BACKGROUND PAPER

CROSS-SECTOR COLLABORATION: IMPLICATIONS FOR GAMBLER'S HELP

the bouverie centre
VICTORIA'S
FAMILY
INSTITUTE

Victorian
Responsible
Gambling
Foundation

RESPONSES TO THIS PAPER

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SERGE SARDO

Research shows that most people with gambling problems also experience other conditions such as health, social or family problems.

Overcoming problems with gambling isn't easy. Many people don't reach out for help until they are in a crisis situation.

In fact, research suggests less than 10 per cent of people struggling with gambling seek formal help.

We also know that when people present to other services for other issues such as mental health, relationship breakdowns, drug and alcohol issues, problem gambling can go unrecognised or untreated.

Addressing problem gambling in Victoria therefore requires a collective effort, not just within the Gambler's Help sector, but through collaboration with other health, mental health and welfare services.

One of the primary functions of the Victorian Responsible Gambling Foundation is to provide treatment services for Victorians affected by gambling.

Taking a public health approach, we have adopted a number of strategies to prevent and reduce gambling-related harm and to make getting help easily accessible and available.

Together with our gambling support service providers, we are adopting a 'no wrong door' approach to streamline referrals and appointment booking processes.

We have also aligned our service catchments with health and human services providers to enhance opportunities for cross-sector collaboration.

In partnership with the Bouverie Centre, we have embraced cross-sector collaboration to enhance how we integrate services.

The Bouverie Centre's expertise in leading innovative approaches to health and welfare services is well known.

In this paper, the Bouverie Centre outlines a compelling case for cross-sector collaboration by drawing on numerous Australian and international case studies where successful outcomes have been achieved.

To promote and support cross-sector collaboration, the Bouverie Centre and the foundation have also developed a set of practice guidelines in consultation with Victorian Gambler's Help services.

The foundation and Gambler's Help welcome cross-sector collaboration as a strategic and practical step forward, which will ultimately help deliver effective and responsive services that make a difference in the lives of Victorians affected by gambling.

Serge Sardo
Chief Executive Officer
Victorian Responsible Gambling Foundation

DR JEFFREY YOUNG

This literature review on cross-sector collaboration exists within an environment in the Victorian Health system where sector reforms have increased interest in the application of collaborative practices.

Policies of system integration and care co-ordination have begun to be implemented and this review makes a timely and valuable contribution to understanding the principles and practices that enable collaborative work to be established, supported and sustained.

Collaborative work is easy to imagine and difficult to implement, hence the need for clearly produced and well-structured resources like this one.

The Victorian Responsible Gambling Foundation has been instrumental in supporting thinking, discussion and strategies which promote cross-sector collaboration in order to deliver co-ordinated quality services.

Just under five years ago the Bouverie Centre was engaged by the foundation to work with Gambler's Help services to increase cross-sector collaboration in order to improve the engagement of those affected by problem gambling.

It is known that many people with a gambling problem have co-occurring conditions.

However, problem gambling is not always recognised or treated when clients present at services for issues such as mental/physical health, substance misuse and family violence.

When organisations collaborate, resources can be utilised more efficiently, services can become more integrated and responsive and a creative and cooperative working environment can be created.

Collaboration facilitates access to services needed by clients irrespective of where they seek help.

Dr Jeffrey Young
Director
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CONTENTS

EXECUTIVE SUMMARY

CROSS-SECTOR COLLABORATION IS A PROCESS WHERE INDIVIDUALS OR ORGANISATIONS WORK TOGETHER TO SOLVE SHARED PROBLEMS USING SHARED RESOURCES.

Over the past two decades, problem gambling has become increasingly acknowledged as a serious issue affecting Victorians. People with gambling problems often experience co-occurring conditions that may include a range of other health and social problems.

However, when clients are presenting at services for mental or physical health issues, substance misuse and family violence, problem gambling may not be recognised or treated.

The Victorian Responsible Gambling Foundation aims to foster and facilitate cross-sector collaboration and service integration by

- providing co-ordinated quality services for people with gambling problems that acknowledge that many people with a gambling problem have co-occurring conditions

- ensuring Gambler's Help services are utilised to their capacity.[1]

This paper explores the evidence for cross-sector collaboration in public health as well as mechanisms that promote collaborative work. Drawing on the existing literature on the subject, this paper considers the particular value of this model of practice for the Gambler's Help sector.

The evidence shows why cross-sector collaboration is a more efficient and effective way of providing services for individuals and/or families with complex needs. Importantly, cross-sector collaboration allows agencies to better manage the complex needs of clients, and provide a more holistic and coordinated service.

This paper contains four sections:

Section 1 explains how the co-occurring conditions often experienced by clients presenting at health services is central to the argument for cross-sector collaboration.

Section 2 outlines the range of benefits for agencies and service providers, their staff and clients and draws on examples of successful implementation from around the world.

Section 3 explores the barriers to cross-sector collaboration and makes recommendations for overcoming these barriers.

Section 4 reviews the factors that promote cross-sector collaboration to allow for effective and efficient partnerships between agencies.

For the purpose of this review, our use of the term 'cross-sector collaboration' includes both inter-agency and intra-agency collaboration or partnership. This broader understanding of the term allows us to account for collaboration within large organisations, across specialist teams, as well as between services (e.g. mental health and Gambler's Help).

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1   Department of Justice, 2011: 11.

