THE UNIVERSITY OF HULL

**Collaborating for children's mental health: A study of the
experiences of health and social care practitioners and
managers working within different models of service
integration.**

being a Thesis submitted for the Degree of

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by

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Dedicated

to my dad, Stan Stericker.

Acknowledgements

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Abstract

The fragmented history of collaboration across health and social care is an acknowledged problem in public services in the United Kingdom. For several decades Government policy documents have recommended improved collaboration to tackle problems associated with people's satisfaction with the quality of public services, the perceived lack of communication across agencies and service inefficiency as a result of the duplication of activities.

Too often the establishment of collaborative structures and processes are mistaken for the realisation of collaborative activity, overlooking the need to nurture identity, relationships and interdependence. This thesis adopts a qualitative methodology to explore the experiences of health and social care practitioners and managers working within interagency and inter-professional teams providing family support and guidance in relation to children's mental health and emotional well being.

There is limited knowledge of the complexity of interagency and inter-professional relationships and the conceptual frameworks that could improve our understanding of the behaviours of people working within, and across, health and social care. This research focuses upon understanding how collaboration is organised at the level of teams, concentrating on models and levels of team integration. Such an approach allows the study of how interagency and inter-professional teams are structured and any impact upon the nature and development of relationships between the people working within such

environments. In so doing, this research connects conceptual frameworks located within both organisational and social theories.

This thesis identified many of the benefits and challenges of integrated team working and concluded that higher levels of satisfaction were experienced by people working within more integrated team structures. The relevance of social identity theory is discussed as managers' and practitioners' experiences were explained as an expression of their need to belong to something which could take the form of an agency, a team and/or a profession. This suggests that, if the public policy goals of collaboration are to be realised, there is a need for practical strategies that pay attention to nurturing relationships, interdependence and building positive social identities within the workplace. Indeed the history of failed collaboration might be explained by a neglect of the people issues.

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1.   Introduction

1.1   An overview.

Collaboration, joint working, partnership working and cooperation are just a few of the many terms to be found within UK Government policy documents encouraging public health and social care services to comprehensively meet the full care and support needs of the population. The benefits for services centre on three main areas; quality, communication and efficiency. Improvement in quality concerns the experiences of those who use the services, improved communication entails improved staff understanding of different agencies as well as improving access to information, and greater service efficiency is about the more effective deployment of joint resources. Collaboration is advocated as a remedy for a variety of problems such as poor professional standards, lack of resources, disputes between health and social care in relation to their responsibilities, the overlap and duplication of service provision and in some instances agencies working against each other.

While collaboration has proven to be an enduring policy ambition, a history of experience suggests that it is not easy to achieve and presents a number of both opportunities and challenges to health and social care agencies. Government's commitment to collaboration remains firm, and is underpinned by recent policy guidance and legislative requirements across the spectrum of health and social care and across all age groups. Collaboration assumes importance within the arena of children's health and social care because Government policy and guidance

continues to recommend collaboration as the cornerstone of improved children's services. The focus of this research is upon collaboration in local authority and NHS children's services. The goal of collaboration continues to permeate policy in this field as is evident in recent policy guidance, for example, *Children and young people in mind: The final report of the National CAMHS Review* quotes a parent stating: "If you do one thing, just get people who know what they are doing to work together better" (DCSF, 2008e:5), and guidance on Children's Trusts reinforces the need to "develop and promote integrated front line delivery organised around the child, young person or family rather than professional or institutional boundaries," (DCSF 2008:8a).

The difficulties of collaboration are well documented in this thesis, and it can be argued that the literature is more prolific in reporting the difficulties and barriers than in recounting any successes. However, notable exceptions that have influenced this research include findings reported by Hudson (2005), Frost et al (2005a) and Tunstill and Allnock (2007) whose studies of interagency team working are optimistic about the potential benefits of health and social practitioners working together more closely. There is a need for continued research and critical analysis that will validate the effectiveness of collaboration and interagency team working, looking at their structures and the processes and conditions required to achieve optimum outcomes. As Dickenson (2007) states:

> "Without understanding how effectively partners are working together, it will be difficult to know whether the expected outcomes should flow from the partnership… Thus it is imperative that partnership evaluations

encompass both the process and the outcome of partnership working. (Dickenson, 2007:85)

The public services context of collaboration therefore remains a legitimate and relevant focus for continued research in support of addressing the practical real world challenges that this policy ambition presents. Government policy has emphasised structural and legislative change as the primary vehicles in support of improved collaboration across health and social care. However, it is maintained that there are limitations to such a narrow focus when attempting to create the necessary conditions that will improve collaborative working relationships. The aim of this research is therefore to extend the evidence base and to explore the development of relationships as collaborative working practices are implemented within the context of the integration of children's interagency and inter-professional teams.

1.2   Identifying the research area.

This research emerged as particularly relevant for the researcher, obtaining employment in 2000 as a social work manager within an interagency and inter-professional service. The teams within the service were tasked with providing services for children, young people and their families, in need of support and with a specific focus on their mental health and emotional well being. It very quickly became apparent that there were many tensions operating across health and social care; for the managers committing resources to the service, and for the practitioners working within the teams.

The researcher therefore contacted colleagues within a neighbouring local authority who were, at the same time, developing a similar service but with an emphasis upon family support and with less focus upon mental health and emotional well being. Discussion revealed remarkably similar tensions, pressures and challenges. As a result the researcher reviewed the literature and identified gaps concerning a knowledge base in relation to models of interagency team working across local authority family support services and NHS child and adolescent mental health services. Therefore, a key concern for the researcher was to ensure that any research should have applicability to real world situations where interagency and inter-professional team working was in operation, offering practical strategies and practical solutions to overcoming many of the challenges encountered.

The opportunity existed for the researcher to investigate the experiences of health and social care practitioners and managers, working within two separate but comparable interagency and inter-professional services for children and families. Each of the two services comprised a similar cohort of children's health and social care practitioners, and they both provided services in support of families, and in particular for children and young people experiencing difficulties with their mental health and emotional well being. However, the two services had adopted two different models for organising their teams, which it was anticipated might have an impact upon practitioners' and managers' experiences of interagency and inter-professional team working. This research was planned and designed to answer the following research question:

"Does the organisation and levels of integration of inter-professional and interagency teams have an impact upon the experiences of practitioners and managers working within them?"

This question is underpinned by a series of related sub- questions (refer to Chapter Six page 174) that guide the researcher to a methodology and framework for data collection that will inform a response to the overarching research question.

Researching such a question requires an understanding of explanatory frameworks that are supported by theoretical constructs. This research considers the application of theory to practice in an attempt to support practitioners, managers and policy makers to make sense of the challenges of collaboration and to develop implementation strategies that are more likely to achieve successes.

1.3   Outline of chapters.

To establish the context of this research, Chapter Two will review the literature and research in relation to the historical policy context of the development of collaboration and integration within public health and social care services. The chapter will examine continued efforts, over several decades and by successive governments, to identify the benefits of collaboration and the potential solutions to overcome the barriers to interagency working across health and social care.

Chapter Three will discuss the policy context of collaboration and interagency working, but with more focused attention upon its development within family support and child and adolescent mental health services. The chapter identifies

slow progress in realising the expected benefits of collaboration and integration for children's health and social care services and for children and families. Government policy initiatives, incentives and legislation are highlighted as some of the strategies adopted to ensure that health and social agencies collaborate in the planning, organisation and delivery of services. However, the chapter highlights the relatively weak evidence base in relation to the expected benefits of integrating health and social care services. It also identifies that little attention has been paid to theoretical frameworks that can help to explain how people within different agencies, and from different professional backgrounds, can work together more effectively.

Chapter Four considers how the language of collaboration is ill-defined, leaving people within agencies to develop their own understandings behind the words. It is suggested that there needs to be a common language to understand the meaning and concepts that underpin collaboration. A clear and shared language will result in an improved and more systematic approach to researching collaboration and developing a theoretically informed analysis of the challenges and opportunities it presents.

The contribution of research to the practice of collaboration across health and social care is reviewed. The need to develop an enhanced understanding of the theoretical basis for collaborative working is discussed as a pre-requisite for understanding the findings of research literature. The synthesis of key social and organisational theories is examined as providing insight into a theoretically informed debate that will have the effect of informing the development of models

of integrated and inter-professional working and the strategies required to create the optimum conditions for more successful collaborations.

As already highlighted, the focus of concern for this study is the experiences of health and social care practitioners and managers working within interagency and inter-professional environments. Therefore, Chapter Five narrows the focus of attention further and reviews the literature and research evidence in relation to interagency working at the level of integrated teams. Different models of interagency teams are discussed, analysed and a typology applied to the interagency teams participating in this research.

Although the services were organised differently, they mirrored each other in so far as they were composed of practitioners from the same professional backgrounds and were providing services in support of children, young people and families. This allowed the researcher to study the different service models and consider the differences in levels of team integration as a variable that might impact upon the experiences of health and social care practitioners and managers working within such interagency team environments.

Chapter Six outlines a qualitative methodology for undertaking this research. Individual semi-structured interviews and focus group interviews were conducted with the health and social care practitioners and managers working within the two interagency services. In the light of a relatively weak research evidence base, a null hypothesis was the starting point for this research in relation to levels of team integration and any impact upon the reported experiences of the participating

health and social care practitioners and managers, that is, the level of integrated working has no difference upon the reported experiences of health and social care managers.

Chapters Seven and Eight report the findings of the research interviews and focus groups. The findings confirmed many of the themes already identified by research into the benefits and challenges of collaboration and interagency team working. However, the research also revealed that the level of team integration did have an impact upon the experiences of practitioners and managers, with more integrated structures and processes promoting more cohesive and harmonious experiences.

The findings are analysed in relation to a framework emanating from organisational theory: inter-organisational network analysis (Benson, 1975, 1983). The application of such a framework facilitates exploration of participants' perceptions of the 'health' of interagency and inter-professional working relationships. A key theme that emerged from the findings was a need for practitioners and managers to 'belong' to something; a profession, a team, or an organisation. The metaphor of 'having a home' is utilised to explain practitioners' and mangers' need to belong to something from where they could assert their identity, their role and their value, and consequently positively reinforce their self esteem. Social identity theory is discussed as a key theoretical framework that can be applied to explain the behaviours of practitioners and managers and their apparent 'need to belong'.

Chapter Nine synthesises the findings into theoretical constructs that aim to

explain "what is going on here?" The juxtaposition of the dynamics of the social, the interpersonal and the organisational are employed to offer a theoretically informed framework which elucidates the conditions that are more likely to lead to successful interagency and inter-professional working relationships as a result of collaboration and integrated team working. Practical suggestions and strategies are offered in relation to how agencies and teams can promote managers and practitioners 'need for a home', their 'need to belong'.

The analysis of the research findings, as discussed in Chapter Nine, initially focuses upon the research findings at micro and macro levels, that is, at the level of the team-working and at the level of localities planning interagency services. However, it is suggested that the findings from this research, and the need to locate collaboration within an explanatory and theoretical framework, directs Government and policy makers to consider how the learning from research literature can be applied to collaboration and interagency working at a macro level, that is at the level of policy making and creating the necessary environment in support of policy implementation.

The thesis concludes that collaboration is a variable property. Barr et al. (2005) hold that inter-professional collaboration is multidimensional; collaboration may be expressed across several levels of activity that constitute collaboration in health and social care, including collaboration within and between agencies and with children young people and families, communities, as well as professions. Thus, interagency and inter-professional collaboration is found on different levels in the social and health care system; from policy formulation, policy implementation,

and service coordination through to integrated service delivery and casework
.What this small scale research aims to contribute to the existing literature is that
effective strategies for making interagency collaboration and inter-professional
teams work will combine inter-organisational theories with social theories that
predict and explain people's behaviours when they are collaborating to plan and to
deliver services.

2.   The public policy context of collaboration and service integration in health and social care.

There is a substantial amount of literature, going back several decades, stating the need for public health and social care agencies to improve how they coordinate the delivery of services. It has been consistently maintained by Government policy makers that only in this way will the State be able to respond more adequately to the varied and often complex needs of people who need a range of services.

More recent policy guidance from Government departments has moved the debate beyond the idea of agencies coordinating service provision to the concept of integration of health and social care services. For example, within the children's policy arena, statutory guidance from Government in relation to the development of Children's Trusts (DCSF, 2008a) identifies the essential features of a Children's Trust as:

- A child-centred, outcome-led vision.

- Integrated front line delivery organised around the child, young person or family.

- Integrated processes; effective joint working sustained by a shared language and shared processes.

- Integrated strategy; joint planning and commissioning and pooled budgets.

- Interagency governance, with robust arrangements for inter-agency cooperation.

Clearly there is an expectation from Government that the integration of services at

a number of different levels is the way forward for the delivery of public services.

The policy goal of collaboration and service integration can be understood by

exploring the historical context of interagency working in health and social care.

The practice and promotion of collaboration cannot be ahistorical or apolitical

because it does not take place in a vacuum but in social arenas where resources

have to be won and the interests of different groups are being served.

The historical context of collaboration and service integration in health and social

care is explored and this chapter reviews the social policies and developments

which affect collaboration and the outcomes it is expected to achieve. It is

maintained that early policy development in the field of the collaboration in health

and social care has focused upon the roles and functions of agencies and

professions when delivering care and support. However, the history of

collaboration indicates that such a functional approach has achieved limited

success when encouraging health and social care agencies to work together to

more comprehensively meet the needs of people in need of care and support.

This chapter discusses how successive governments, over the past two decades,

have developed strategies in an attempt to accelerate the implementation of more

successful collaborative working practices across health and social care agencies.

The current approach, termed New Public Management, attempts to enforce

collaboration between health and social care through the identification and

achievement of whole population based outcomes for public services, with an

associated framework for the joint reporting of performance indicators. For

example, reducing public fear of crime would constitute a public service outcome

requiring many agencies to work together. Performance indicators are then the measures against which all agencies must collaborate to achieve the necessary indicators and outcomes.

This chapter concludes by considering continued challenges to collaboration as a result of a New Public Management approach to policy development and implementation. Government has increasingly distanced itself from the mechanisms of delivering health and social care services, leaving the nature of partnerships and collaborations to deliver outcomes be determined by local agencies. The risks of such an approach are discussed alongside a continued neglect of issues surrounding interdependence and specifically interrelationships.

