district. In view of the regional specificities mentioned by the participants, our findings regarding collaboration with CPS may not be transferable to other regions.

To obtain a broader view of the current state of collaboration between ECI and CPS, future research should include new geographical areas or even conduct a study at the national level. Future studies should also encompass a more diverse sample that allows for a more complete view of the patterns of collaboration between services. Specifically, it is recommended to include the perspectives of CPS professionals and of multi-assisted families. In order to obtain a deeper understanding, future research could

also use triangulation of methods (Coutinho, 2008). Therefore, future studies should include other data collection strategies, such as observation and documentation analysis.

Conclusion

Notwithstanding the difficulties and obstacles identified, the participating professionals seem to show favourable attitudes towards collaboration between the two systems which can be fostered as a resource for the development of institutional practices and policies for promoting greater collaboration. Portuguese ECI and CPS are currently in the one-to-one stage of development of their collaboration and would benefit from efforts to proceed to more advanced stages of collaboration (see Hodges et al., 2003), setting up the conditions to reduce or eliminate the systemic barriers highlighted by our participants (Anderson et al., 2002).

The barriers and facilitators identified in this study point out a diverse set of implications for the definition of practices and policies. Thus, institutional policies should be explicitly oriented towards the promotion of collaborative processes, including (a) allocation of time for regular contact between services, namely to ensure appropriate planning and organization of collaborative processes; (b) the organization of joint training sessions, particularly with regard to intervention models with families; (c) provision of resources for the implementation of collaborative practices; and (d) definition of labour policies that allow greater stability and continuity of functions.

This study contributes to the understanding of collaborative processes between ECI and CPS systems in a European country where the two systems are implemented at the national level. Importantly, barriers and facilitators highlighted here may help to inform the development of collaboration processes in ECI and CPS systems in other countries or regions. One important lesson, for example, is that a legal mandate for collaboration is not sufficient for systematic collaboration processes to occur and

collaboration policies are needed to guide practices in the field. Overall, findings suggest that collaboration is a practice perceived by ECI professionals as important for the provision of high-quality services. However, based on the perspectives of ECI professionals, collaboration between these services is still at an embryonic stage, with great potential for further development.

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Table 1

Categories, number of participants, number and percentage of meaning units

	Categories	Participants	Meaning Units	
			n	**%**
1.	Definition of Collaboration	18	53	6%
2.	Collaboration Objectives	19	86	10%
3.	Advantages of collaboration	18	70	8%
4.	Negative perception of the current state of collaboration	15	114	13%
5.	Positive Perception of the Current State of Collaboration	15	64	7%
6.	Specificities of Each Case	8	12	1%
7.	Particularities of each service and/or locality	3	4	1%
8.	Common Target Population	3	4	1%
9.	Collaborative Intervention Process	11	28	3%
10.	Isolated Intervention Process	16	32	4%
11.	Type of Contact	18	71	8%
12.	Participants in the collaborative process	16	37	4%
13.	Success as a Collaborative Process	17	33	4%
14.	Success in Terms of Results	15	38	4%
15.	Barriers to collaboration	19	109	13%
16.	Collaboration Facilitators	19	108	13%
Total			864	100%