COLLABORATION TO ADDRESS COMPLEX NEEDS OF CLIENTS

CROSS-SECTOR COLLABORATION FOR HEALTH SERVICES

Practice shows that people who access health services are likely to have co-occurring conditions. This notion is central to arguments that support cross-sector collaboration[2] due to strictly divided or siloed service systems (e.g. alcohol & other drugs, mental health and problem gambling) not being responsive to those clients presenting at services with several inter-related needs.

If issues are addressed discretely, other areas of concern can "fall through the cracks" of the service system.[3] Alternatively, if clients are engaged with a number of programs it can be a struggle for them to attend multiple appointments due to organisational or location issues.[4]

While service providers may be unaware of the inter-related issues their clients may have, clients too are often not aware of the variety of services available to them.[5]

Indeed, a high percentage of clients with complex needs do not access multiple services nor do many receive help of any kind.[6]

For instance, a nation-wide survey in 1999 revealed only 10 per cent of problem gamblers sought help[7]. A 2005 study by the New Zealand Ministry of Health revealed a similar statistic. Nevertheless, evidence suggests that when people seek professional help it benefits the gambler as well as their partner and other immediate family members.[8]

According to the Australian federal government, cross-sector collaboration has the potential to overcome the limitations of a siloed service system.[9]

This approach is evident in the Victorian Dual Diagnosis Initiative that began in 2001.

The initiative promotes the development of understanding between alcohol and other drug and mental health services in relation to their policies, practices, procedures and culture. It also recommends the placement of clinicians in partner agencies as a strategy to foster understanding,[10] and encourages strong leadership that identifies shared issues and a common vision of cohesive, consumer centred services.[11]

The Victorian Dual Diagnosis report cites the Jigsaw service for young people at Barwon Health as an example of practice change where it has become normal practice to consider factors other than the clinician's expertise (alcohol and other drugs or mental health) when allocating clients to case managers.

Allocation of clients to case managers now happens at daily meetings with consideration for a practitioner's particular skills and knowledge, and no client receives two or more case managers to improve the continuity of care.[12] Over time, the role of a clinician is being defined by an integrated treatment approach rather than through specialisation.

The US Department of Health and Human Services promotes a process of "systems integration" which assumes the development by health services of a mechanism and system to provide care for individuals with co-occurring conditions (mental health and substance misuse).[13]

One of the fundamental arguments informing their position is that there is always a relationship between mental health and substance misuse, and that effective responses to each must be compatible.

Their approach emphasises that system integration is a complex process involving different service components (e.g. screening, assessment, and treatment planning), and needs to occur on different levels (e.g. individual practitioner, agency, and state).[14]

For the successful implementation of this model of systems integration, various layers and components of the system have to interact, regardless of their size and complexity.[15]

By working together, service providers utilise their resources in a more efficient way.

They can access the specialist skills and knowledge of their colleagues from different professional backgrounds and different service systems such as mental health, alcohol and other drugs, family violence and problem gambling.

2   Cameron et al., 2012; Lee et al., 2010: 62; Provan et al., 2004; Scott, 2005.
3   McDonald and Rosier, 2011: 6; Milward and Provan, 1998: 340; van Eyk and Baum, 2002; Preston et al., 1999.
4   Scott and Campbell, 1998: 450.
5   Ibid.
6   Lee et al., 2010, mental health sector.
7   Australian Productivity Commission, 1999, cited in Clark et al., 2007 and Evans and Delfabbro, 2005.
8   Allingham and Caddy, 2002: 15.
9   McDonald and Rosier, 2011: 1.

10   Australian Healthcare Associates, 2011: 31; see also Croton, 2007.
11   Australian Healthcare Associates, 2011: 32.
12   Australian Healthcare Associates, 2011: 40-41.
13   Center for Substance Abuse Treatment, 2007: 2.
14   Center for Substance Abuse Treatment, 2007: 3.
15   Minkoff and Cline, 2004.

The sharing of resources, expertise and skills allows practitioners to deliver better services to their clients (individuals and families) who often have complex needs.[16]

When agencies with a range of expertise come together, they can discover that individual clients, as well as their significant others, have already received or are receiving help across different sectors.

The studies that form the basis of this document all assert that collaborative approaches can help address the challenges faced by the public health sector when supporting clients with complex needs in an environment where funding is limited. Researchers have stressed that when cross-sector collaborations are implemented consistently over time, they are likely to provide substantial benefits for both clients and organisations.

CROSS-SECTOR COLLABORATION FOR GAMBLER'S HELP

Studies identify that problem gambling is highly prevalent among disadvantaged demographic groups who can have a range of problematic behaviours and health issues.[17] For instance, it is common for problem gamblers to suffer from mental health issues such as anxiety and depression.[18]

Feelings of guilt and loss associated with gambling can often be complicated by a loss of trust in relationships caused by repeated instances of stealing or borrowing money in order to gamble.

Family relationships can deteriorate as compulsive gambling "can devastate the family system, adversely affecting the marriage, parent-child relationships and the psychological development of children".[19]

Financial problems resulting from gambling can also lead to homelessness as it may become impossible for the person to pay rent or make repayments on their mortgage.

If problem gambling is not recognised and addressed, existing (co-occurring) conditions can intensify due to increasing stress levels from accumulating difficulties.

Workers in the problem gambling sector therefore often face a multitude of issues when working with their clients.