2.I A historical perspective of the development of public policy in support of collaboration across health and social care.

Loxley (1997) states that concern for the 'sick and needy' has been expressed through public policies since the Elizabethan Poor Law Act in 1658. Public health measures were developed in the nineteenth century to keep up with demographic changes in the population and the growing complexity of local government. It was during this period that links between the environment, behaviours in society and health were clearly recognized. Measures introduced were predominantly welfare led and focused upon social and environmental strategies. Examples of the public health measures taken included the establishment of standards for housing, working conditions, sanitation, and personal health care. The provision of such services depended very much upon a range of private, public and voluntary

provision.

The twentieth century witnessed significant developments in biomedical knowledge and technology. Baggott (2000) argues that the prestige associated with expert knowledge supported the growth of a dominant medical profession. The medical profession then increasingly sub-divided into specialisms that were powerful enough to influence public policy.

Foucault (1980) believed that organisations such as hospitals, prisons and schools were sites of disciplinary power. A complex set of working practices emerge from the way disciplines conduct their daily business in the workplace. These practices become not just the routine, but the common sense, self evident experience and personal identity that defines each person within the discipline. Therefore, disciplinary power is not located primarily in the individual, but is embedded within all social relations and organisational practices.

Foucault's notion of disciplinary power is considered by Hatch (2006) to be important as it highlights how different disciplines internalize particular ways of behaving, and as a consequence ensures conformity and self-surveillance from its members. This self-regulation then has an impact upon how different disciplines experience working together.

In the period between the two world wars and during the Second World War it became clear that adequate health services could not be maintained without significant changes to their organisation and funding. Loxley (1997) suggests that

early attempts to address the issues were considered prior to the National Health Service Act, 1946. The debates leading up to the Act had rejected earlier proposals for a unified health service based around local government because of medical opposition and in response to arguments that funding needed to be national and that local authorities were too small to provide the necessary breadth of care and services required.

Implicit in the expansion of the health and welfare services at that time was the recognition that society must take some collective responsibility for the well-being of its people. The aims of the newly established NHS were to eradicate, as far as possible, the inequalities of health experience (Gormley, 1999).

In 1948, a tripartite public service structure was implemented comprising hospital and specialist health services, the GP service and local authority public health services. Health and social welfare services cut across organisational boundaries and each local authority's Medical Officer for Health was responsible for public health and community services. The newly established NHS hospitals employed their own social workers to address the social care needs of patients. Parallel developments in the organisation of welfare services saw Social Services Departments being organised into five separate welfare departments with separate responsibilities, but under the control of a local authority. Social workers were employed by each of the welfare departments in 'specialist' positions.

After the NHS was established, the health of the population did improve considerably, and mortality rates are often used as tangible evidence of the

improvements. Life expectancy is a widely used indicator of the state of the nation's health. Large improvements in expectancy of life at birth have been observed over the past century for both males and females. The Social Trends report (ONS 2007) noted that in 1901, males born in the UK could expect to live to around 45 years and females to around 49 years. By 2005 life expectancy at birth had risen to 77 years for males and to just over 81 years for females. Similar dramatic improvements were recorded in maternal deaths, infant mortality and prenatal mortality rates.

Gormley (1999) commented that concerns were raised at this time regarding the apparent fragmentation of health and social care services. The nature of health problems had changed from acute illness to more long-term and chronic illness and this coincided with a growing elderly population in need of different patterns of health and social care. It had become apparent that while demand for services was open ended, resources were not and that changes in the organisation and management of health and welfare were being driven primarily from the search for efficiency and value for money. It appeared to be the case that at the highest level of generality, the goal of a healthy society was agreed. The outstanding questions were ones of definition, strategy and method, with collaboration, co-ordination and service integration as just one strand of the debate.

In 1968, the Seebohm Report reviewed the structures of the local authority and allied personal social services. This report was a landmark in terms of influencing the continued provision of health and, in particular, social care services. Seebohm took a more holistic view of the person in their family, environment and social

situation. The report concluded that the existing structure of the personal social services was characterized by a division of responsibilities based upon definitions of certain problems, age groupings and legal and administrative classifications:

> "Such divisions do not reflect the fact that families comprise members falling into a variety of categories or that individuals may face a combination of inter-related problems for which different services (or none) are responsible to treat both the individual and the family as a whole and to see them in wider social contexts creates accentuated difficulties of co-ordination at both policy and field levels."
> (Seebohm, 1968:31).

Seebohm also observed a growing interest in undertaking preventative work. This necessitated a broader view of social and individual problems and their relationship to preventative health and social care. Such a preventative approach often demanded considerable collaboration between several agencies and professions. Seebohm concluded that the divisions of responsibilities between and within health and social care were a major shortcoming.

Seebohm (1968) reported that medicine and social work shared responsibilities in the field of "disturbed personal relationships and social maladjustment". Together they might be more effective in diagnosis as well as providing care and support for the many persons in serious social and emotional difficulties. The report argued that in the field of mental health, it is particularly important that local social care and medical services should be co-terminus. The report ventured to comment about the future of psychiatric services:

"Care of the mentally ill patient and his family requires teamwork between hospital psychiatrists, family doctors and social agencies. A consultant psychiatrist should be seconded on an appropriate part-time basis to provide expert advice to social service departments." (Seebohm (1968:225)

Organisational issues were of crucial importance when considering the effects of divided responsibility upon policy, use of resources, public accessibility, accountability and service coordination. For example, Seebohm considered that separate departments were organised and funded to achieve the specific objectives of those departments rather than to meet their clients' full range of needs. This clearly militated against the prospect of a single practitioner helping a family or individual with multiple needs or through a close-knit professional team with comprehensive responsibilities (Seebohm 1968:35).

The Seebohm Report (1968) was significant as an early example of attempts to construct an ecological, holistic approach to public service provision and delivery. He argued for supporting the reorganisation of existing structures to facilitate the closer co-operation of agencies and practitioners in meeting the needs of their client or patient group. Specialisation was recognized above a basic practitioner level of service provision, but the report was clear that organisational structures must support closer working together.

Seebohm (1968) recommended a new local authority department providing a community based and family orientated service, which would be available for all. This recommendation was implemented in 1971 and led to the creation of new

generic social services departments, bringing together services for children, families and for adults. It was believed that the new structures would enable a more comprehensive and coordinated approach to social care provision, would attract greater resources and would facilitate improved planning to identify and meet a full range of health and social care needs within an area more effectively.

In 1974 the National Health Service was also reorganised and assumed responsibilities for preventative health services in the community (with the exception of environmental health) from local authorities. The NHS was centralised under Government control, rather than responsible to locally elected governing bodies. Despite the recognition of the close interdependence of health and social care provision, for the first time community health and social services were completely split for administrative purposes.

Continued problems of communication between health and welfare were predicted as a result of the health and social care re-organisations. A working party on collaboration between the NHS and Social Services was established in 1972. They argued that co-operation was a logical response to the inter-relationship between client needs and services. The working party stressed that the aim of co-operation should be to secure genuinely collaborative methods of working throughout the planning process (DHSS 1973:10). In the face of restricted budgets, it also seemed to be a logical step to prevent the duplication and fragmentation of services.

The 1973 NHS Act addressed itself specifically to the practices and procedures of

collaboration. It laid out four categories of collaboration, which were:

- The sharing of services.
- The co-ordination of service delivery
- Joint planning.
- Joint prevention.

During this period of major re-organisation, the concept of joint planning was given priority status. Joint planning was recognition of the interdependence between health and social services, as well as the need for effective strategic planning. Section 10 of the National Health Service (re-organisation) Act (1973) placed a statutory duty on local authorities to collaborate when planning services.

The history of collaboration, and the introduction of policy to support implementation, indicates how the late nineteen sixties and early nineteen seventies had witnessed a Government focus on collaboration between health and social care. Various structures were recommended in support of collaboration, for example Joint Consultative Committees were formed between health and social services as the mechanism through which joint planning would take place. Government maintained its commitment to encouraging increasingly coordinated public services through the publication Joint Care Planning (DHSS, 1976). Challis et al (1988:2) argued that here collaboration was seen as a rational response to the complex, untidy sprawl of social boundaries and responsibilities and to the problem of resource scarcity. The assumption was that coordination would replace competition between health and social care agencies. Challis et al (1988) state:

"If a joint and more coherent approach to social policies is to have any chance in succeeding, departments and Ministers must be prepared to make some adjustments, whether in priorities, policies, administrative practices, or public expenditure allocations. (Challis et al 1988:3)

In 1976 Government introduced joint financing measures, offering further inducements for collaboration. These were to be used as mechanisms for the re-allocation of health resources to fund local authority social services where it would increase the total volume of care available in the community. Challis et al (1988) observed that it was hoped that joint funding would foster greater reciprocity of relations, and provide the impetus for a more integrated national health policy.

In recognition of a continued failure from health and social care agencies to systematically implement coordinated planning and service delivery, the NHS Act (1977) laid a statutory duty to cooperate on health and local authorities. Booth (1983) reported five major factors driving Government policy for collaboration between health and social services at this time:

- There is an inter-relationship of needs in the community. Health and social services needs overlap and shade into one another.
- There is a complimentarity of services. The health and social services depend upon each other, which may lead to problems if their priorities pull in different directions.
- Collaboration in resource allocation is vital to prevent duplication of services.
- If plans and priorities are not aligned then bottlenecks may appear to the detriment and quality of services.

- Collaboration is seen as a pre-condition of the progress in a national strategy for developing community care. This would involve the shifting of resources and responsibilities between the NHS and Personal Social Services.

(Booth 1983:10)

Booth (1983) went on to argue that structural differences between health and social care services proved to be problematic when considering attempts to collaborate. Both agencies came under the ministerial responsibility of the then DHSS. The health service was responsible to central government, while social services were responsible to locally elected councils. Due to their different statutory accountability and sources of finance, effective collaboration had proven to be difficult. The NHS was funded from general taxation and was usually free at the point of access. Social services were financed from local authority budgets and services were not necessarily free. Both health and social care services faced different demands upon resources and different perceptions of their priorities.

The re-organisations of health and welfare services during the nineteen seventies and early nineteen eighties could be considered to amount to corporate rationalism; seeking through planning, management and budgeting to meet the needs of the public sector both equitably and efficiently. Bean et al (1985) suggested that the reforms were essentially structural and managerial, not philosophical. Demand-led health and welfare services remained the order of the day.

Throughout the nineteen eighties, a continuing theme in policy options advocated by a materialist approach was the collapsing of divisions between the social,

economic, health and welfare sectors. However, despite the initiatives for (and rhetoric of) collaboration and service integration, the evidence at that time suggested there was a continued lack of success (Townsend, Davidson and Whitehead, 1988).

Walker (1984) described inter-professional demarcation as a significant difficulty for agencies and practitioners when attempting to align the provision of services more closely. He concluded that professional autonomy and power between the health and social services made collaboration difficult. Wilding (1985) argued that the professional 'caring' agencies had developed around their own sectional interests rather than those of the client:

> "Services organised around professional skills are a tribute to the power of professionals in policy making. They also bear witness to a failure of professional responsibility. This is a failure to recognize that services organized around particular skills may be logical for professionals, but may not meet the needs of clients". (Wilding, 1985:82)

Walker (1984) suggested that there was a general lack of commitment from successive governments, over the years, to develop strategic collaborative planning for the health and social services. He stated that priority was routinely given to planning economic policy, and therefore health and social care services were susceptible to the changes in economic fortune and policy. Local authorities in particular found it difficult to commit themselves to longer-term projects in the face of changing local government political parties and the potential for frequent budgetary changes.

Despite the difficulties and absence of significant successes, cooperation and collaboration remained a key stated Government policy to achieving improvements in health and social care. In 1986 , the impetus from central Government to enable agencies to collaborate received a further boost in the form of policies advocating 'care in the community'.

The term 'community care' had been used since the turn of the century when it was adopted by the local Government Board to recommend 'more homely' accommodation than the workhouse (PSSC/CHSC. 1978:6). Ever since that time, the term 'community care' has been sporadically used to promote a community approach to social policy. It is the aim of a community approach to provide support and resources to both formal and informal networks of carers or services within the community, and make them more reliable and comprehensive.

In 1988, the Government appointed Sir Roy Griffiths to review the way in which public funds had been used to support community care policies. In his report, Griffiths (1988) stated a need to develop structures and resources to support coordinated initiatives, and that collaboration between the NHS and local authority social services was vital in all stages of planning, financing and implementation of services. The aim was to provide a 'seamless service' for patients and clients of the services (Griffiths 1988)

Like so many reports in the past, the Griffiths Report (1988) concentrated upon collaboration as a way of preventing the duplication of services and therefore saving money. Griffiths did recognize the insularity of professional groups as

creating barriers to successful collaboration. There were problems of communication and different perceptions of each other's competence. To overcome these problems, Griffiths advocated collaboration in joint training programmes at all levels between all services (Griffiths, 1988:1-28). Since nineteen ninety, the Department of Health has exhorted funding and professional bodies to promote and commission inter-professional and shared learning across health and social care to meet present and future employment needs.

Based on the recommendations contained within the Griffiths Report (1988), the Government introduced significant reforms to health and social services. The reforms (DOH 1989a, 1989b, 1990) directed local health authorities and local government authorities to concentrate on assessing the needs of the population for health and social care services. Their main role was to purchase services to meet the needs of the populations they covered, and not necessarily manage or provide the services directly.

The early nineteen nineties therefore saw increasing separation between state authorities' purchasing and providing roles. Thus, in both health and social care, state purchasing authorities controlled what was provided and how it was provided through contracts for services, with an increasing private sector as providers and their 'own' internal but independent service providers.

The increased development of private sector provision and the separation of purchaser and provider activities reinforced the need for collaborative structures between the agencies. Leathard (2003:13) considers that this phase of public

policy was characterised by an agenda to reduce public provision, involve a greater range of independent sector providers, and therefore create a mixed economy of health and social care provision. It was expected that costs would be reduced through the introduction of markets and competition. Internal health and social care markets would be developed with purchaser and provider splits.

