3. Collaborative intervention

3.1 The assessment/course of action meeting involves something that community social pediatrics has termed *collaborative intervention*, i.e., a way of ensuring cooperation between the community social pediatrics team and the family, social and institutional networks that cuts across traditional hierarchies, and where the entire focus is placed on coming up with solutions together to best meet the child's needs.

Definition

3.2 Collaborative intervention in community social pediatrics is defined as a way of working collectively based on shared leadership. The goal is to foster a common understanding. Shared leadership, which is the main feature of collaborative intervention, is defined as a process whereby "each participant, as well as the group as a whole, plays a leadership role and contributes his or her expertise with the aim of reaching a common goal. This goal itself becomes the real group leader" (Luc 2010). In the community social pediatrics context, the goal is none other than meeting the child's needs. As Luc explains: "At the heart of shared leadership is the interplay between the participants' varied and complementary input that moves ideas forward and acts as an impetus for collective action" (2010, p. 8).

3.3 Collaborative intervention is a way of turning collective skills into true collaboration where all those present, including the child and family, participate on an equal footing, with the community social pediatrics team acting as coordinator. The child's needs are the primary concern and the child plays an active role in identifying them. Rather than being the subject of the conversation, he or she becomes an active partner in seeking solutions to his or her problems.

3.4 Intervening as a team stems from the need for professionals from different disciplines to support one another so they can better grasp the complexity of real-life situations. That means recognizing everyone's professional limitations, as well as the need to get another perspective to be able to respond more effectively during assessment/course of action meetings. There are no gaps in the discussion since a member of the community social pediatrics team (physician or clinical assistant) always picks up where the other has left off. Seamless collaboration between team members is crucial for exchanges to remain fluid and horizontal. All the professionals present, as well as members of the family network, are on a level playing field. The child and family are equal partners in the search for solutions, thereby moving from a managed-care approach to one of empowerment.

Case Management vs Empowerment

Case Management	Consequences
Judgments, fears and loss of power	
Educating and intervening	
•Managing cases in isolation without necessarily considering stressors affecting the family	•Feeling of being judged •Possible lack of acceptance of suggested solutions •Constant fear of losing their children and feeling powerless •Anger and incomprehension •Possible lack of legal consultation •Risk of losing contact with workers and professionals involved with the child and family

Empowerment	Consequences
Accompaniment, taking back power and family well-being	
Ongoing support and care	
•Develop a concerted and integrated action plan adapted to the child's overall needs •Give the parents tools, while mobilizing significant people around them and considering stressors affecting the family •Seek solutions in partnership with the child and family, as well as social, community and institutional networks	•Buy-in to solutions with trust and less stress •The child and family reclaim power for making decisions that concern them •Access to legal advice and mediation tools •Increased chances that the child will fully develop his or her capacities in line with fundamental rights

3.5 A debriefing session can take place between the doctor and the clinical assistant after each meeting to go over the situation and any concerns they may have. The

community social pediatrics approach systematically includes this kind of review because it contributes to a better overall understanding of complex, multi-faceted problems.

Participants' roles

3.5.1 There are four primary players involved in assessment/course of action: the child, the family, professionals from external organizations (school, youth protection, social workers from other organizations, etc.) and the community social pediatrics team comprising the physician and the clinical assistant (the lead pair) and sometimes another professional who is closely involved with the child and has developed a trusting relationship with him or her (lawyer, psychoeducator, special education teacher, art or music therapist, etc.). The role of each of these players is described below.

3.6 Child's role

3.6.1 The child plays a guiding role in assessment/course of action through what he or she says and does: the child's gestures become messages. It is therefore crucial to observe, listen to and decode these messages throughout the meeting.

3.6.2 The child plays a pivotal role in terms of information gathering. The child's history and life experiences need to be fully understood by participants in the meeting so they can really get to the heart of the child's problems. The child brings key information to the meeting that can totally change the course of events. This information comes out through gestures, behaviour, sharing secrets, and sending messages, which often occur during the physician's clinical examination.

3.6.3 The child also plays a role as key partner in decision-making. It is important to remember that the Canadian Paediatric Society (2005) recommends that children

and teenagers become the primary decision makers for themselves once they are competent enough to be able to make decisions. In community social pediatrics, children and teens are encouraged to participate in decisions that concern them, whenever appropriate. Denying their participation in decision-making could be interpreted as a violation of their fundamental rights (Canadian Paediatric Society 2005).