By developing a collaborative model of work to deliver services to people with complex needs, service providers are in a position to benefit from the pooling of cross-sectoral resources and expertise. This is the rationale behind the current model for the Victorian Gambler's Help service system, which identifies the following key issues:

• Problem Gambling rarely occurs in isolation

• There is evidence of co-morbid conditions for problem gambling

• Problem gamblers present at services with complex and severe issues

• Client complexity may prevent access to Gambler's Help services in some cases

• Alcohol and drug services, family services and mental health services are priority areas for joint action. [20]

On 1 July 2012, responsibility for the delivery of Gambler's Help services transferred to the newly established Victorian Responsible Gambling Foundation.

The foundation is committed to maintaining the delivery of Gambler's Help services, as an integrated service within the broader health and human services sector.

CONCLUSION: COLLABORATION TO ADDRESS COMPLEX NEEDS OF CLIENTS

Cross-sector collaboration is a model of work that despite various challenges has proved to be effective for services that deliver support to populations with complex issues and needs.

A growing body of research on problem gambling suggests that people with a gambling issue face multiple problems and therefore it is reasonable to propose that if Gambler's Help agencies employ a collaborative model, more effective and efficient work will result.

16   McDonald and Rosier, 2011: 1-2; Gibb et al., 2002: 340.
17   Saugeres et al., 2012.
18   Saugeres et al., 2012: 17; see McIntyre et al., 2007 for a comparative multivariate study of the prevalence of problem gambling in the populations with bipolar disorder, major depressive disorder and general population; and Echeburua et al., 2011 on the co-occurrence of problem gambling in patients diagnosed with schizophrenia.
19   Abbott et al., 1995: 260-261, cited in Darbyshire, 2001: 25.

20   Victorian Department of Justice, 2008.

WHY COLLABORATE?
BENEFITS OF CROSS-SECTOR COLLABORATION

CROSS-SECTOR COLLABORATION HAS A RANGE OF BENEFITS FOR AGENCIES WHO PROVIDE HEALTH SERVICES TO THE COMMUNITY.

Importantly, cross-sector collaboration also allows agencies and their staff to better manage the complex needs of clients by providing a more holistic and coordinated service.

Cross-sector collaboration has been promoted by governments and researchers in countries such as Europe, the United States and Australia, with literature citing examples of successful implementation where positive outcomes have been achieved for everyone involved.

BENEFITS FOR AGENCIES

Agencies and service providers can benefit from cross-sector collaboration in a number of ways.

Cross-sector collaboration can give agencies access to resources that may be unavailable to them if they work alone, as well as new funding opportunites, new knowledge and new clients. [21]

Securing funding and attaining more referrals can be particularly beneficial for smaller service providers whose services are under-utilised.

Resources can also be used more efficiently as collaboration offers the possibility to cut down on the "overlap and duplication between services."[22] Single agencies that participate in collaboration can "influence the behaviour of partners or third parties in ways that none of the partners acting alone could."[23]

A good example of successful collaboration between community mental health and integrated community nursing teams in the United Kingdom resulted in

- improved communication
- pooled expertise
- enhanced creativity in problem solving and more responsive services.[24]

Cross-sector collaboration has also been found to be useful in

- bringing together skills and sharing information;
- achieving continuity of care;
- ensuring responsibility/accountability;
- co-ordinating the planning and delivery of resources for the benefit of service users.[25]

BENEFITS FOR AGENCY STAFF

The literature also shows that clinicians find working in multi-disciplinary teams more satisfactory.[26] Moreover, working collaboratively can reduce staff stress.[27]

It has been found that clinicians who experience a high degree of stress and overload are also more likely to be positive about cross-sector collaboration.[28]

Workers can perceive collaboration as a way to decrease caseloads and share the burden of complexity, which can decrease work-related stress.

Collaboration can also encourage the implementation of innovative practices.[29] Researchers have argued that when a collaborative team gains more authority in decision-making about its working practices, practitioners feel encouraged to come up with new approaches.[30]

One particular case study from England cites how teams of nurses working collaboratively were able to ease the workload of one of the teams during the seasonal flu vaccination by dividing their responsibilities.[31]

Not only were more clients vaccinated quickly, but the health centre was able to open an extra evening service for the clients who did not manage to receive their vaccination during the day.

21   Provan and Milward, 2001: 420.
22   Van Eyk and Baum, 2002: 262.
23   Glasby and Laster, 2004: 8.
24   Cook et al., 2001: 146.

25   Glasby and Lester, 2004: 8; Payne, 2000; Jonson et al., 2003.
26   Cook et al., 2001: 142 with reference to Robinson and Wiles, 1994.
27   Davidson et al., 2012: 160; Smith and Mogro-Wilson, 2007.
28   Milward and Provan, 1998: 397.
29   Norman and Peck, 1999: 221 (study reflects on the multi-professional dialogue between clinicians, service managers and academics who discussed challenges faced by mental health practitioners who work in teams in the UK).
30   Cook et al., 2001: 147.
31   Ibid.