Underpinning policies of care in the community were expectations that resources would be transferred from resource intensive institutional and hospital care to preventative services in the community. The nineteen nineties saw the recognition that resources were not being transferred to support community care at the rate that was required to support the policy. Care in the community was criticized for enforcing collaboration through the application of top–down requirements for change, it was seen as mandated and statute driven. Hadley and Clough (1996) observed:

> "One of the lessons to be learnt from the systems imposed on public services by Conservatives is that collaboration and co-operation cannot be taken for granted when changes are imposed. They are by-products of wider systems in which people find that it is worthwhile and possible to work with others." (Hadley and Clough, 1996:210).

Such an observation has direct relevance for the purpose of this study. In the face of decades of public policy increasingly mandating for collaboration across health and social care, it remains unclear what the critical factors for success are and what are the key challenges that hinder progress? Perhaps it is necessary for research to consider the circumstances in which people find it worthwhile to collaborate. Clearly successive Governments' focus upon mandated structural

reforms was impacting very slowly, if at all, upon the creation of collaboratively minded agencies in health and social care.

The current New Labour Government advanced the evolution of the collaboration agenda into a further phase of policy development – supporting 'strategic collaboration'. This Government emphasised the need for health and social care agencies to work together at a strategic level and within a single strategic delivery framework. Government's management of policy implementation focused on supporting agencies to broadly agree what the needs of the local population were and to seek to encourage a range of service providers to compete for contracts to deliver services that would meet identified needs.

Since 1997, the New Labour Government has produced a stream of policy guidance and legislation, backed by substantial amounts of ring fenced funding to develop partnerships between the NHS and local authority agencies. Table 1 illustrates only some of the governmental reports and guidance in support of collaboration policies across adult and children's health and social care services.

The review of some of the key policy documents advocating collaboration and integration over the past three decades reveals progressive moves, by successive Governments, to mandate for agencies to cooperate, collaborate and integrate. The policy guidance contained within Table 1 illustrates a shift by Government from general guidance on collaboration and working in partnership to the increased use of statutory powers, financial incentives and legislation to encourage and enforce more fully integrated health and social care services.

Table 1

The journey to integration: a summary of Government guidance.

Guidance	Summary
Working Together for Better Health (DoH, 1993).	Promoting the belief that "healthy alliances" would secure more effective use of resources, and break down barriers between partners.
Partnership in Action. (DoH 1998).	Proposals for removing constraints and introducing new incentives for partnership working. Provided a scathing critique of the state of partnership working at that time.
Modernising health and social services: National Priorities Guidance 1999/00 – 2001/02, HSC (98) 159 LAC (98) 22.	The guidance identifies social services as the lead organisation in relation to children's welfare and a shared health and social services lead for mental health.
The Health Act 1999.	Removing legal barriers. The pooling of health and social care budgets, delegating commissioning responsibilities to a single 'lead' commissioning organisation, the creation of integrated providers within a single managerial structure.
The NHS Plan (2000).	Local authorities, health authorities, primary care groups and primary care trusts will receive incentive payments to reward joint working.
Primary Care Groups/Primary Care Trusts: (DoH, 2001a, 2001b, 2001c).	The mandatory representation of local authority social services departments in the governance of Primary Care Trusts and a new statutory 'duty for partnership' on all NHS organisations, with shared service objectives and joint investment plans.
The Health and Social Care Act (2001).	Places a duty of partnership on public agencies. Contains measures to allow the secretary of state for health to compel the use of the new flexibilities upon the NHS and local authorities.
Every Child Matters, (2003).	Introduced a raft of changes in support of the integration of key children's services.
The Children Act (2004).	Recommended integrated health and social care Children's Trusts, supported by the opportunity to establish and maintain pooled resources.
Our Health, Our Care, Our Say (DoH 2006):	Greater integration between the NHS, social care, community and voluntary sectors. Budgets and planning cycles are streamlined and based upon a shared outcome-based performance framework. Performance assessment and inspection regimes are aligned.
Strong and Prosperous Communities. The Local Government White Paper (DCLG 2006).	Engendering systematic partnership working through, for example, greater use of joint appointments, pooled budgets and joint commissioning. Legislating a duty to cooperate.
The Children's Plan (2007).	Introduced a series of system wide reforms to strengthen integrated working across children's services.

The New Labour Government's vision for integrated service delivery is clearly articulated in the following quote:

"Our aim is to ensure that patients and users have access to an integrated system of care. This will be given expression through joint planning and joint service delivery, for example local one-stop health and care centres. Better partnership working needs to go further than improving the interface between health and social care. It should bring together health, social services and local government more widely to tackle the health agenda as well as integrating services" (DoH, 1999:3/4)

However, the evidence to date suggests that collaboration has rarely been experienced as an easy process. Loxley (1997) states that conflict is interwoven within interagency and inter-professional working and she identifies deep-rooted social differences in the division of labour, which have developed over the last two hundred years in the health and welfare services.

Despite the difficulties, it would appear from the direction of policy travel that Government presumes by demolishing structural and legal difficulties to collaboration, local agencies should be able to create effective partnerships. However, with such a longstanding history of guidance on collaboration and integration, the seemingly slow progress with implementation would suggest the presence of considerable forces working against such a vision for service delivery. Dickenson (2007) suggests:

"Whilst government has been fairly attentive to questions of structure (such as legal and bureaucratic issues) it has been less so to organisational and individual matters – yet arguably these are the challenges in which

local health and social care economies require most support." (Dickenson, 2007:85)

It is the intention of this research to explore some of the gaps that Dickenson (2007) refers to: the organisational and individual matters that support or hinder collaboration and the integration of health and social care services.

2.2 Analysing public policy and the 'modernisation' of health and social care services.

Sullivan and Skelcher (2002) believe that the re-design of state institutions is connected, in part, with the re-definition of public policy problems. Up until the nineteen nineties, there was clearly an emphasis upon functional definitions of policy problems. The strategies for policy implementation highlighted in this chapter clearly focus upon structural solutions, such as re-designing public services, creating new structures to address specific problems and re-defining the roles and functions of practitioners as well as agencies.

Sullivan and Skelcher (2002) maintain that a functional approach focuses upon public service provision that is deeply embedded in the contributions of national, regional and local health and social care organisation, upon departmental structures and areas of professional expertise. However, the historical context of collaboration and integration, as highlighted in this chapter, illustrates how such an approach has achieved little success and appears to have made little progress in tackling the barriers to achieving this policy ambition.

During the late nineteen nineties, the New Labour Government introduced the concept of the 'modernisation' of public services. This 'modernisation' was underpinned by a gradual shift to an outcome based approach to policy implementation. An outcome based approach concentrates upon the identification of cross cutting issues and population-based outcomes, without clearly specifying the mechanisms or structures for delivery.

This approach to public policy implementation, termed 'New Public Management' (NPM) reforms, was drawn mainly from the private sector emphasising a shift from traditional public administration to public management. Key elements include various forms of decentralising management within public services (e.g., the creation of autonomous agencies and devolution of budgets and financial control), increasing use of markets and competition in the provision of public services (e.g., contracting out and other market-type mechanisms), and increasing emphasis on performance, outputs and customer outcomes. (Larbi, 1999).

A key focus for Government, when implementing New Public Management approaches, is the identification of outcomes containing cross cutting issues which are believed to have a fundamental effect on citizens' sense of well-being, yet continue to be resistant to the actions of governments and others to address them. For example, reducing fear of crime and social exclusion are outcomes which rely upon agencies working together more closely. A joint outcome, to which all partners must subscribe, is not necessarily agency specific, but provides the vehicle for health and social care agencies to collaborate and enter into

partnerships to integrate the delivery of services.

Significant strands of New Labour's public policy agenda have therefore consisted of tackling cross-cutting themes and reflected the shift in concern to the achievement of outcomes – crossing agency boundaries and requiring collaborative activity to be successful. It is suggested that Government's drive to re-define policy problems in terms of outcomes, rather than functions, has been central to a renewed emphasis upon more integrated working structures across health and social care. It is argued that such an approach involves assuming a leading role in the identification of what services need to be provided, but a reduced role in determining who will provide them and how they will be provided. This approach opens up the potential for a range of service models and for independent and voluntary sector providers to enter the public services 'marketplace' and to deliver health and social care.

The argument, as expounded by LeGrand (2007), is that through exposing the public sector to competitive processes it will improve the economy and efficiency of activities. In theory, markets could be created in which service users had more choice and this would increase the responsiveness and consumer orientation of public services.

There is disagreement about the extent to which this approach has strengthened or weakened central Government control over policy implementation. Saward (1997) argues that separating the making of policies from their implementation, combined with stronger central regulation, has given government the best of both

worlds. Governing at 'arms length' enables politicians to distance themselves from implementation, while at the same time increasing political control and scrutiny over performance.

Perri (1997) argues that the persistent gap between policy intent and policy implementation raises questions about how effectively central Government is able to regulate or steer semi-autonomous agencies tasked with the implementation of population based outcomes. The implementation of policy becomes increasingly difficult to enforce, thus exacerbating the 'implementation gap' by hampering the development of coherent and coordinated policy responses. Lupton (2001:10) argues that the result is that the state becomes less able to confront intractable social problems such as social exclusion and unemployment which require cross-cutting policy solutions and collaborative activity to achieve the identified outcomes.

Clarke and Glendenning (2002) recognize the central role of partnership in support of policy implementation. They argue that it exemplifies the drive to move beyond the old politics of organising and delivering public services towards a market driven approach to health and social care provision:

> "Despite the wide variations in organisational, and social relationships, processes and arrangements, partnerships provide a key overarching and unifying imagery of this third way approach to governing" (Clarke and Glendinning, 2002:33).

Sullivan and Skelcher (2002) maintain that partnerships and collaboration in health and social care are catalysed by changes in state relationships between

government departments, for example health and social care. This, in turn, motivates further change in the prevailing patterns of governance, accountability and the organisation and delivery of health and social care services. This point is important for this research, informing a chosen methodology that emphasises an exploration of the dynamic nature of the public policy environment and highlights the need to explain collaborative activity in terms of relationships and their impact upon these fundamental dynamics.

Sullivan & Skelcher (2002) maintain that the achievement of outcomes in key policy areas, such as health and social care, is predicated upon the operation of local partnerships established to deliver targets, as set out by the Government in national strategies. Although collaborative activity in the United Kingdom has increased substantially, they maintain that the capacity of the different partners to effect joint action remains questionable. Key outstanding issues that need to be addressed are how to secure the good governance of collaborative activity and how to achieve improvement in collaborative practice and outcomes.

2.3   Summary.

This chapter has described the broad public policy context in which collaboration between health and social care services has evolved. The need for public health and social care services to work together, to coordinate the delivery of care, and more latterly to integrate their separate roles and functions, has been an enduring policy aspiration dating back to at least the eighteenth century. More recently, Government changes to their management of policy implementation have raised

further questions in relation to the impact of the New Public Management approach upon collaboration and whether it will have the desired impact of successfully ensuring the implementation of seemingly intractable policy problems such as improved collaboration across health and social care.

A review of the broader public policy context of collaboration is important as it forms the background to the focus of this research project; collaboration between health and social care services for children and young people, and more specifically within child and adolescent mental health services and family support. Therefore, having contextualised the historical development of coordination and collaboration, it is necessary to locate the parallel progress of coordination and collaboration as it has developed within the public policy arena of children's health and social care services, including children's mental health services.

3. Collaboration across health and social care services promoting family support, child and adolescent mental health and emotional well being.

Chapter Two discussed how successive governments have identified the need for health and social care agencies and practitioners to work together to promote the health and social welfare of a wide range of people. Different Government and agency structures and legislative frameworks have been implemented over the decades, but progress has been slow in getting agencies and practitioners to work together and in a way that Governments have intended. This chapter narrows the focus of discussion to collaboration and integration within the policy and service environment of children's health and social care services. It is argued in this chapter that child and adolescent mental health services (CAMHS) and local authority children's social care services have experienced similar difficulties when attempting to collaborate and integrate service provision.

This chapter discusses the case for health and social care services to collaborate when developing services that aim to provide children, young people and their families with support, with a particular focus upon mental health and emotional well being. Definitions of mental health and emotional wellbeing in children and young people are discussed and related to the factors that both promote mental health and emotional well being and also present risks. It is concluded that the need for health and social care to consider how their services both overlap and complement each other is evident.

The more recent policy context of collaboration across children's health and social care services is reviewed alongside the research literature and evidence base for increased levels of integration. This chapter concludes with the need to re-examine the opportunities for, and barriers to, collaboration and the need to build a more theoretically informed debate that will influence future strategies for addressing the reported gap between policy guidance and more successful policy implementation.

3.1 Mental health and emotional well being in children and young people: exploring definitions and prevalence.

The factors that predispose children and young people to experience difficulties with their mental health and emotional well being are discussed. Knowledge of the pre-disposing factors of mental ill-health then guides practitioners to the nature of interventions that are likely to support children, young people and their families achieve positive mental heath and well being. The case for agencies to collaborate and to coordinate their activities when trying to improve the mental health and emotional well being of children, young people and their families is then reviewed.

When discussing the needs of children and young people, it is important to be clear who is being talked about. Children and adolescents are generally defined as young people between 0-18 years of age (Children Act 1989). For the purpose of this thesis, the term 'mental health' refers to not only diagnosed mental illness, but also a range of emotional or behavioural difficulties that can cause concern or

distress and/or interfere with normal childhood development. Therefore, the term 'mental health' and emotional well being is not confined to children and young people with severe and diagnosed mental health difficulties; it is used generically to cover a range of types and severity of psychological and psychiatric difficulties.

In view of the complexity of defining children's mental health, the World Health Organisation's (2004) definition for mental health would seem to offer a positive starting point:

> "A state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." (WHO, 2004: 10)

Such a definition focuses upon the positive aspects of mental health and emotional well being rather than a problem based description. It places an understanding of promoting children and young people's mental health firmly within the scope and abilities of many agencies and practitioners or professional groups. It aims to demystify the term 'mental health' and enable exploration of the physical and mental well being of the 'whole' child or young person within a single paradigm.