3.6.4 Lastly, the child plays a role in approving and agreeing to carry out the action plan. The child needs to agree to the plan that has been drawn up since he or she will be the one who needs to implement it, in large part. The community social pediatrics team explains what is involved in the plan, and makes sure the child understands it fully and is motivated to follow through with it. His or her consent should always be sought (Canadian Paediatric Society 2005). Simple questions like: "Are you happy with what you are going to do?" or "Do you have any questions?" are effective ways of including the child in the process.

3.7 The family's role

3.7.1 Families play a role in transmitting information. They provide important facts to the community social pediatrics team during the assessment/course of action phase (family history, child's development, health and social problems, etc.) and give their opinions and points of view.

3.7.2 Families also play a role as partners in confirming hypotheses and seeking solutions. The community social pediatrics team works together with families to analyse hypotheses related to problem areas and to seek solutions. This role enables parents to participate actively in and take charge of their children's lifecourse trajectories.

3.7.3 Families also play a role in consolidating the divergent interpretations of treatment plans. Families at risk often find themselves surrounded by a number of professionals and, at times, diverging views on their situation. During assessment/course of action, therefore, the families' contributions help to consolidate differing points of view about the child's problem areas.

3.7.4 Families also play a role in carrying out the concerted action plan developed during assessment/course of action. They are the most important stakeholders in implementing and following up on the plan. It is crucial for them to state their disagreement when they believe something in the plan has been misunderstood.

3.8 Role of external professionals

3.8.1 Community social pediatrics complements services provided to children and families through institutional networks. Having professionals from external networks participate in the process ensures that difficulties are understood in the same way by all concerned.

3.8.2 External professionals thus play the role of system representatives. They are there to make sure the child is protected by ensuring that requirements are met and procedures are followed, as specified by laws and institutional regulations.

3.8.3 External professionals also play a role in transmitting information. With their expertise, they contribute specific information on the child's and family's situation.

3.8.4 Like families, they play a role as partners in confirming hypotheses and seeking solutions. Bringing their expertise to the table, they participate fully in developing

hypotheses and offer their advice on implementing an action plan adapted to the child's needs.

3.8.5 External professionals also play a role in ensuring follow-up on the plan. In fact, since some services are provided by agencies within the network, having professionals from these institutions present during assessment/course of action ensures that the plan is understood in the same way by everyone and that services are set up within their agencies.

3.8.6 External professionals can also play the role of trusted friend. This might apply, for example, to staff of grass-roots organizations who may have a special, trusting relationship with children and families because they are so familiar with one another.

3.9 Role of the community social pediatrics team

3.9.1 When community social pediatrics first began, the basic team was a social pediatrician and a nurse. Today, the practice has evolved and has adopted an interdisciplinary approach which includes a health sciences professional (social pediatrician, family physician, nurse) and a social science professional (social worker or, in some community social pediatrics centres, a psychoeducator). A specific or specialized professional joins the team when the child receives other services such as legal aid, art or music therapy, or attends a stimulation group, among others.

3.9.2 This team is at the core of assessment/course of action and acts as the bridge between the clinic and the child's milieu. During assessment/course of action, the physician is the leader or "orchestra conductor" and the social worker is the clinical assistant or "first violin". Each team member has a specific role to play

during the meeting, but their roles complement each other's and may be interchangeable. Here is a list of the main roles:

Physician	
Coordination role (orchestra conductor)	The role of the physician is to coordinate the clinical process and lead discussions during assessment/course of action. He or she makes sure that all the steps in the clinical process are followed (see Clinical process); that all participants have a chance to express themselves fully during the meeting; and that decisions are made consensually and include input from all actors at the table.
Role as co-worker	He or she needs to be able to share expertise while maintaining confidence in and leaving room for the clinical assistant's contributions. This approach ensures a more complete analysis that includes important psychosocial information. The doctor needs to make sure that communication remains horizontal during the meeting.
Role as medical expert	It goes without saying that the physician is in charge of providing overall care to the child. He or she diagnoses, treats and can refer to specialists if needed. He or she plays a key role in preventive treatment and ensures that the clinic uses an evidence-based process.
Referral or advisory role	The physician follows the child's development by guiding and advising the family on appropriate resources or therapies that are adapted to the child's needs. He or she is the clinical reference on diagnosing the children and offers advice to the other professionals on individual follow-up.
Knowledge transfer role	The physician needs to be aware of scientific advances in child development and well-being, and ensure that this knowledge is