BENEFITS FOR CLIENTS

When services integrate, the clients receive "a broad range of needed and coordinated services."[32] Pooled resources enable agencies to focus on addressing the needs of clients who are most in need. An individual or a family can access multiple care providers at once, instead of trying to navigate through a system of fragmented services that are often inconsistent and discontinuous.[33]

If clients do not have to look for "the right person" to help them, their complex needs can be addressed by the service in a more comprehensive way.[34]

In the mental health sector, some authors have argued that more collaboration between clients and formal and informal carers, is the most efficient and holistic response to de-institutionalisation. This so-called integrated model of care stresses the importance of "extensive education, training and consultation for sufferers, carers, primary care teams and all other agencies and people in the community that are involved in the provision of mental health care."[35]

Collaboration also improves the transfer of information between professionals, which ultimately leads to more holistic and coordinated service delivery.[36]

In one study from the UK, staff members reported that sharing expertise encouraged mutual professional support and more effective responses to client needs. The study cites an example where collaboration between community social workers and psychiatric nurses facilitated a more creative approach to a client with problematic drinking and mental health issues, which resulted in an extension of his capacity to abstain.[37]

Similar positive outcomes for clients were reported in another UK study with community support workers and community mental health practitioners.[38] For them, collaboration promoted more flexible responses to the needs of service users, and their approach to service delivery became increasingly preventative rather than crisis-oriented.

CONCLUSION: BENEFITS OF CROSS SECTOR COLLABORATIONS

The most advantageous aspect of cross-sector collaboration lies in the benefit to clients whose complex needs are met in a holistic manner. When agencies collaborate, not only do they exchange knowledge, but their clients can learn about a variety of services which they could benefit from.

If organisational barriers are considered at the level of policy-making and planning with a focus on the multiple needs of clients, individual service providers and agencies can achieve a more efficient utilisation of scarce resources; those of time, money, facilities and key employees.

Sharing of resources may include an increase in cross-referrals and means that services such as Gambler's Help can raise awareness about problem gambling among other practitioners and provide help to clients whose problems with gambling would otherwise not be addressed.

BENEFITS FOR AGENCIES, STAFF AND CLIENTS

Cross-sector partnerships can be beneficial for agencies/service providers, workers and clients.

For agencies / service providers
- Improved accountability
- More efficient distribution of resources[39]
- More efficient cross-sector communication pathways[40]

For staff members
- Pool of knowledge and expertise, creative problem-solving[41]
- An increase in staff morale resulting from a decrease in isolation
- A sense of common purpose
- Improved cross-sector communication[42]
- Joint training opportunities

For clients

A more efficient and flexible service; increased responsiveness of services to clients.[43]

32   Provan and Milward, 2001.
33   Glasby and Laster, 2004: 11.
34   Gibb et al., 2002: 344.
35   Falloon and Fadden, 1993: 57.
36   Cook et al., 2001: 141-2.
37   Cook et al., 2001: 146.
38   Gibb et al., 2002: 345.

39   Glasby and Lester, 2004; Payne, 2000; Jonson et al., 2003; Salsky and Parker, 2006; Provan and Milward, 2001; Van Eyk and Baum, 2002.
40   Gibb et al., 2002.
41   Payne, 2000; Glasby and Lester, 2004; Cook et al., 2001.
42   Cook et al., 2001.
43   Glasby and Laster, 2004; Payne, 2000; Salsky and Parker, 2006.

BARRIERS TO CROSS-SECTOR COLLABORATION

CROSS-SECTOR COLLABORATION IS A MORE EFFICIENT AND EFFECTIVE WAY OF PROVIDING SERVICES FOR INDIVIDUALS AND/OR FAMILIES WITH COMPLEX NEEDS.

There are, however, barriers to this model of work which are important to consider.[44]

These barriers are often categorised in research according to the participants and systems concerned ie organisations, practitioners, clients and families/carers and wider systems beyond the public health sector.

ORGANISATIONS

Resources

Research shows organisations face several barriers to collaboration, particularly around resourcing. In a 2012 study, organisations claimed barriers included the need to sacrifice some autonomy and to prioritise mutual goals over individual ones and to share (often scarce) resources.[45]

A study on the integration of four public health services in Adelaide concludes that one of the main barriers that hindered the collaboration process was the redistribution of resources between agencies or services.[46]

In general, the redistribution of money available to collaborating agencies is seen as a problem because:

- staff can feel threatened that their responsibilities are being transferred to another group of professionals or agencies
- the lack of existing funding can undermine the willingness of staff to collaborate[47]

If practitioners are concerned their clients may be lost to other services, they are unlikely to be drawn to collaborate and this can ultimately lead to poorer service provision.[48]

Other barriers at the organisational level include different budget streams and inconsistent accountability systems.[49]

History of working together

Adopting a collaborative work model might be more problematic for services that have no previous history of collaboration and/or are historically hostile to one another. Issues of trust may be more relevant to agencies that have not worked together before.[50]

A 2012 study from the UK, cited above, shows that two teams of practitioners had to rely on different means to make their collaboration successful.[51]

The community mental health team built on existing good relationships and previous cross-agency work between practitioners who were part of the collaboration. The other group, consisting of community nurses had less of a collaborative work history and for them, the successful negotiation of roles depended on trust being developed between them.