When considering the prevalence of mental health and emotional well being difficulties in children and young people, the report *Children and Young People in Mind: The final report of the national CAMHS review* (DCSF, 2008e), concludes:

> "In general, there is a lack of consistent national data on the overall psychological well-being of children and young people in England, and

also on the prevalence of 'lower-level' mental health problems that do not meet the criteria for a clinical diagnosis".(DCSF, 2008e)

However, by contrast, the report (DCSF, 2008e) states that there is data on the prevalence of diagnosable mental health problems. By 2004, up to ten percent of those aged between five and fifteen received a diagnosis of emotional, conduct or hyperkinetic disorder. The report also identifies that some children and young people are significantly more likely to experience mental health difficulties than the general population:

- Children in care (50% with a clinically diagnosable disorder, 70% in the case of those in residential care).
- Children in special schools/Pupil Referral Units for behavioural, emotional and social difficulties (BESD).
- Children with an identified learning disability.
- Those in contact with the youth justice system (40% with a mental health problem, 90% for those in custody).
- Children with physical disabilities or experiencing serious or chronic illness.
- Teenage mothers (three times more likely than older mothers to suffer post-natal depression and mental health problems in the first three years of their baby's life).
- Although evidence in relation to black and minority ethnic groups is "inconsistent and at times contradictory", factors such as discrimination, racism, stress, low self-esteem, socio-economic disadvantage and the experience of seeking refuge or asylum may all exacerbate mental health problems. (DCSF, 2008e:21)

The above list makes it apparent that those children and young people at increased

risk of developing mental health and emotional well being difficulties are those who have complex health and social care needs, experience socio-economic disadvantage and are therefore more vulnerable than those in the general population.

If health and social care services accept a holistic definition of child and adolescent mental health, then it follows that it is possible to explore how the needs of children and young people can be met and by whom. The *Children in Mind* (DCSF, 2008e) report discusses the issue of who is responsible for children and young people's mental health and concludes:

> "Everybody has a responsibility to make sure that children and young people have good mental health and psychological well-being as they grow up." (DCSF, 2008e:27)

The family is of central importance to the mental health of young people. As *The Children's Plan* (DCSF, 2007) noted, parents bring up children, not governments or local services. Parents and carers have significant responsibilities to ensure their children grow up to be healthy. However, family life is constructed around a network of relationships within a larger setting of community, social and legal structures. A wide range of the social, emotional and psychological behaviours of children occur in the contexts in which they live and interact. This results in a broad network of associations, causative factors and consequences.

Any problems or difficulties are therefore systemic and structural as well as personal or individual. This justifies a range of initiatives from focused support delivered to children, young people and their families through to public provisions

for parent support and education and includes national policies on employment, taxation, housing, health and social services, all of which serve to help parents, families and communities to function adequately in their everyday lives.

It is clear that responsibility for ensuring the mental health of young people cannot be confined to one individual person, profession or agency. A holistic approach to children and young people's mental health assumes greater validity when considered against the research into young people's mental health and known risk and resilience factors. This has been reviewed and summarized by the Mental Health Foundation (1999) as follows:

Table 2

Identified risk and resilience factors for children and young people's mental health.

Risk factors in the child	Risk factors in the family	Risk factors in the community
Genetic influences.	Overt parental conflict.	Socio-economic disadvantage.
Low IQ and learning disability.	Family breakdown .	Homelessness.
Specific developmental delay .	Inconsistent or unclear discipline.	Disaster.
Communication difficulty.	Hostile and rejecting relationships.	Discrimination.
Difficult temperament.	Failure to adapt to a child's.	Other significant life events.
Physical illness especially if	changing needs.	
chronic and/or neurological .	Physical, sexual and/or emotional	
Academic failure.	abuse.	
Low self-esteem.	Parental psychiatric illness.	
	Parental criminality, alcoholism	
	or personality disorder.	
	Death and loss – including friendship.	

Resilience factors in the child	Resilience factors in the family	Resilience factors in the community
Being female.	At least one good parent-child	Wider supportive network.
Higher intelligence.	relationship.	Good housing.
Easy temperament as an infant.	Affection.	High standard of living.
Secure attachment.	Supervision, authoritative discipline.	School with positive policies for
Positive attitude.	Support for education.	behaviour and attitudes.
Good communication skills.	Supportive marriage/absence of	Schools with non-academic and
Planner, belief in control .	severe discord.	academic opportunities.
Humour, religious faith.		Range of sport/leisure
opportunities.		
Capacity to reflect.		

(Mental Health Foundation, 1999:7-10).

The presence of any of the risk or resilience factors in the table increases or decreases the risk of mental health problems for a child or young person. There is a complex interplay between the range of risk and resilience factors in a young person's life, their severity, duration, and relationship with each other.

The evidence in relation to risk and protective factors provides a framework for recommending effective interventions at the level of the individual child, the child within the family and in the wider community and social context. The Mental Health Foundation's (1999) report argued that the most effective means of improving the mental health of children and young people was to improve the ability of all the mainstream organisations/public agencies to deliver help and support to children, young people and their families before problems become intractable.

When considering what services are necessary to improve the mental health and

emotional well being of children and young people, it is necessary to review our understanding of child and adolescent mental health. This chapter has considered a holistic definition of child and adolescent mental health. Such a definition can assist in the identification of a range of appropriate interventions and services that are able to make a positive impact upon the mental health and emotional well being of children and young people. It is argued that if health and social care agencies accept the value of such a holistic definition of child and adolescent mental health, they can then consider how they are able to work together in the best interests of children and young people.

It is suggested that the above is not new knowledge and, as indicated in Chapter Two, collaboration across health and social care has been a policy ambition across all groups of the population, including children's services. This Chapter narrows the focus of inquiry to the public policy context of collaboration and service integration within children's health and social care services.

3.2   The public policy context of service integration across children's mental health and social care services.

The history and development of children's mental health services and children and families social work services are closely intertwined. The first mental health social work training course in the United Kingdom was introduced at the London School of Economics in 1929. The training was influenced by psychosocial explanations of mental distress and social workers were subsequently employed in child guidance clinics as well as psychiatric hospitals. At the time, hospital-based

social workers were the only professional group of mental health workers to bridge both the health and social care settings. Much of their work was focused on the assessment of family and social circumstances.

In parallel to the wider public policy context of cooperation and partnerships within health and social care, the emphasis within child and adolescent mental services has also been upon cooperation, collaboration, and more recently service integration, as mechanisms to improve services for children, young people and their families.

In 1995, the Health Advisory Service (HAS) conducted a review of child and adolescent mental health services (CAMHS) and published a report entitled: *'Together We Stand: The commissioning role and management of child and adolescent mental health services.* (HAS, 1995) It was the intention of the review to establish information on the status of CAMHS services, to consider the future challenges and to identify recommendations that would lead to positive changes in the management and delivery of services.

The *Together We Stand* (HAS, 1995) report expressed significant concerns regarding the operation of CAMHS services across England and Wales. It found little cohesion and coordination across agencies and disciplines. The services were characterized by gaps and overlaps in provision and little, or no, evidence to demonstrate effectiveness or efficiency. Concerns were expressed at the poor and underdeveloped relationships between services, both within health and with other agencies (HAS, 1995). The report stated:

"Good collaboration ensures that interacting human factors such as family discord, child abuse, socio-economic disadvantage, racial and sexual discrimination, learning disabilities, developmental delay, mental health disorders and illness and severe and chronic illness are considered as a whole. (HAS, 1995:1)

The report identified a requirement for collaboration at every level of service management and delivery. Closer working relationships between practitioners and a variety of disciplines were considered essential, as was more joint commissioning across agencies. Training emerged from the HAS (1995) review as key to the achievement of these objectives. It was argued that there was a clear need to develop multi-disciplinary, and shared, training alongside uni-disciplinary staff development processes.

The HAS (1995) review highlighted processes and tasks rather than promoting any particular model of service organisation. There was no intention to be dogmatic regarding any one style or approach. The underlying principles were that of family centered and closely integrated services, regardless of the organisational structure.

To address the reported difficulties, the *Together We Stand* (HAS 1995) report supported an interagency framework for integrating the provision of health, education, social care and voluntary sector services, working within a four-tiered model of service delivery. The overall goal was to provide comprehensive child and adolescent mental health services that delivered seamless, multi-sectoral, mental health care for children, young people and their families. The HAS (1995)

report recognised a number of themes that were required to provide a strategic framework that would begin to address the issues for agencies working across traditional service boundaries. The themes included the following:

- Joint commissioning across agencies.
- The ownership and sharing of strategy and agenda for action by the chairs of agencies and their chief executive officers.
- Collaboration at every level of service management and delivery within and across agencies.
- Close working relationships between practitioners of a variety of disciplines.

(HAS, 1995:11)

To assist agencies to conceptualise the issues, a framework was developed by the Health Advisory Service that recognised four tiers of provision for children and young people across all agencies (refer to Table 3). In this model each tier essentially addressed different types of difficulty, with the level of severity increasing from Tier 1 to Tier 4:

The four tiers of the model were not intended to be stages of progression for children and young people to be referred through, but were designed to describe a dynamic configuration of services that, between them, seek to meet the holistic mental health needs of young people in an integrated, flexible and responsive way.

The model was designed to provide a united approach across agencies to ensure easier access to services for children, young people and their carers, to

assessment, diagnostic and therapeutic processes. However, the model is a framework only and does not stipulate how agencies and organisations should structure their services to 'operationalise' the aspiration of delivering coordinated and more integrated services.

Table 3

A strategic framework for commissioning and delivering a comprehensive child and adolescent mental health service.

Tier 1: Services provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers), who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services.
Tier 2: Services provided by specialists working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.
Tier 3: Services usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialised service for those with more severe, complex and persistent disorders.
Tier 4: Services for children and young people with the most serious problems. These include day units, highly specialised outpatient teams and inpatient units, which usually serve more than one area.

(DoH, 2008e:17)

The Health Advisory Service report (HAS, 1995) recognised that a significant complication for CAMHS was that partnership, integration and coordination were required between three powerful public services; health, social care and education. Cooperation and collaboration in this context are tripartite activities and considerable difficulties existed in establishing a joint approach that included such a large number of different priorities and interests. It was acknowledged as the responsibility of the government to create the structures and climate to facilitate this task (HAS, 1995).

In 1999, the Mental Health Foundation conducted an inquiry to review the progress of the attempts by agencies to address the problems identified by the *Together We Stand* (HAS 1995*)* report. The outcomes of the inquiry were compiled and presented in the *Bright Futures* report, *(*Mental Health Foundation, 1999).

The *Bright Futures* Report (MHF, 1999) identified the existence of parallel services, with little or no relationship to each other. Parents reported a seemingly endless round of appointments with different practitioners and agencies. Many parents felt that there was a lack of communication between the different agencies, with different approaches and often different diagnoses recording their children's problems. Young people reported that it was difficult for them to find their way into services and many described professionals being unresponsive to their needs. Parents, carers and young people were recognised, by the report, as partners in multi-agency working, but their experiences were not being listened to or taken seriously.

The Mental Health Foundation's (1999) report identified significant differences in political climate, dynamics and accountability between the services and differences in financial structures that collectively led to a general lack of joint planning and interagency working *(*Mental Health Foundation, 1999:73-75). The evidence pointed to a CAMHS service that was essentially "unplanned and historically determined, fragile and vulnerable to the financial and political tensions that existed between statutory authorities" (Mental Health Foundation, 1999:74).

The findings contained within the *Bright Futures* report (Mental Health Foundation, 1999) were mirrored in a report by the Audit Commission (1999) entitled *Children In Mind*. This followed a national audit, over two years, of specialist CAMHS services and was designed to make recommendations to assist health authorities and health trusts to make improvements in the economy, efficiency and effectiveness of their services. The report considered that if children and young people were to receive the help they needed, health authorities must link their activities with those of other agencies to provide services that were inter-dependent and planned together. (Audit Commission, 1999:78) It was concluded that little progress had been achieved across the country in developing Child and Adolescent Mental Health Services that were inclusive, coordinated and comprehensive with a strategic vision for the future.

Consistent with the wider policy guidance at the time, incentives such as the NHS Modernisation Fund and the CAMHS Mental Health Grant were introduced by Government as funding mechanisms to expand and develop more coordinated

child and adolescent mental health services. In 2002, the Local Government

Association of Directors of Social Services and the NHS confederation published

Serving Children Well (LGA, 2002). It was conceived to promote the co-

ordination of services whilst avoiding the dangers inherent in structural change:

> "Its aim was to facilitate measures for improving services by locating them
> at a local level in the framework of a national performance management
> system which pulls together agencies in a model of cooperation and
> partnership." (LGA, 2002:9).

Children and Young People's Strategic Partnerships were promoted in the report

with the objective of reconfiguring existing partnerships so that they contained the

full breadth of partners and services across the voluntary, community, statutory

and business sectors (LGA, 2002:15). Ensuring policy in the children's sector was

complimentary to the wider policy environment for coordination and integration,

the report promoted an outcomes framework for the delivery of services. The

report argued that the more outcomes were detached from individual agencies, the

greater flexibility there would be to integrate a mixture of services to achieve

outcomes in accordance with local conditions and the needs of children and young

people. This approach was clearly driven by the New Public Management

framework for the delivery of public services, as discussed in Chapter Two.

Lord Laming's inquiry into the death of Victoria Climbié (Laming, 2003) proved

to be the catalyst behind the current drive in children's services to achieve more

integrated working practices across agencies. The reported comprehensive failure

of so many services to protect Victoria Climbié led to strengthened demands that

services for all children be better integrated, culminating in the report, *Every*

Child Matters (DoH, 2003)

The *Every Child Matters: Change for Children* (DfES, 2004) guidance set out the

Government's agenda for the reform of children's services, including a

requirement for agencies to work together through Children's Trust arrangements,

to achieve improved outcomes in five key areas (being healthy, staying safe,

enjoying and achieving, making a positive contribution and achieving economic

wellbeing). It was supported in legislation by the Children Act 2004. This extract

from *Every Child Matters: Change for Children* (DfES, 2004) highlights some of

the workforce challenges of service coordination and more integrated working

practices:

> "To work effectively on an inter-agency basis professional and support
> staff need both a strong commitment to flexible working and appropriate
> clinical or professional supervision to support continuous improvement in
> the delivery of specialist interventions. Lines of accountability need to be
> clear, and to support staff development as well as integrated working.
> Multi-disciplinary teams will need to ensure effective day-to-day
> leadership as well as professional supervision and guidance". (DfES,
> 2004: 17)

The report also recommended that local authorities create the new statutory post

of Director of Children's Services. The key coordinating role for achieving

outcomes across local agencies was assigned to the new Director. However, the

role did not have any management remit over a wide range of children's services

such as acute mental health, community health services, schools, youth justice and

Connexions. In these circumstances the capacity of the Director of Children's Services to achieve coordination would depend very much on the extent to which other agencies would act on their duty of partnership under section ten of the Children Act (2004).