	transferred and understood by other members of the team.
Role as advocate[1]	The physician needs to take a proactive approach when it comes to making parents, educators, politicians, opinion leaders and other stakeholders aware of the effects of toxic stress and the potential benefits of preventing or reducing sources of toxic stress among children living in a specific community.
Clinical Assistant	
Pre-assessment role	The clinical assistant is responsible for assessing the children's and parents' needs before the initial assessment/course of action meeting.
Psychosocial assessment role	The clinical assistant must be able to complete a psychosocial assessment on the child in his or her own surroundings and to gather whatever information is needed to understand the problem areas.
Role as co-worker	Given the clinical assistant's psychosocial expertise, he or she is part of the assessment team and needs to be able to share his or her know-how while leaving room for the doctor's contributions.
Trusting relationship role	Creating a close relationship between the social worker, the child and the family is a key factor in getting the family to take action and ensuring more effective support. This is essential for building a lasting trusting relationship.
Liaison role with the community network	The clinical assistant is in charge of referrals to neighbourhood organizations that can offer support to the children and families. He or she needs to be aware of preventive programs that are available within the community or, if there are none, to see what is available elsewhere.
Role of ensuring follow-up on action plan	The clinical assistant must ensure that the child's progress follows the agreed-upon action plan, and must be able to

[1]American Academy of Pediatrics 2012.

	recommend modifications as the situation changes. This will help ensure that support services for the child are coherent and that adjustments will be made based on the clinical assistant's reading of the situation.
Specialized Professional	
Trusting relationship role and rallying others	The specialized professional (lawyer, psychoeducator, art or music therapist, psychologist, etc.) is often the person who has developed the strongest trusting relationship with the family, in large part because they are a constant presence. The family has confidence in this person so having him or her present reassures the family during assessment/course of action.
Role in transmitting information	The specialized professional has specific information on the child's situation that can contribute to a better understanding of problem areas.

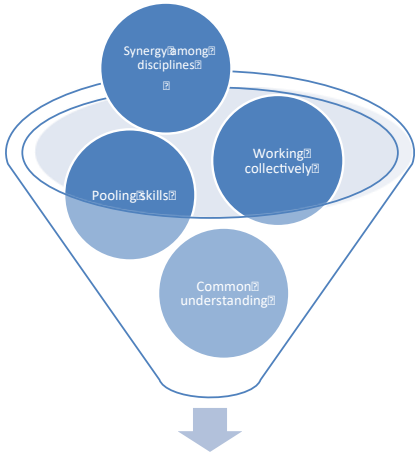
Circular organization

3.10 As we can see from the different participants' roles during the assessment/course of action meeting, there is a certain circular logic to the organizational structure. In other words, on the one hand, there is a clear distribution of power between the community social pediatrics team and the other participants, which leads to a more effective and flexible organizational model. On the other hand, the importance of participation and cooperation in the assessment process cannot be overstated, given the relevance of notions such as empowerment, autonomy and organizational democracy (Romme 1997). Circular models imply that all members can participate in decision-making, either directly or indirectly (Romme 1997).

3.11 This kind of circular organization (Endenburg 1988; Van Vlissingen 1991; Ackoff 1981, 1989, 1994; Romme 1995, 1996) is based on three principles[2] that are the basis for the community social pediatrics model:

Principle	In CSP, this principle means that…
Consensual decision-making	All points of view and opinions are listened to and taken into account during the child's assessment, whether they come from the parents, the CSP team or other professionals. It is only after everyone has provided their input that decisions are made about an action plan. It is also worth noting that all ideas for solutions are explored consensually.
Double linking	There is a leader or "orchestra conductor" who gets things started and works in tandem with an assistant or "first violin". A sort of circular hierarchy is set up where each discipline complements the other. In this way, balanced participation is maintained.
Members or participants chosen following an open discussion	The participants in each assessment meeting are determined based on the child's needs. Anyone who is important to the child can participate in the discussions. After the first meeting, the team often suggests other participants who could be invited to future meetings (schools, parents, neighbours, psychoeducators, etc.) so they can bring additional elements to the table that are relevant to the objectives set out in the child's action plan. Decisions around inviting new participants to the meeting are made by mutual consent.

[2]We interpret and explain these principles as they apply to assessment/course of action in CSP.



3.12 In summary, joint intervention involves creating a synergy between disciplines, pooling skills, working together efficiently and a shared understanding of the situation. The idea is to set up coherent services that benefit the child. It must be noted, however, that this type of joint intervention also presents certain challenges (Justome 2010):

- When experience levels vary, there may be an adaptation phase.
- Each participant needs to be extremely flexible and adaptable.
- Effectiveness depends on the genuineness / sincerity/ legitimacy of those involved in the process, and on continuity.
- Consultation is an essential component.
- Groundwork cannot be restricted to organizational aspects, but must also cover clinical case content.

3.13 Furthermore, it is important to specify that joint intervention becomes truly collaborative when combined with the EEDA method (Establishing, Exchanging, Decoding and Action) since emphasis is placed on fostering horizontal discussions, as explained below.

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