In another study focusing on services for individuals with co-occurring conditions in California, historical differences between mental health and alcohol and drug services were identified as the main barrier to collaboration and the effective provision of services to clients with co-occurring conditions.[52]

One identified means of overcoming this barrier is through professional and staff training programs.[53]

PRACTITIONERS

Collaboration between services can be impeded if practitioners have insufficient belief in the effectiveness and advantages of the proposed model of work, a lack of knowledge about other services, and if their roles are not clearly defined.[54]

The authors of a 2008 UK case study argue that a lack of role clarity can be the result of an entrenched myth. For example, in the area of adult mental health, "team working necessarily involves all team members having an equal say on all decisions".[55]

In addition to a lack of information and knowledge, practitioners may lack the necessary skills and confidence to work across different areas of practice.[56]

44   Cameron et al., 2012; Research to Practice Note, 2010; Davidson et al., 2012; Glasby and Laster, 2004.
45   Cameron et al., 2012; Provan et al., 2004; Mellin, 2009; Scott, 2005; Agranoff, 1991.
46   Van Eyk and Baum, 2002: 266 and 268; see also Darlington et al., 2005; Wiles and Robinson, 1994: 326.
47   Van Eyk and Baum, 2002: 267.
48   Johnson et al., 2003 (case study from Ohio, USA; agencies that work with young children with disabilities and their carers).
49   Norman and Peck, 1999.

50   Clasby and Lester, 2004: 14.
51   Cook et al., 2001: 147.
52   Grella and Young, 1998: 88 (survey of administrators of county departments of mental health and alcohol and drug programs in California regarding services for individuals with co-occurring mental and substance abuse disorders.).
53   Grella and Young, 1998: 90.
54   Webber et al., 2011: 2.
55   Norma and Peck, 1999: 227.
56   Slack and Webber, 2008.

Poor collaboration can also be caused by inherent differences between professionals from different services including education, to status or financial rewards.[57]

Staff members may also feel that they have to neglect the main priorities of their organisation for the sake of the shared goal.[58] That is why a mandate or 'permission' from management to work on an innovative collaborative project is important.[59]

Along with collaboration-friendly policies, the presence of strong leadership and supervision support can make the process of integration easier for practitioners.[60]

If clinicians believe that their organisation supports innovation or a shift to new practice, they are more likely to go beyond their business as usual approach.[61] For individual staff, it is harder to believe in the efficiency of collaboration if it is not widely supported by the organisation as a whole.

Collaborative ways of working have a greater chance of being successful if they are supported by senior managers who hold authority over the utilisation of resources.[62]

The working environment can inform worker attitudes, beliefs and knowledge to a greater extent than organisational policies.[63] Workers' "collective beliefs" can also influence the way they interpret interactions with staff members from other agencies.[64]

Negative collective attitudes towards other agencies are likely to impede collaboration. Lack of trust between workers in collaborating agencies[65] and insufficient communication and exchange of knowledge[66] can present significant barriers to collaboration at both inter-personal and inter-organisational levels.

A lack of communication not only undermines trust, which is fundamental in partnerships, but also causes a lack of clarity around roles and responsibilities. This is likely to happen if roles change significantly and continually throughout a collaboration, and can eventually lead to inappropriate referrals.[67]

Miscommunication can also precede clients receiving conflicting advice or substandard care.[68]

In a qualitative study of team work in primary care in England, health visitors reported feeling that their roles were not clearly understood by other participants in the collaboration. In addition, changes in primary care placed some of the responsibilities for preventive work, which was previously performed solely by health visitors, with general practitioners (GPs) and practice nurses.

Health visitors believed this devalued their professional knowledge, and led to preventive work being inadequately performed by practice nurses who did not have any specialised knowledge and skills.

The problems associated with negative assumptions and beliefs, lack of skills and knowledge and an inter-professional "language barrier" can be solved through the provision of professional training, where practitioners have a chance to get to know each other personally and to find ways to understand each others' professional language.

However, this needs to be done at the organisational level so that practitioners can allocate time for attendance, especially when there is a high volume of cases.[69]

Concerns surrounding the redistribution of power and resources can be identified as a barrier for both agencies and individual workers.

Redistribution of power in particular may be perceived by some professionals as a threat to their roles.

For instance, in one study from England, GPs who were not involved in a collaborative project with community nurses felt "disconcerted", because decision-making was exercised almost exclusively by a team of community nurses. Some of those GPs preferred to discuss issues with managers rather than the team itself, which resulted in the teams' newly acquired autonomy being undermined.[70]

By collaborating, service providers become more aware of the client's relationships and the roles they inhabit.

Family issues may be revealed that are impacting, and being impacted upon, by the clients' presenting concerns. The complexity and multiplicity of client needs require service providers to search for solutions that are inherently cross-sector.

57   Norman and Peck, 1999: 222.
58   Van Eyk and Baum, 2002: 268.
59   Van Eyk and Baum, 2002: 268-9.
60   Cameron et al., 2012: 5; Department of Human Services, 2010: 5-6; Johnson et al., 2003: 201.
61   Smith and Mogro-Wilson, 2007.
62   Johnson et al., 2003: 206.
63   Smith and Mogro-Wilson, 2007: 554.
64   Smith and Mogro-Wilson, 2007, with a reference to Sandfort, 1999.
65   Provan et al., 2004; Johnson et al., 2003.
66   Research to practice note, 2010: 4; Webber, 2011: 2.
67   Wiles and Robinson, 1994: 327.

68   Wiles and Robinson, 1994: 327-328.
69   Johnson et al., 2003.
70   Cook et al., 2001: 148.

As a result, when practitioners' adopt a family-centred approach the expansion of professional boundaries is encouraged as a "strength rather than deficits perspective".[71]

However, without specific training and managerial support, practitioners are likely to resist involving friends or family members.

Such resistance may come from practitioners not wanting to step outside of their professional role which is defined by focus on a specific category of clients.