In 2004, *The Children's National Service Framework* (DoH, 2004) set out a ten year programme to raise standards, including a specific focus on the mental health and psychological well-being of children and young people, which included a number of 'markers of good practice'. *The Children's National Service Framework* (NSF) was based on key *NHS Plan* (DoH 2000) values that included modernisation through breaking down professional boundaries. It also promised that the NHS and social care would work together to deliver a comprehensive CAMHS by 2006. A comprehensive CAMHS is described by Salmon (2004:160) as delivering a diverse range of services appropriate to the age and circumstances of children and young people and to their different levels of need.

The language in *Every Child Matters* (DoH, 2003) and *The Children's NSF* (DoH, 2004) consistently refers to integration rather than cooperation, reflecting a shift in emphasis for agencies working 'in partnership'. In many ways, the aspirations of *Every Child Matters* (DoH, 2003) and *The Children's NSF* (DoH, 2004) could have come from any or all of the previous policies going back to the Seebohm Report of 1968, with considerable emphasis upon community development, prevention, the role of the voluntary sector and the importance of partnership, collaboration and specifically service integration to achieve the desired outcomes.

The following diagram, extracted from Every *Child Matters: Change for Children* (DfES, 2004) and known as 'the onion model', illustrates Government's vision for more integrated children's health and social care services:

Figure 1

The Government's vision for integrated children's services.

(DfES, 2004:6).

The *Every Child Matters: Change for Children* (DfES, 2004) guidance identifies the following key components of integrated services:

- A child centered, outcome-led vision, clearly informed by the views of children young people and their families.
- Integrated front line delivery organised around the child and family rather than organisational or professional boundaries

- Integrated processes – where effective joint working is sustained by a shared language and shared processes.

- Integrated strategy (joint planning and commissioning) – the joint assessment of local needs, identification of available resources and integrated planning to prioritise expenditure and action.

- Interagency governance: Robust arrangements for interagency co-operation to set the framework of accountability for improving and delivering services. (DfES 2004:7/8)

The centrality of outcomes within the diagram reflects Government's attempts to ensure health and social care agencies move away from the more traditional methods of service delivery to more integrated approaches that make certain there is a shared accountability for achieving the identified outcomes.

The *Every Child Matters: Change for Children* guidance (DfES, 2004) articulated Government's belief that there was a case for structural change to effect better coordination of children's services. In particular, the creation of Children's Trusts emerged as an important part of Government's strategy for improving collaboration across children's health and social care services. In 2005 the Government issued a suite of five documents all offering guidance on Children's Trust governance and strategic planning. One of the documents entitled *Children's Trusts: Leadership, co-operation, planning and safeguarding* (DoH 2005) was issued as statutory guidance on interagency cooperation to improve the wellbeing of children through the creation of Children's Trusts.

The main agencies collaborating to form Children's Trusts are Local Education Authorities, Children's Social Services and Children's Community and acute

Health Services. The proposals allow Primary Care Trusts (PCT's) to delegate services to the Children's Trust and to pool funds with the local authority. Children's Trusts could then commission and deliver services, second staff or directly employ them. The guidance encouraged considerable local flexibility to respond to local needs and opportunities. The key characteristics of a Children's Trust include co-location of services; inter-professional teams; common assessments; information sharing and the joint training of practitioners.

Robinson et al (2008) state that the *Every Child Matters: Change for Children* (DfES, 2004) 'onion' model for integrated services, shown above, displays a clear separation of different levels of integration, and a focus on both structure and process. At the level of integrated governance, Atkinson et al (2008) identify a choice between *legal agreement,* where a Children's Trust Board is established, and *collaboration between partners*, where the local authority and health trusts remain separate but accountable bodies.

At the level of integrated strategy, joint planning and funding models involving either aligned or pooled budgets are discussed as potential options. At the level of integrated process, *Every Child Matters; Change for Children* (DfES, 2004) highlights, for example, information sharing and the Common Assessment Framework (CAF) as supporting more integrated working practice. Finally, at the level of front line delivery, this involves new ways of working for practitioners and managers, such as interagency and integrated teams.

In 2007, Government published *The Children's Plan: Building brighter futures (DCSF, 2007),* setting out new aims and objectives for achieving the *Every Child*

Matters (DoH, 2003) outcomes and focusing on the faster integration of services for the most vulnerable. *The Children's Plan* (DCSF, 2007) makes it explicit that services are required to work together, to intervene early and to prevent problems turning into crises. The expectation is that services are joined up and shaped around the needs of children and their families, reflecting the lives they lead rather than professional boundaries. The Children's Plan (DCSF, 2007) states:

> "Managers at all levels must support and promote integrated working, for example by leading the development and implementation of integrated services and common processes, and seeking opportunities for networking between colleagues from different backgrounds to develop and promote integrated working practices. They must also ensure that their staff are clear about their responsibilities and reporting lines, and that they get the continuing professional development they need to carry out their role" (DCSF, 2007:153)

In 2008, Government also published *Children's Trusts: Statutory guidance on interagency cooperation to improve well-being of children, young people and their families* (DCSF, 2008a) The guidance was intended to build upon the lessons learnt since the publication of *Every Child Matters: Change for Children* (DfES, 2004) and *The Children's Plan* (DCSF, 2008).

Key issues raised in the document included a view that the 'Duty to Co-operate' as contained within section 10 of the Children Act (2004) was not sufficient to secure the improvements that partners wanted Children's Trusts to make. The document proposed to legislate to strengthen and clarify the governance arrangements for Children's Trusts by requiring each local area to have a statutory Children's Trust Board, and making the Board responsible for developing and

monitoring an overarching Children and Young People's Strategic Plan for the local area. The legislation would extend the duty to cooperate to all schools and colleges and also to Jobcentre Plus.

During 2008, Government was also consulting on proposals to give Sure Start Children's Centres a specific statutory basis, and attempting to legislate for interagency and integrated Early Years Services for children and families. The presented legislative options suggest that central Government continued to find it necessary to be more prescriptive around the shape and content of the governance arrangements for integrating children's services.

In parallel to Government's focus upon outcomes and mandating for collaboration and integration through legislation and policy guidance, a further approach to steering agencies to deliver more integrated services is reflected in Government's concerted efforts to provide direct guidance to 'modernise' the health and social care workforce. It is anticipated that such an approach will enable staff to work within more integrated organisational and service structures.

Recent children's workforce guidance: *Building brighter futures: Next steps for the children's workforce* (DCSF, 2008c) states that local areas were putting in place different structural models to integrate universal and specialist services for children and families and many were using a combination of approaches. For example, some Children's Trusts had developed permanently co-located multi-agency teams, placed in and around schools, children's centres and other community settings. In addition to permanent team members (or the "core" team),

there were usually a number of "virtual" team members who contributed on a part-time or "as required" basis.

In other examples, the report identified more use of "virtual" multi-agency teams. These were teams of named practitioners with different professional backgrounds who regularly worked together in a multi-agency team while remaining employed by their "home" service. Sometimes they participated in a multi-agency locality team on a part time basis and worked within their own service for the rest of the time. (DCSF 2008c:47-48)

In some areas, the report stated that multi-agency working was achieved through the embedded use of common processes across all partners, rather than relying on fixed multi-agency arrangements. In these examples, practitioners from different professional services would come together to deliver integrated services around the needs of an individual child or young person, rather than being part of permanent team structure.

The workforce policy guidance *(DCSF, 2008c)* found that some areas reported difficulties reconfiguring services and establishing interagency teams. Schools had identified that there were insufficient targeted resources to meet identified needs of children and young people experiencing difficulties with their mental health. The report concluded with the following:

> **"**Despite good progress, there is consensus that there is still a long way to embed the sort of culture required for mature, sustainable integrated working across services, even in those areas that are furthest ahead. For

this to happen, the principles of integrated working must be seen throughout leadership, management and the workforce." (DCSF, 2008c: 51)

The difficulties in relation to achieving significant progress with service integration extended into services for children and young people experiencing difficulties with their mental health and emotional well being. The *Children and young people in mind* (DCSF 2008e) report documented the following:

"During the Review, we found that people are very focused on wanting to improve services and outcomes for children. Nonetheless, very real barriers remain to prevent people from working together in a child and family-centred way" (DCSF 2008e:60).

The *Children and Young People in Mind* (DCSF, 2008e) report concluded that it is notable that Government policies across health and social care have not always been developed on a joint basis nationally, or implemented on a joint basis locally. The implication of this is unhelpful tension between services, disjointed support for children, young people and families and missed opportunities to effectively collaborate and integrate services.

Historically, responsibility for children and young people's mental health and emotional well being has rested within the Health sector and outside of the direct responsibility of local authorities and, more recently, Directors of Children's Services. The primary guidance for the NHS in relation to children's mental health and emotional well being has been contained within the NHS Children's National Service Framework (DoH, 2004), thus, it could be concluded that

children and young people's mental health has been placed on the margins of the *Every Child Matters* (DoH, 2003) integration agenda, leading to patchy and variable progress across the UK.

The volume of recent Government policy guidance in relation to integrated working across health and social care is substantial, perhaps reflecting a level of frustration with seemingly slow progress. Chapter Two discussed the trend by Government to increasingly mandate and legislate for collaboration and integration and this is reflected within the children's policy arena. In the face of such a deluge of policy guidance, it is useful to review the evidence base for Government's relentless pursuit of this policy ambition.

3.3   Reviewing the evidence in support of collaborative and more integrated working practices in children's health and social care.

Although Governments have not been prescriptive in relation to models of integrated working, attempts to develop organisational structures have been explored in recent years and a number of integrated models have arisen in children's services. For example, Sure Start Children's Centres are working examples where health and social care agencies and practitioners have come together, within a single building, to deliver integrated early years' services to children and families.

The national initial evaluation of the Sure Start programme (DfES, 2005b)

produced controversial findings. The report concluded that they found little

evidence of the impact of the Sure Start programme in those areas targeted by the

initiative. However, for practitioners who were co-located within the same

buildings, it was stated that the Sure Start 'badge' helped them to lose attachment

to specific organisations or agencies. It remained uncertain if this positive

'badging' would transfer readily to the larger context of emerging Children's

Trusts. The Sure Start evaluation found that some workers identified with Sure

Start precisely to avoid identification with mainstream services**. (DfES, 2005b:56)**

Morrow et al (2005) looked critically at the performance of a Sure Start

Children's Centre, receiving referrals for multiple issues. They observed no single

point of receipt, no clear process to follow, no agreed format for multidisciplinary

meetings, and overt and covert resistance amongst its members for breaking down

professional barriers. However, the final report evaluating the Sure Start

programme (DCSF, 2008d) concluded that integrated working by local

authorities, health services, schools, the voluntary and community sectors and

parents had provided some success stories when linked to the achievement of

improved outcomes for children, young people and families.

The successes were not universal and the report noted difficulties associated with

the move to more integrated models of delivering services. These included

domination of partnerships by a single agency, threats to professional identities

and conflicts of interests between partner agencies. Successful management

arrangements were characterised as being unified and coordinated across

agencies. Despite challenges, front line staff and managers widely reported enthusiasm for working in interagency and inter-professional teams.

The National Evaluation of Children's Trust Pathfinders Final Report (UEA, 2007) found concerns with the early experiences of working in new ways, in new structures and in developing new organisational forms. A key finding of the evaluation related to the sheer scale and complexity of the task facing the managers of Children's Trust's. The report stated:

> "By scale we mean both the challenges of organisational scale working across health, education, social care and youth justice and other agencies, and the size of the pathfinder population. By complexity we mean the conceptual and managerial difficulties of the task facing children's trusts as they seek to secure interagency governance and strategic and operational relationships which will produce improved outcomes for children. This task necessarily involves the co-ordination of different professional groups and different organisations working with children with multiple needs." (UEA, 2007:1)

The complexity of Children's Trust arrangements led the evaluation report to conclude that interagency governance is effective if the Children's Trust is part of a Children and Young People's Strategic Partnership. This ensures that Chief Executives of partnership agencies are involved in developing strategy, plans and formal agreements. Interagency governance arrangements were considered to be less secure when Children's Trust arrangements were facilitated by a group that is separate from the partnership without the involvement of Chief Executives and Directors as senior leaders of the agencies.

Further research into the difficulties experienced by Children's Trusts was highlighted in the Audit Commission report: *Are we there yet? Improving governance and resource management in children's trusts.* (Audit Commission 2008). The report found that nearly a third of Directors of Children's Services said there was confusion about the purpose of Children's Trusts.

Kinder et al (2008) conducted a study evaluating the impact of integrated children's services. A key finding was that local authorities and their partners had no common definition of integrated working and the report recommended a need to be clear about a definition of integration. The use of the language of collaboration is a theme that will be explored in the following chapter.

Kinder et al (2008) found that many local authority participants reported an increased workload when the expectation was reduced workloads through reduced duplication of effort across agencies and the more efficient utilisation of resources. However, what the report identified as reassuring was that children, young people and parents reported a range of improvements in the services they received. Given the small sample size and self selecting agencies participating in the study, Kinder et al (2008) concluded that it was difficult to establish a causal link between integration of children's services and impacts or outcomes.

The Children's Workforce Development Council's report *Progress towards integrated working 2007/08 evaluation* (CWDC, 2009) presented a positive picture in relation to the implementation of integrated working practices in children's services. On the basis of the responses received from the participants in

the study, the majority (eighty nine percent) thought that substantial or tremendous progress in integrated working had been made in the twelve months leading up to June 2008, with more systematic implementation across local areas. In relation to the evidence of improved outcomes for children and families, the report stated that most respondents said that they had some evidence of improvement in outcomes for children as a result of integrated working.

Robinson et al (2008) conducted a review of the literature in relation to integrated services research. It was concluded that there was a lack of consistent evidence for improved outcomes for children and families and for practitioners. The following was reported:

> "There is some indication within the literature that more advanced integration places greater burdens on those involved in terms of partnership development and the time and resources required." (Robinson et al, 2008: viii)

However, on a more positive note, Robinson et al (2008) also reported that practitioners involved in collaboration and service integration express feelings of 'unification and equality' and recognize the potential of their partnership for children and families.

The number of government policy directives and guidance in support of the recommendations of *Every Child matters: change for children* (DfES, 2004) identifies the development of integrated children's services working across health and social care as a fundamental part of their message. The emerging evidence

would suggest the implementation of more integrated children's services is producing mixed results, with new interfaces and fresh challenges for the governance and strategic planning of health and social care services, which will need to be reconciled with evidence of improved outcomes for children and young people and their families.

Within the field of child and adolescent mental health services, research conducted by Petit (2003) reported that school staff working with CAMHS identified that joint work with practitioners from other agencies had lead to an increase in children's happiness and well being. Joint working was also associated with better outcomes for children and young people and lower levels of stress for staff. However, when considering models of collaboration, it is important to note that this research focused upon joint working through improved coordination and not integrated teams.

3.4   Summary.

This chapter has highlighted the case for children's mental health and social care services to work closely together. The complex interplay between factors that both promote resilience and pose risks to a child or young person's emotional well being and mental health has been discussed. The argument in favour of health and social care agencies to work together in support of children and families is unequivocal. It is on this basis that recent Government has been introducing a raft of policy guidance and legislation in support of interagency and integrated working practices.

Collaboration and, more recently, the service integration agenda in children's services has a powerful momentum. This momentum is enhanced by the political significance of cross-cutting health and social care issues with less attention to the precise organisational structures and processes required to deliver the necessary outcomes. It is reasonable to conclude that partnerships have emerged as the core of public sector activity, and the integration of Local Authorities and Primary Health Care Trusts are the main vehicles through which this Government agenda is to be delivered.

Underpinning this policy ambition the principles and rationale for coordination and service integration remain intact, that is, to utilise public resources more efficiently and to improve the experience of people in receipt of services by meeting their needs more comprehensively. However, this chapter's review of the evidence base for more integrated children's services remains inconsistent with considerable variation across the country with local interpretation of models of integration and their achievements.

Reviewing progress from the establishment of the Seebohm Committee in 1965 through to the CAMHS review (DCSF, 2008e), what emerges is a strong sense that many of the aspirations for more joined up working across health and social care, and specifically children's mental health and social care services, have not been successfully implemented. However, as this chapter has illustrated, the current Government remains resolute in tackling the difficulties of collaboration and integration by introducing a range of policy guidance across areas such as

workforce, legislation, and organisational structures (such as Children's Trusts) to deliver more integrated children's services.

It would seem that, in the face of only limited success, changes in Governments and in the way in which health and social care public policy problems have been defined, concepts such as cooperation, partnership, collaboration and service integration have remained a remarkably resilient public policy ambition. What remains unclear is why the evidence base for more integrated services to deliver improved outcomes for people in receipt of services remains relatively weak and why agencies agree with the principle, but find the practice of collaboration and service integration so difficult to implement.

Glasby (2005) suggests the challenge for policy makers is not only to produce the vision in the first place, but also to be clear about the implementation mechanisms that they will use to make sure that proposals for collaboration and integration deliver the desired outcomes, and in particular why this will work when previous changes have not. It is the aim of this research to further examine concepts such as collaboration and integration and to consider how this agenda can be further understood through exploration of theories of cooperation and integration.

4. Building a theoretical framework for collaboration and service integration.

The previous two chapters highlighted a longstanding and significant amount of official promotion and guidance in relation to the need for health and social care agencies to work more closely together, strategically and operationally. The journey would seem to be an international concern:

> "Collaboration is now central to the way in which public policy is made, managed and delivered throughout the world. Globally partnership is the new language of public governance." (Sullivan & Skelcher, 2002:1)

As Peters (1998) puts it: 'The administrative holy grail of coordination and horizontality is a perennial quest for government and policy makers' (Peters, 1998:295). With collaborative activity so widely promoted, and government policy increasingly reliant upon the operation of partnerships to deliver policies and programmes, some further investigation of the concepts is essential. There is an absence of universally accepted and understood definitions of, for example, partnership and collaboration, making it difficult to begin to understand the complex dynamics that impact upon their activities.

This chapter starts the investigation by exploring definitions and the use of language. Hallet and Birchall (1992), Miller and Ahmad (2000) more recently the CAMHS Review (DCSF, 2008e) have stated that the lack of shared understandings and shared definitions has contributed to a confused picture when attempting to comprehend the implementation of more coordinated and joined up

working practices between agencies that might be termed partnership working or collaboration. Despite increasing pressure for agencies to work in a collaborative way, particularly with respect to specific groups of vulnerable children, there is still no definitive concept of what such collaborations should look like in practice.

Kutash & Duchnowski, (1997) consider that differing definitions produced disparate identification criteria and processes across agencies. Moreover, when agencies use different definitions, there is an assumption that the children who receive services are also different:

> "The absence of agreed upon definitions impedes the ability of agencies to integrate services for the children in need and their families." (Kutash and Duchnowski, 1997:66)

Therefore, before it is possible to set out a framework for partnerships and collaboration which describes the skills and conditions required to organise it successfully, this chapter reviews the language and definitions in more detail. It is argued that common definitions provide the basic building blocks in support of theory building when researching collaboration and integrated services.

Having explored a common understanding for collaborative activity, this chapter goes on to review the contributions of theory to collaboration. As discussed in the previous chapters, implicit in the concept of collaboration is recognition of interdependence requiring individuals to interact. Therefore, social theories are explored alongside organisation theories in an attempt to illuminate a theoretical understanding of agencies interacting when going about their daily business.

It is suggested that the relative inattention to theory and the absence of clearly defined theoretical frameworks has undermined this approach to public policy and contributed towards the continued slow progress with implementation. To develop a more informed debate surrounding the practice of collaboration, it is necessary to consider the contributions of research and how this can assist in developing a theoretical framework for collaboration. Frost and Robinson (2004) argue that the literature on collaboration and service integration remains stronger on rhetorical calls for increased joined up thinking than on providing clear ideas for improving process and outcomes.

This chapter aims to develop a greater and shared understanding of the rhetoric, and actual practice, of cooperation, integration, collaboration and partnership. The chapter therefore sets out to map the nature of collaborative activity and to provide a theoretically informed analysis of its emergence, operation and impact. It will be argued that it is necessary to acquire this knowledge to assist agencies to move beyond the rhetoric and to develop policies, frameworks, and operational models based on a shared understanding of meaning and on a more informed and theoretical basis.

4.1   Defining coordination, collaboration and service integration.

Collaborative practice cannot be left to make sense of itself. There needs to be a dialogue with theory to create models and frameworks that are coherent and consistent, challengeable and testable. The words cooperation, collaboration, partnership and integration are often used inter-changeably and have been

repeatedly spoken about as a 'good thing' by policy makers. The confusion in definitions reinforces the need to examine, in more detail, the possible differences of definition and interpretation.

Leathard (2003) identifies fifty two separate terms which have been used to refer to partnership, a number of which are often used interchangeably. McLaughlin (2004) suggests that it is the very lack of definitional clarity over the term "partnership" that has helped it to become so popular. By being relatively broad and encompassing, partnership has been seen as the answer to any number of difficulties in much health and social care policy over several decades.

Multi-disciplinary and inter-professional training courses for health and social care practitioners are used interchangeably to indicate shared learning. As Barr (1994) points out, the crucial distinction is that inter-professional work moves beyond sharing, or simply learning together and relies much more on interactive learning, on developing new ways of thinking and jointly applying this to new ways of working.

To progress the debate further, it would be helpful to disentangle the language and identify shared definitions. The situation is complicated by different agencies' and professions' use of different terminology. For example, the terms collaboration, integration, partnership, inter-professional and inter-disciplinary are all used interchangeably and preferred by people in different agencies at different times. This can result in a confused understanding of their meanings and may result in very different ideas about structures and processes to achieve shared outcomes or

goals. Weiss (1981) notes:

> "Co-ordination is discussed in the political arena as though everyone knows precisely what it means, when in fact it means many inconsistent things and occasionally means nothing at all." (Weiss, 1981:21)

In 2008, the CAMHS review report (DCSF, 2008e) looked more broadly at the professions' use of language and considered the barriers to cooperation and coordination created by their different use of language when going about their daily business:

> **"To improve consistency and promote greater cooperation and coordination, there should be a shared development of the language used to describe services, so that all services can understand that they are part of the comprehensive range of provision to address mental health and psychological well-being." (DCSF, 2008e:67)

Hallett and Birchall, (1992) in their review of the literature, noted that the different words have commonsense meanings that are closely related. They identify collaboration, coordination and cooperation as forms of combination that are often confused. In an attempt to illuminate the confusion that surrounds the concepts and their meanings, the following is a list of commonly reported definitions:

Coordinate:
> Separate groups working alongside each other in pursuit of individual/ organisational goals. Actions and decision making are coordinated.

Cooperate:

To work jointly with each other to achieve a shared goal.

Collaborate:

To work together to achieve something that neither individual/agency could achieve on their own.

Integration:

"A single system of service planning and/or provision put in place and managed together by partners. A single system for a particular service would, for example, unite mission, culture, management, budget, accommodation, administration and records. This is absolutely differentiated from an approach which aims to coordinate separate systems." (ICN, 2004:12)

Partnership:

The Audit Commission (1998) discusses partnership as:

" a joint working arrangement where partners are otherwise interdependent bodies cooperating to achieve a common goal; this may or may not involve the creation of new organisational structures or processes to plan and implement a joint programme of work, and share the relevant information, risks and rewards." (Audit Commission, 1998:8)

The Audit Commission emphasise that Partnership is not necessarily a single system and partners are not tied into a partnership forever. If we attempt to connect the above definitions with the commonly used language of collaboration, then the picture becomes further complicated:

Inter-professional and Multi-professional:

Inter implies interaction and describes relationships between different

professional groups. The term inter-professional is preferred in this

research as the teams participating in the study consisted of professionals

working within integrated teams.

Inter-disciplinary and Multi-disciplinary:

How two or more different branches of knowledge, usually within the

same profession, work together to achieve a common goal. Again, the

application of the prefix 'inter' of 'multi' depends upon the extent or

degree of interaction, interdependence and integration.

Interagency Collaboration:

Describes how agencies or organisations interact to achieve an outcome

that neither agency could achieve on their own.

Each of the definitions identified implies different levels of relationships and

interaction between professionals or agencies. For example, the effects of

introducing a single, integrated service structure, including management

arrangements and comprising practitioners from different professional/

practitioner backgrounds, is likely to have a greater impact upon agency and

professional identity than two agencies maintaining separate identities but

forming a partnership to coordinate the arrangements for service delivery.

Biggs (1997) maintains that, while the various definitions of collaboration give a

different slant or emphasis, it is possible to identify similar concerns and tensions

across them. The similarities centre on the question of agency and professional

identity and, most importantly, the fear of loss of identity. Biggs (1997) considers that the success of collaborative ventures will depend upon the balance being achieved between the maintenance of separate identities, merging to fulfill a shared objective and the resolution of conflicting loyalties.

If collaboration and integration, as major Government policy goals, are to be successfully implemented, then it is necessary to understand the meanings that underpin the words contained within the debate. If it is possible to implement a common and shared understanding of collaboration, then agencies will be in a better position to progress the concept as a phenomenon that can be studied and evaluated.

Having outlined the language used in the debate, and having identified that the language is used interchangeably, it is concluded that those using the terminology might not always be familiar with their definitions. Service planners and policy makers might not have been clear about the definitions and precisely what kind of relationships or structures they were describing. If they were, then it is clear from the literature that definitions and understandings vary considerably and there is scope for misinterpretation and misunderstanding. The idiosyncratic use of the terminology is a feature of the debate. It would therefore be of value to create a common and shared understanding of the language in an attempt to provide clarity to what is being discussed and agreed when entering the debate.

For the purposes of this thesis, the term 'collaboration' has been adopted as an all encompassing concept to capture the full range of activities involved when

agencies work together in an attempt to achieve a goal that could not be achieved individually. The term therefore describes activities involved in forming partnerships, coordinating and integrating services.

4.2   Choosing integration or better coordination.

Hallett and Birchall (1992) summarise policy goals associated with greater collaboration which they refer to as the 'optimistic tradition' in this field. They are said to include:

- The achievement of greater efficiency in the use of resources and improved standards of service delivery through the avoidance of duplication and overlap in service provision.
- Reduction in gaps and discontinuities in services.
- The clarification of roles and responsibilities arising in frontier problems and demarcation disputes between professions and services
- The delivery of comprehensive, holistic services.
- Services driven by objectives and outcomes rather than by professional interests. (Hallett and Birchall, 1992:17)

Chapter Three discussed how Government policy guidance has more recently emphasised service integration as the ultimate realization of the benefit of collaboration. However, the evidence base for the outcomes of collaboration presents a mixed and uncertain picture. Therefore it remains unclear why, when and how service integration should proceed as the preferred option to, for example, a service model that effectively coordinates activities to achieve the benefits of collaboration.

Sullivan and Skelcher (2002) maintain that there are a series of individual and organisational factors that are important in explaining the propensity of collaborations to emerge beyond a vague notion of coordination and 'working in partnership' as a good idea and to function effectively to achieve such goals. These include leadership, risk and trust. Beyond these, Sullivan and Skelcher (2002) suggest there are questions of balance between the demands of the collaboration and those of the partner agencies and these include, for example, professional and organisational or agency allegiances.

If improved coordination between agencies and practitioners is likely to be as effective in achieving the stated policy goals as service integration, or vice versa, then questions remain regarding what particular model or framework for collaboration is likely to deliver the required outcomes, in what circumstances and for whom. Promoting resilience and reducing risks in children, young people and families requires services to meet their full range of diverse needs. Collaboration is therefore complex when considering when to integrate services and/or when to coordinate services more effectively.

Boundaries between health and social care are organisational and to a large extent functional, although there are areas of overlap. In theory, health and social care fit well into Levine and White's (1962) Model for Exchange: shared goals require agencies to recognise that they need to exchange resources to effectively achieve such goals. However, the success or otherwise of collaborative activity must also take into account contextual factors including political, organisational and professional roles and relationships.