One study showed that mental health practitioners had a poor response to collaboration with a child protection service as they believed it was not "their role to safeguard children".[72]

Training that provides practitioners with knowledge about other services and the skills to work together as a team can be seen as one of the crucial elements of a collaborative strategy.

CLIENTS AND FAMILIES/CARERS

As mentioned above, barriers for collaborating agencies include differences in philosophies, values, language and approaches to treatment. Clients may contribute to existing disagreements by allying with one service provider against another and positioning them as "a mutual enemy".[73]

Some researchers believe that it is important to remember that 'collaboration' does not mean absence of conflict but it rather "requires the effective management of conflict".[74]

The wider system

State policies regarding the operation of multiple arms of the health and welfare system can also be contradictory. For instance, a study on health services in the UK points to the lack of clarity in the government's guidelines on collaboration.

On one hand, the recommendations encourage the blurring of distinctions between professions, and on the other hand, makes these boundaries more explicit so the accountability of particular services is clear.[75]

Moreover, some research refers to government requirements that promote segregation of service providers. For example, in the UK, despite the state encouraging collaboration between public health

and social care sectors, there is no unified system of performance reporting for these sectors.[76]

CONCLUSION: BARRIERS TO CROSS-SECTOR COLLABORATION

The promotion of shared beliefs and improved communication can minimise some of the greatest barriers to collaboration, such as the reluctance of some agencies to sacrifice their autonomy and a lack of trust between staff members.

Although changes to practice happen in the field where individual workers directly interact with clients, the importance of strong leadership, support of inter-organisational work, and the clarity of government policies cannot be underestimated.

Working together can also help staff become aware of clients' familial and other relationships which can lead to a family-inclusive approach to care. This is one of a number of constructive ways to overcome strict cross-sector divisions and avoid the duplication of work.

Coordinated cross-sector training has the potential to improve workers' understanding of other services, strengthen professional relationships and confidence to refer clients as well as fostering a common approach and language across professional disciplines.

71   Scott, 2005 with reference to Walter and Petr, 2000.
72   Slack and Webber, 2008.
73   Scott, 2005: 136.
74   Scott, 2005: 136.
75   Payne, 2006: 146.

76   Glasby and Laster, 2004: 11.

FACTORS THAT PROMOTE CROSS-SECTOR COLLABORATION

FOR CROSS-SECTOR PARTNERSHIPS TO GO SMOOTHLY AND TO BE EFFICIENT, AGENCIES NEED TO OVERCOME THE BARRIERS DISCUSSED PREVIOUSLY IN THIS PAPER.

In this section, some of the general characteristics that have been identified as promoting cross-sector collaboration are reviewed.

FACTORS THAT PROMOTE CROSS-SECTOR COLLABORATION

Individual workers/agencies:

Interpersonal relationships and information sharing:

- better understanding and knowledge of the culture and professional vocabulary of other services;[77]
- calls returned and time made for staff from other services;[78]
- whole team visits, sharing of practice examples;[79]
- co-location: direct personal communication, sense of trust, information sharing;[80] or "learning across professional boundaries";[81]
- project team-building events and regular project team meetings;[82]
- negotiation of roles with a focus upon client needs[83]

Management:

- strong leadership;[84]
- organisational support of collaborative activities;[85]
- clarity of roles, responsibilities and shared goals;[86]
- commitment/dedication to providing the best possible care for clients;[87]
- mutual respect and shared core beliefs.[88]

INTER-PERSONAL RELATIONSHIPS AND INFORMATION SHARING

As previously noted, the sharing of funding resources can provide the main incentive for agencies to collaborate. However, the prospect of sharing resources, particularly when they are scarce, can also make agencies reluctant to be involved in collaborative projects.

There are a number of factors that can encourage agencies to become less protective of their resources, and to allocate them more efficiently. These include:

- a commitment to keeping the patient/client at the centre of the collaborative effort [89]
- communication[90]
- strong leadership[91]
- mutual respect and
- clarity of roles.

An Australian study in Adelaide highlighted how mutual respect between medical staff was promoted through regular monthly meetings which resulted in a greater focus on clients' needs rather than 'just individual glorification'.[92]

Communication on an inter-personal level can be advanced if workers:

- understand the culture (rules, values, communication, structure)
- learn the language of other services
- return calls and make time for the other agency's staff.[93]

Regular project team-building events, project team meetings and whole cross-sector team visits are essential for cross-sector partnership.[94] Co-location, for instance, allows staff members from different agencies or teams to get to know each other personally.[95]

Such informal contact promotes mutual understanding, sharing of information and a sense of trust on an inter-personal and

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77   Johnson et al., 2003.
78   Research to practice note, 2010.
79   Davidson et al., 2012.
80   Cameron et al., 2012; Department of Human Services, 2010; Katz and Hetherington, 2006.
81   Johnson et al., 2003; Cook et al., 2001.
82   Cameron et al., 2012; Johnson et al., 2003.
83   Slack and Webber, 2008; Payne, 2006; Gibb et al., 2002.
84   Johnson et al., 2003; Cameron et al., 2012; Department of Human Services, 2010.
85   Smith and Mogro-Wilson 2007; et al., 2002.
86   Glasby and Lester, 2004.
87   Johnson et al., 2003; Gibb et al., 2002.
88   Gibb et al., 2002.