Morrison (1996) observes that integration often proceeds without an appreciation of contextual factors and their true complexities. Morrison (1996) argues that if integration is to become a reality, then it must be ingrained and modelled within agencies'structures, cultures and working relationships which seek to reward collaboration rather than competition (Morrison 1996:155). Morrison (1996) goes on to state that the extent of interagency collaboration will depend upon how far a coherent service can be provided to a shared group of people in receipt of services and in a shared location, which does not eclipse the guiding principles and strategic objectives of each participating agency.

Collaboration then requires decisions to be made that result in, for example, the coordination of activities or the integration of people within single agencies and services. Loxley (1997) stated that agencies large enough to meet all the requirements of people in need of services may fall apart under the strains of internal coordination. Agencies small enough to be comprehensible to individuals and local communities are unlikely to contain, on their own, a sufficient range of expertise and resources to meet the full range and complexity of need.

In the previous chapter, Children's Trusts were identified as an example of a model for service delivery, where the creation of a single agency or service entity aims to overcome fragmentation by bringing together health and social care practitioners and services. The Integrated Care Network (ICN, 2004a) suggests that the necessary transition might be described as a journey from fragmentation to coordination to integration:

"To drive the necessary change, Government is depending on the combined energy of partnerships between what are fundamentally independent bodies. Establishing partnerships will naturally have the side effect of curtailing to varying extents the freedom of action of the individual partners. Another necessary shift therefore can be represented in a transition from autonomy towards integration." (ICN, 2004a:13)

However, as discussed in previous chapters, there is as yet no clear cut or uncontested evidence that the integration of services brings people in receipt of services greater benefits than other methods of collaboration, for example improved coordination. The Integrated Care Network Report (ICN, 2004a) states that better coordination, while not the same as integration, can also result in gains for people in need of services. It can deliver many, if not all, of the benefits to service users of an integrated system and it can be a positive, facilitating step towards an integrated system.

The Integrated Care Network report (ICN, 2004a) states that a coordinated approach, in which practitioners from different agencies form an informal cooperative network to meet people's needs, does have advantages as a means of overcoming fragmentation of service delivery. Agencies agree roles and responsibilities for delivery of services and a single practitioner would then be tasked with responsibilities that include communicating plans to different agencies and coordinating the input of others to avoid duplication of activity and confusion over input. The task of coordination is intended to be greatly improved through the introduction of shared processes, for example, the common assessment process and lead professional role in children's services.

Biggs (1997) considers that a focus on agencies coordinating services more effectively can be inward looking, in so far as little attention is paid to the different parts of a service system and its operation as a whole system. Coordination tends to be narrowly focused upon service delivery to people in receipt of individual services, case management and performance management – often obscuring a more holistic view of services which are located within a wider social and economic system, thus obscuring social deprivation and need. Such an observation would lend support to a more integrated approach to delivery which, in theory, should result in less attention being paid to structures for communication and coordination with more attention to meeting the full range or 'holistic' needs of the child or young person.

The experience of coordination to date raises two fundamental questions. Firstly, whether coordination is possible to sustain over-time and, secondly, a need to consider if a single integrated system is likely to be more suitable than coordination of existing separate activities. The ICN report (2004a) suggests that integration is more likely to result in more of the separate activities being combined and undertaken by a reduced number of people. However, no single service can meet the entire complex and 'holistic' needs of all children and families all of the time. Therefore, the challenge remains to explore and understand the factors that lead agencies to adopt frameworks or models of collaboration that are primarily based upon coordinated or integrated services.

The benefits of interagency coordination should not be dismissed, as much may depend upon the nature of tasks required to meet client need and the value of

practitioners being in possession of advanced or specialised skills in a particular field, with access to an agency infrastructure that supports the development of such skills. Single agencies with integrated services may find it difficult to develop such an infrastructure across such a broad range of skills and activities.

Any plans to deliver services in a coordinated or integrated way must therefore carefully consider the client group and their needs, the abilities of practitioners to meet a range of client needs, the degrees of inter-dependence between practitioners to achieve the necessary tasks and, where necessary, the appropriate and timely input of more specialist skills and resources.

Leutz (1999) argues that messages from international research suggest that integration is most needed and works best when it focuses on a specifiable group of people with complex needs. Leutz (1999) also points out the converse of this is also important: the vast majority of people with non-complex needs will continue to be served well by organisations and practitioners acting more or less independently of other services and meeting the full range of client needs.

The World Health Organisation (WHO) developed a framework for integration. The authors, Grone and Barbero (2002), recommend integration as a means to improve services in relation to access, quality, service user satisfaction and efficiency. They distinguished coordination (the relation of parts) from integration (the combination of parts into a working whole), as illustrated in Table 4.

Table 4

Comparing concepts of autonomy, coordination and integration. (Adapted

from Grone and Barbero, 2002:2).

	Autonomy	Coordination	Integration
Information	Circulates mainly within a group of the same partners	Circulates actively among groups of different partners	Orients different partners work to meet agreed-upon needs.
Vision of the system	Influenced by each partners perception and possibly self – interest	Based on a shared commitment to improve the overall performance of the system	A common reference value, making every partner feel more socially accountable
Use of resources	Essentially to meet self-determined objectives	Often to ensure complimentary and mutual reinforcement	Used according to a framework for planning organisation and assessment activities.
Decision making	Independent coexistence of decision making modes	Consultative process in decision making	Partners delegate some authority to a unique decision mode
Nature of partnership	Each group has its rules and may occasionally seek partnership	Cooperative ventures exist for time-limited projects	Institutionalized partnership is supported by mission statements and/or legislation

Grone and Barbero (2002) suggest the table supports an understanding of the

strategies required to progress implementation of the different levels of

integration. They report that neither integration nor coordination were

automatically assumed to be preferred models and therefore it would seem

pragmatic to adopt an approach that is based on a thorough understanding of

people's needs and the competencies of practitioners to meet different needs and

different levels of need. Service integration or coordination should therefore be

considered in relation to the needs of people rather than dogma located within

professions, agencies or government policy.

Grone and Barbero (2002) caution that integrated care refers to concepts aiming to

improve the performance of systems. It is not an outcome, but a means to achieve

outcomes such as improved quality, client satisfaction, access and efficiency,

which are means to achieve an improvement in population health. It is suggested

in this thesis that the Government's approach to coordination and integration has

been based upon little research evidence and a weak theoretical base. This has

resulted in the policy ambition becoming an outcome in itself, with little attention

paid to performance, actual outcomes achieved or improvements in health and

well-being.

The value of collaboration as a public policy goal would seem to reside primarily

in its end product or outcomes, that is, health and social care efficiency gains and

improved health and well-being of the population. The New Public Management

approach, as adopted by Government, does not specify models or frameworks for

coordination or integration, leaving it to local agencies to determine service

configurations. However, the difficulty with this essentially positivist perspective

is that it pays insufficient attention to the process of collaboration and the

contribution this makes to, for example, improved communication and relationships between individuals in different agencies and professional groups.

This thesis has reviewed the policies of collaboration as a means of achieving shared outcomes, but argues they have an undeveloped evidence base, a poorly articulated theoretical framework and are therefore not understood and are ill-defined. It is maintained that the challenges and benefits of improved coordination and frameworks for service integration are in need of further examination and research activity.

4.3   The contribution of research to the practice of collaboration.

Collaboration has emerged as a means to an end; to meeting the health and welfare needs of communities or individuals by removing agency and professional barriers to service delivery and avoiding the inefficient and uneconomic duplication of services.

It has been argued in this thesis that how agencies understand collaboration remains confused and variable. The commonsense idea is that collaboration is a good thing, but the lack of research evidence and an explicit theoretical basis for the requirement of collaboration means that the difficulties tend to be put down to a failure of the agency, awkward attitudes of individuals, professional power, or the lack of skills. The call for legislation, the identification of targets and shared outcomes, the sharing of budgets, joint education and training go some way to address the challenges of collaboration but further research is required identify

underlying causes that manifest themselves as implementation difficulties.

Reports of collaborative approaches have been described and published over many years, but attempts to systematically evaluate outcomes in terms of Hallett and Birchall's (1992) stated policy goals remains a relatively recent phenomenon. When examining concepts such as collaboration through coordination, integration and partnership, Glendenning et al (2002) identify the following issues:

- Difficulty of definition – rhetorical invocation of a vague ideal.
- The partnership literature amounts to methodological anarchy and definitional chaos.
- No clear theoretical framework with which to analyse the operation and outcomes of partnerships.
(Glendinning et al, 2002: Chap 1)

It is suggested that, from an examination of the briefs and forwards of Government policy documents, it is evident there has never been a coherent philosophy of collaboration, nor any hard evidence for most of the assumptions made. Stanley and Manthorpe (2004) argue that policy recommendations for collaboration in children's services have been driven by the negative evidence from inquiries, that is, the lack of collaboration between health and social care as the cause of many of the tragedies in children's services.

Chapters Two and Three highlighted that research evidence in support of collaboration and service integration presents a confusing picture. Edwards (2007) has drawn on the national evaluation of the Children's Fund (NECF) to conclude:

"The knowledge exchange developed through partnership working was judged to have supported the resilience of children and families."

(Edwards, 2007:261)

However, Rummery (2002:43) found little evidence to suggest that partnership working delivers improved services and that it could sometimes have a negative effect. This view has been reiterated by Hudson (2006b) who pointed to the lack of a substantial body of empirical work showing that welfare partnerships lead to improved outcomes for people and communities.

In an American study, Glisson and Hemmelgarn (1998) evaluated the effects of organisational climate and inter-organisational coordination on the quality and outcomes of children's services. They conclude that a focus on improving positive organisational climates within services was beneficial in terms of improving outcomes for 'at risk' children. In contrast, inter-organisational coordination had a negative effect on service quality and no effect on outcomes. (Glisson and Hemmelgarn, 1998:401).

Dowling et al (2004), in an extensive search of the literature, found there was little evidence about health and social care partnerships affecting service user outcomes and that the majority of partnership evaluations tended to focus on process rather than outcomes. That is, focusing upon how practitioners and agencies work together rather than if working in that way necessarily impacts on the outcomes for people in need of services.

Lord et al (2008) published *Evaluating the early impact of integrated children's services: Round 1 summary report.* This study looked into the perceptions of fourteen local authorities of the impact of integrated children's services with three specific vulnerable groups; looked after children, children and young people with autistic spectrum disorder and young people with high rates of absence from school at key stage three.

The research found that children, young people and parents reported a range of improvements in outcomes as a result of the support they received from integrated services. Local authority staff reported integrated work as improving support to children and young people in need, for example, better access to services, quicker and more coordinated responses, and earlier identification of needs. This was considered to be the case in particular where the contextual evidence to the interviews undertaken suggested integration was more mature. (Lord et al, 2008)

Challenges and concerns identified by the study included increased workload implications, particularly in relation to making 'working together' happen and a lack of sign up from all agencies such as schools and health. However, the limitations of this study included an absence of perspectives from wider agencies such as practitioners and managers and from health agencies, who could have a very different perspective in relation to which outcomes may have improved and in what way.

Within the wider public policy arena of integrating health and social care, Dickenson (2007) argues that a number of evaluations of health and social care

partnerships had consistently found little in the way of improved outcomes for people in need of services, citing Peck et al (2001), Brown et al (2003), Kharicha et al 2004, Townsley et al (2004) and Davey et al (2005). However, Dickenson reported the lack of evidence related, in part, to the 'scale of the evaluation challenge' rather than a lack of demonstrable evidence per se.' (Dickenson, 2007:80)

Ham et al (2008) report international evidence that highlights the benefits and improved outcomes from integrating health and social care services. Factors identified as important include, for example, umbrella agency structures to guide integration, multi-disciplinary team work with a single point of contact with standardised referral procedures, joint training and shared information systems, coordinated care packages and financial incentives to promote prevention and rehabilitation. Despite the mixed body of evidence, it can be deduced from the research literature that certain messages about collaboration and integration are both reliable and enduring and, if heeded, can help to improve understanding of the issues.

Cameron et al (2000) undertook a systematic review of the literature on collaboration between 1983 and 2000. The authors conclude that the same problems keep coming up with remarkable regularity, indicating there had been failure to learn from research. The findings of the review were adapted and translated by the Integrated Care Network into a series of statements which were associated with successful collaborations:

1. The political climate is favourable. There is a shared vision at senior/executive level.

2. Friction between Local Authorities, NHS and independent sector is minimised. Differences in cultures, processes and basic goals should be accepted and not ignored.

3. Senior managers and professional leads are supportive. Promotes leadership and links to planning processes.

4. Overall objectives are clear and realistic.

5. Resources, including staff skills and time, are adequate. Funding uncertainties can jeopardise progress and make staff feel insecure.

6. The negative impact of continuous change is minimised. Organisational instability can undermine relationships.

7. The clash of professional philosophies and risk of tribalism are being minimised. Shared values and collective trust are essential.

8. The right people with the right skills are involved. All stakeholders should have a say.

9. Communication in and between teams is good at all levels.

10. Staff has 'ownership' of service development.

11. The roles and responsibilities of staff are clear and understood. Clear policies and procedures help.

12. Management accountability is clear and professional support routines are in place.

13. Accommodation and IT are shared.

14. Joint training and team building is supported.

15. Monitoring and evaluation strategies are in place.

(ICN, 2004a:21)

The task of this research is therefore to attempt to understand and explain the essence of these statements. There is a need to apply a theoretical framework to explore why this list of statements is likely to lead to successful collaborative activity. To achieve this level of understanding research needs to identify collaborative work and evaluate it against well-founded criteria. Until this is done,

agencies and practitioners trying to work together may be re-inventing the wheel or pursuing a myth that, by its existence, is preventing the search for other ways of meeting needs effectively, efficiently and comprehensively. Loxley (1997) recognises the difficulties and states:

> "Collaboration must be disentangled from a muddle of belief, strategies and skills and from the suspicion of those afraid of losing autonomy, so that it can be understood, the necessary structures can be put in place, and the essential skills learned and applied. If this can be done, collaborative effort can be explicitly purposeful, the necessary resources obtained and the outcome evaluated against agreed intention." (Loxley, 1997: vii)

The literature reviewed within this thesis indicates that, to date, there has been a top down approach to collaboration drawing upon public policy and legislation to ensure compliance and implementation. In contrast, the 'bottom up approach' relies on research, description and reflection. Le Grand (2007) argues that, taken together, the two approaches could begin to address the common themes which highlight the difficulties of collaboration and would suggest some of the conditions for success. In this way it can be established if collaboration does address the separation of health and social care and the associated costs of wasteful duplication. It would then be possible to more fully exploit the potential benefits of collaborating, the nature and models for collaboration, and if such activity outweighs the supposed costs of not collaborating.