89   Glasby and Laster, 2004: 14; Gibb et al., 2002: 348.
90   Department of Human Services, 2010; Johnson et al., 2003: 205.
91   Johnson et al., 2003: 201.
92   Van Eyk and Baum, 2002: 266.
93   Department of Human Services, 2010: 4.
94   Cameron et al., 2012; Johnson et al., 2003.
95   Cameron et al., 2012; Department of Human Services, 2010; Katz and Hetherington, 2006.

cross-sector level ("learning across professional boundaries").[96] Studies identify trust as one of the most important underlying principles of improved cross-sector cooperation.[97]

Team learning is one of the means to promote "a shared ethos" that eventually makes services more user-oriented. "Through the sharing of knowledge and experience, situations can be reconstructed and understood in a client-focused way".[98]

If a common philosophy is not promoted, members of the collaboration are likely to be more protective of their status and professional ambitions rather than focused on the needs of clients.[99]

Learning from each other also helps practitioners see themselves as a project team rather than the sum total of individual members.[100] This will allow them to pool knowledge, exchange professional expertise, be self-reflective and evaluate their work.

Practitioners who share professional knowledge and expertise through a collaborative project can be seen as "a community of practice".[101]

Such communities are based on members sharing knowledge they want to exchange. The value of participation to the members is what keeps the community together.

Being bound by the same interest, participants (learn to) speak the same professional language which encourages them to move across professional boundaries.

Communities of practice is a useful vehicle to assist professionals working on a collaborative project to come together and critically reflect on their work together, share practice wisdom and keep updated on the progress of the project. [102]

The theory linked to communities of practice points to the importance of recognising and responding to changes in professional identities.

The latter refers to the process of practitioners' becoming less protective of their membership to a specific discipline and becoming more comfortable identifying with a commitment to a form of practice which is shared with colleagues from other disciplines.[103]

A qualitative study from the UK on child welfare suggests that attention and responsiveness to such shifts in the attitudes of practitioners are important factors that contribute to the success of multi-agency teams, both at the start of the project and over time.[104]

Some workers can resist such de-identification (e.g. not 'a nurse' but simply 'a practitioner')[105], so it is important to address such difficulties during transition to a new 'business as usual' to ensure the sustainability of the collaborative project.

Apart from sharing interest and knowledge, practitioners who are involved in a collaborative project can overcome professional barriers by trying to understand the other agency's culture.[106]

To do this, workers need extra time. It has been found that clinicians spend only around 30% of their working time on direct interactions with clients; the rest of their time (60-70 per cent) is devoted to communication with managers, administrative staff, other professionals and clients' families or friends.[107]

Time was considered the most significant "resource" in order to develop "effective working relationships" with other staff members.[108]

Acknowledgement and respect of the expertise and skills of colleagues from various disciplines is often assumed to be a challenge in the collaboration process due to differences in philosophies and values.

Some studies point out that in particular situations, clinicians in multi-disciplinary teams might focus on identifying who holds the most useful knowledge and skills to deliver a service rather than adhering to traditional boundaries between roles.[109]

The negotiation of roles for optimum service provision is more likely to take place when there are overlaps in roles and responsibilities.[110]

Moreover, the negotiation of roles enables workers to learn more about their colleagues' practice as well as being able to draw on a pool of knowledge and as a result, be more creative and flexible in problem-solving.[111]

96   Johnson et al., 2003: 205; Cook et al., 2001: 145.
97   Katz and Hetherington, 2006; Provan et al., 2004; Van Eyk and Baum, 2002.
98   Gibb et al., 2002: 341 with reference to Bond, 1997.
99   Norman and Peck, 1999.
100   Hart and Fletcher, 1999: 60.
101   Wenger, 2000: 229; see also Wenger, 1998; Heron, 1971.
102   Ranmuthugala et al., 2010: v.
103   Wenger, 1998.

104   Robinson and Cottrell, 2005: 559.
105   Robinson and Cottrell, 2005: 554.
106   Johnson et al., 2003: 206.
107   Walker and Mitchell, 1995: 11, with reference to Bar-on, 1990.
108   Katz and Hetherington 2006: 429.
109   Payne, 2006: 148 with reference to Opie, 2003.
110   Gibb et al., 2002: 344.
111   Gibb et al., 2002: 345.

MANAGEMENT

In the course of implementation, the clarity of roles and responsibilities can be ensured through managerial support for practitioners.[112] Management support and strong leadership are important in legitimising the innovative practice of collaboration.[113]

In an Australian study on the collaboration between hospitals and community health services, participants emphasised the importance of managerial support for staff as it provided credibility for their innovative collaborative work.[114]

Some studies emphasise the 'developmental' or 'emergent' nature of inter-organisational or cross-sector partnership, implying that it takes time and effort ('preplanning and continual hard work') for such partnerships to be successful.[115]

Preplanning may include the establishment of a project committee to identify similarities and differences between the cultures of participating agencies or teams, as well as key issues, potential problems, goals and outcomes of the collaboration.[116]

Such planning also needs to consider a system of accountability for staff from different disciplines and professional settings. It is often suggested that accountability should be based on the identification of shared roles and responsibilities which are separate from the unique skills that each discipline contributes.[117]

Activities centred on client interaction (service delivery level) are believed to be essential in order for services to co-operate. These activities may include linkages such as "referrals sent, referrals received, case co-ordination, joint programmes, and service contracts".[118]

Cooperation at this level also requires the sharing of resources including "personnel, equipment, money, and facilities".[119]

However, even if agencies have enough resources to implement collaboration, it cannot be successful unless practitioners learn to work outside of their professional silos.[120] This means breaking down barriers constructed by differences in language, philosophy, values and approaches to problems (e.g. a focus on prevention, intervention, recovery, etc.).[121]

To overcome these 'cultural barriers', practitioners need to learn to respect the knowledge and contribution made by other disciplines.

The basis for such respect can be derived by focusing on a shared value that many public health service providers hold: *care for the well-being of their clients*.

In practice, this value can be emphasised through regular contact and meetings with other agencies, joint training and co-location.[122] Informal contacts are as important as formal ones. If practitioners know each other personally, they are likely to trust the expertise of their colleagues[123], instead of seeing them as "others" from different disciplines.

CONCLUSION: FACTORS THAT PROMOTE CROSS-SECTOR COLLABORATION

Service provision becomes most efficient and beneficial for clients when practitioners communicate better, share knowledge and skills and clearly understand their responsibilities and common goals.

An understanding of shared goals needs to be coupled with joint structures and systems for practice, e.g. "entry points for clients, systems of case documentation and lines of professional support [supervision]".[124]

Clarity around mutual goals, individual roles and responsibilities within project teams is more easily achieved if managers are supportive of this model of service provision, and if staff members are involved in the (pre)planning and decision-making processes.

Successful collaboration requires training where practitioners can learn about the services with which they partner and acquire the special skills necessary for working in partnership.

112   Cameron et al., 2012, Johnson et al., 2003.
113   Van Eyk and Baum, 2002.
114   Van Eyk and Baum, 2002: 268.
115   Johnson et al., 2003: 201; Van Eyk and Baum, 2002: 264.
116   Johnson et al., 2003: 207.
117   Norman and Peck, 1999: 220; see also Lee et al., 2006.
118   Milword and Provan, 1998: 390; Agranoff, 1991: 536.
119   Provan et al., 2004: 175.
120   Payne, 2006.

121   Norman and Peck, 1999; Johnson et al., 2003.
122   Cameron et al., 2012; Johnson et al., 2003; Cook et al., 2001.
123   Katz and Hetherington, 2006; Provan et al., 2004; Van Eyk and Baum, 2002.
124   Gibb et al., 2002: 344.

CONCLUSION

The evidence presented in this paper supports the case for cross-sector collaboration between public health services and Gambler's Help services in Victoria, and shows why it is a more efficient and effective way of providing services for individuals and/or families with complex needs.

As outlined in **Section 1**, cross-sector collaboration can be beneficial to health service agencies, their staff, and ultimately, their clients.

If problem gambling is dealt with in isolation, agencies are likely to duplicate the work of other services or have limited information about the co-occurring conditions that affect their clients.

Working together to deliver more efficient and holistic services enables agencies to better address the needs of clients, particularly those with complex and multiple needs.

The many benefits of cross-sector collaboration for agencies were explained in **Section 2**, citing a number of international examples where health services have collaborated successfully.

Section 3 explored the barriers to collaboration which are often rooted in the differences between agencies and a lack of experience working together.

As the evidence in this paper shows, shortcomings in collaboration are likely to be embedded in the implementation of a model or practice initiative rather than the specific interventions of the model or practice initiative itself.

It is therefore crucial to achieve consistency in the implementation of collaboration, including careful planning that starts with the identification of what each agency may gain from participation and what challenges are likely to arise.

Section 4 reviewed the factors that promote cross-sector collaboration, emphasising the importance of implementation and communication.

Integral to the success of effective cross-sector collaboration is strong leadership and management supported by a clear plan of implementation and clarity around roles and responsibilities.

Importantly, agencies need to allocate resources to the initiative and ensure cultural barriers between practitioners and agencies are overcome.

By focusing on the shared value to care for the well-being of their clients, agencies can learn to respect each other's knowledge, expertise and contributions.

Looking forward, Gambler's Help services would benefit greatly from collaboration and support from practitioners within mental health and alcohol and other drug and family services.

Collaboration will enable Gambler's Help services to contribute to a growing pool of knowledge, expertise, funding, shared referrals and other valuable resources. But ultimately, cross-sector collaboration will benefit Victorians affected by gambling who may also be experiencing multiple other health conditions or problems.

OTHER RESOURCES

PRACTICE GUIDELINES FOR CROSS-SECTOR COLLABORATION

The Bouverie Centre and the Victorian Responsible Gambling Foundation have published practice guidelines to promote and support cross-sector collaboration in the Gambler's Help sector. This resource includes principles for effective cross-sector collaboration and provides practical cases examples of creative ways in which Victorian services have collaborated within the broader health and human services system.

The guidelines and additional case studies are available at responsiblegambling.vic.gov.au/for-professionals and bouverie.org.au

TOOLS FOR MEASURING CROSS-SECTOR COLLABORATION

Two surveys have been developed by the Bouverie Centre as part of the Beacon strategy. These can be completed prior to the commencement of cross-sector collaboration, and again after three to four months.

These are available at responsiblegambling.vic.gov.au/for-professionals and bouverie.org.au

RESOURCES FOR PROFESSIONALS

The foundation provides information and resources for health professionals and staff working with clients affected by gambling.

This includes information on identifying a gambling problem, counselling techniques, referrals, fact sheets, brochures, research papers and much more.

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PRACTICE GUIDELINES
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