Research plays an important role in understanding the complexities and multi-dimensional nature of collaborative working. Rhodes (1997) states there is no universal applicability of the findings from research as the methodology is mostly

too limited to produce solid findings for general commendation, and what might be useful in one place may be inappropriate in another. However, this is not unusual in social sciences and the key is to attempt to understand the uniqueness of the methodology, compare the outcomes from different studies and understand them within theoretical frameworks.

There are also many other factors, apart from research evidence, to consider when deciding how to improve public services. For example, available resources, legislation, timescales, public opinion and professional experiences must all be taken into account as contextual influences upon agency structure, service design and delivery. However, this should not negate the value of carefully designed and executed research, and decision making can nevertheless be usefully informed by theory and by research findings.

As already discussed in Chapter Three, improved health and well being for children and young people is not a product but a process of interaction, interdependence and inter-relationships within and between individuals and societies in which they live. In this interactive process, by definition, the ability to collaborate is essential. Therefore, when further developing the theoretical knowledge base of concepts such as collaboration, partnerships and integration, theories based upon understanding social processes and social structures will be of value. The recognition of health and welfare within society as an interactive, adaptive process, without an end, becomes a basis for strategies, policies and practices.

Different theoretical perspectives provide some lines of enquiry to research and evaluate the practices of collaboration. A review of the difficulties and successes of collaboration can clearly be related to sociological concepts of power, culture and agency structures. Research that aims to discover the social influences which affect attempts to work together and to find what individuals working in different agencies might share, as well as what divides them, could provide valuable information in the search for understanding collaborative activity within a clearly articulated theoretical framework.

4.4   Exploring a theoretical framework for collaboration across health and social care.

Sunol (2001) and Grone and Barbero (2002) both suggest that the research evidence in relation to the effectiveness of different models of integrated care is still rare. McDonald (2005) reports that research into partnerships has, with some justification, been criticised for being theoretically underdeveloped. Grone and Barbero (2002) recommend that it is appropriate to identify models and examples of good practice and provide guidance on core elements necessary for the development of an integrated care system stating:

> "In addition to quantitative evaluations of integrated care programmes, triangulation techniques and qualitative evaluations should be used in parallel in order to identify the critical components of a programme and to increase the generalisability of integrated care strategies." (Grone and Barbero, 2002:5)

Robinson et al (2008) undertook a literature review of studies of integrated

working in children's services in order to build an overview of the theories and models of such working. The report identifies four major dimensions for analysis; the extent of integration, the structures, the processes and the reach (the inclusion of partnerships such as the voluntary sector, children and families). The report concludes that service integration is progressed in different ways for different localities, and for different service user groups. Integration was considered to be intricate and multi-faceted as a consequence of varied interpretation and the development of varied models.

The fieldwork component of this research, conducted as part of this thesis, utilises theoretical frameworks to inform the research design and methodology in an attempt to 'get beneath' the complexity and enrich the evidence base for collaborative approaches. Therefore it is anticipated that this research will contribute to an enhanced theoretical understanding that underpin the operations of the different models for organising and delivering more integrated services.

When negotiating the range of health and social care needs and services, complexity and diversity have to be taken into account in responding comprehensively and effectively to individual and population needs. The management of diversity requires the professions and agencies involved in health and social care (and others) to work together. The historical context of collaboration, discussed in Chapters Two and Three, clearly illustrate how the totality of people's needs has challenged agencies' delivery of services. The complexity of society, and the historical growth and development of valuable skills and detailed knowledge within professions and agencies, challenges the

ability of a single, all encompassing agency or practitioner to meet the full range of a person's needs.

If practitioners within professions and agencies are to work together, they need to know what makes it possible. Working together implies allocating resources, building structures, managing processes and employing skills. Working together requires knowledge and education, not only for responding to people's needs, but also for relating to other practitioners with different skills, potentially located across several services and agencies.

In order to develop our understanding of how such complex interactions and processes may be understood, it is necessary to turn to some of the social theories which are particularly relevant to the understanding of collaboration. These include general systems theory and complexity theory (which address the concept of 'wholes'), social exchange theory (which considers social transactions) and the question of costs and benefits and cooperation theory (which attempts to illuminate the impact of power relationships upon opportunities of working together). A broad exploration of the theories and their contribution to the collaboration debate allows more detailed consideration of more specific theoretical perspectives.

4.5   General systems theory.

The biologist Von Bertalanffy, in his study of living organisms and ecology, began to be aware of the limits of specialist disciplines in addressing complex

social problems. Von Bertalanffy (1971) maintains that the 'whole' is greater than the sum of its constituent parts; interactions between entities are purposeful, boundaries between them are permeable, and cause and effect are not linear but interdependent.

One of the crucial characteristics of general systems theory, relevant to health and social care, is the exchange across permeable boundaries between one system and another. This exchange in a social system can be in the form of goods/equipment, knowledge, and direct physical input. Exchange is experienced as an interdependent process of events. The exchange is regulated by feedback and through structures and processes, so that stability and meaning are maintained and adaptability is promoted (Bertalanffy, 1971).

General systems theory therefore offers a shift of perception from understanding not only the impact of separate parts of a system, to an understanding of the processes of interaction which take place within and between whole entities. Using the concept of system it becomes possible to acknowledge the component parts as themselves separate systems, but also relating to others within a greater whole.

The key elements from general systems theory relevant to an understanding of collaboration are those of interaction and interdependence, an emphasis on the management of processes, and the recognition of a need to achieve common goals or outcomes. General systems theory allows the realisation that it is possible to manage complexity and difference through the identification of commonalities

which apply both to the parts and to a whole, that is, shared experiences. Systems theory maintains that change in any one part of a system will bring about change in others. Clare and Corney (1982) argue that the essential interaction between health and social care means that change can be achieved by working with either.

Pincus and Minahan, (1973) adapted the general concepts of systems theory and applied it to social work practice. Their model set out a descriptive analysis of a whole system for social work intervention and comprised of the *change agent system*; those employed to bring about change, the *client system*, those who would benefit from the intervention, the *target system*, those who needed to change and the *action system*, those who work together to bring about the change.

The significance of the model, to understanding collaboration, is that it assists in bringing clarity to identifying the client system and highlighting the relationship between the target system and the action system. It also highlights the need for members of the latter to work together to accrue sufficient power to lever the target system towards the necessary change. Systems theory, therefore, usefully draws attention to relationships, structures, processes and interdependence across the whole system.

Hildebrandt and Rippmann (2001) state that the development of integrated services requires the involvement of all stakeholders and respect for their interests. Frequently, however, factors inherent to the dynamics of systems prevent straightforward solutions. A common problem is that the improvement of the system outcome has a perverse effect for some stakeholders: for example,

strategies aiming to improve population health may signify a loss of (perceived) power, control or resources for agencies carrying out intensive and specialised care.

Grone and Barbero (2002:4) maintain that health systems with centralising planning and financing functions in the hand of governments have an advantage over systems dispersing those functions over various governmental and non-governmental institutions, agencies and associations (for example a tax system vs. social insurance system). They argue that the structural characteristics of a system can therefore facilitate integration of health and social care but they do not pre-determine the degree of integration or the outcomes achieved. They suggest that this level of understanding remains elusive.

Schon (1971) asks the question "What can actually be done to engage with systems practice in a policy context?" He suggests that it is appropriate for Government to determine what the priorities and directions of policy and action should be. He considers the error being made by Government is that it has attempted to prescribe how policies should be implemented – through legislation, targets, and incentives. Instead, he recommends that once the 'what' has been established, a systems approach would then involve as many stakeholders, delivery agencies and end-users (people in receipt of services) as possible to establish an agenda for action. Schon (1971) discusses the learning taking place through the iterative process of using systems concepts to reflect upon and debate perceptions of the real world, taking action in the real world and again reflecting upon the happenings using system concepts.

General systems theory therefore offers a useful and practical perspective, when applying research methods to a theoretical framework for collaboration, that attempts to understand the 'whole' system and how it operates. The emphasis upon understanding the different levels of interactions and interdependencies between the different stakeholders could provide a focus of enquiry for attempts to disentangle the complex nature of collaborative activity. Such an approach also enables policy makers and service planners to move away from conceptualising collaboration as an outcome. It facilitates a view of collaboration as an on-going process, subject to the wider contextual influences of an ever changing environment.

4.6   Complexity theory

Complex systems are those with a large number of separate but related networks that are interconnected and interact in a dynamic manner. Complexity theory aims to extend an understanding of general systems theory through studying how patterns emerge from seemingly random interactions and form complex dynamic systems. Complexity theory explores how order emerges from chaos and provides insight into ways of designing and managing agencies. Downs (2007) claims that complexity theory provides an enhanced understanding of how and why agencies behave in a certain way, which will in turn enable the activities of agencies to be managed more purposefully.

Chapman (2004) argues that the NHS is too often treated as an agency which, though complicated, just needs better solutions and clearer thinking. As a

consequence, policy makers are too mechanistic, reductionist and linear in their approaches and therefore the mental models they use are inadequate in the modern world. He states the NHS is not merely complicated, it is complex. This complexity is found at the level of team, agency and the wider NHS as a whole. He states that policies and interventions have unpredictable and unintended consequences and complex systems such as the NHS have demonstrated remarkable resilience in the face of efforts to change them.

It is suggested in this thesis that an approach based on an understanding of complexity and systems thinking would allow for much more diversity in approach to policy design and implementation:

> "A systems approach suggests the need for a shift in the goals that can be realistically achieved by policy, and places policy implementation in the context of a learning organisation that ensures its maximum effectiveness. Rather than proposing any sort of panacea or silver bullet for policy, I am suggesting a shift of paradigm for it." (Chapman, 2004:25)

In other words, support for implementing a policy of collaboration must recognize the complexity of interdependence and interactions and move away from simple and linear enforcement solutions. Plsek (2003) attempts to explain how complexity theory works:

> "A complex adaptive system is a collection of individual agents who have the freedom to act in ways that are not always totally predictable, and whose actions are interconnected such that one agent's actions will change the context for other agents" (Plsek 2003:2)

Chapman (2004) argues that systems thinking is holistic and deals with complexity by increasing the level of abstraction, unlike current policy approaches which seek to divide the problem into manageable, but separate, elements. He states that systems thinking should not be seen as a competitor to reductionist thinking; the two are complementary and in practice some combination of holistic systems and reductionist thinking will prove to be the most useful. Plsek (2003) identifies some properties that are relevant to an understanding of complex systems:

- Relationships are central to understanding the system: The behaviour of a complex system emerges from the interaction among the agents.
- Structures, processes and patterns: We can describe complex systems by their structures processes and patterns.
- Actions based on internalised simple rules and mental models: In a complex adaptive system, agents respond to their environment using internalised rule sets that drive action.
- Systems are embedded within other systems and co-evolve: The boundaries of a complex system are somewhat arbitrary.

To illustrate the above, a child and adolescent mental health service may be a complex system comprising of relationships between psychiatrists, psychologists, nurses and social workers. This, in turn, is embedded within a wider system such as an NHS mental health agency which has its own internal patterns and sets of behaviours, which in turn interact with a children's social care system, which in turn are embedded within wider and national health and social care systems. All the systems interact to form a complex system, with the different components exercising power and competing for resources. The evolution each of these

complex systems influences and is influenced by that of the other systems. Therefore, any attempt to develop a theoretically informed understanding of collaboration that supports an explanation of the behaviours of individuals and agencies, must also consider the relevance of complexity theory.

Byrne (1998) states that, historically, quantitative research tends to analyse relationships between variables within a linear model of causality, collecting data and analysing in the form of a statement of single cause and consequent effect. He argues that when researching complex social situations, the whole system contains things which are not deducible from a description of any single part of it - there are multiple interactions to consider and it is the task of social research to identify and understand those complex interactions when their effects are not linear or additive in nature.

Byrne (1998) further points out that social research takes place in the real world. The real world is complex, consisting of multiple interactions between people and processes. He suggests that, whereas in principle the complex can be reduced to the simple, principle is not practice and that it is essentially pointless to attempt reductionist explanations when they are not needed. He considers the significance of the complexity approach lies precisely in the recognition that whilst there is no linear law, no single answer, it remains possible to analyse in order to see what the possible set of outcomes are, and, in situations of complexity, where intervention will have an impact upon achieving the outcomes required.

The applicability of complexity theory to understanding collaboration and service

integration is based upon the number of different systems and 'actors' engaged and interacting to deliver health and social care. Downs (2007) suggests that complexity research makes us think about the ontology of agencies – in other words, what things agencies consist of, and what structures connect the component parts. Appreciation of the complex relationships between elements in the system is an example of the qualitative insight that complexity can provide.

4.7   Social exchange theory.

The basic assumption of social exchange theory is that social structures can be understood through an analysis of interpersonal transactions; understanding interactions is the key to understanding complex social behaviours between groups. The theory's two fundamental concepts are exchange and negotiation. The underlying principle is that an individual will join a group that provides a specific benefit and that, in return, he or she must help the group attain its objectives: this is the exchange. D'Amour et al (2005) stated that the negotiation process begins when an individual offers to contribute specific expertise to the group and, in return, expects to receive specific benefits. Individuals and groups are thus constantly engaged in negotiations to try to optimise benefits, reduce costs and move forward under conditions that will be fair to all.

Gitlin et al. (1994) expanded social exchange theory into a four-parameter model: exchange, negotiation, building an environment of trust, and role differentiation. Their model involved a series of activities occurring in five overlapping stages: (1) assessment and goal setting; where participants examine their individual and institutional goals and assess the need for developing a collaborative relationship

and its cost-benefit ratio; (2) determination of collaborative fit; in which participants meet to exchange and negotiate potential project ideas and roles and begin to establish an environment of trust; 3) identification of resources and reflection; where individuals return to their group to re-assess the resources needed for a collaborative effort and the benefits of participating; 4) refinement and implementation; where ideas are refined and put forward and the individual contributions differentiated and 5) evaluation and feedback; where team practices and roles are analysed and future goals are established. Gitlin at al (2004) suggest that this model explains the how and the why behind any step towards a culture that supports collaboration.

Social exchange theory emphasises a calculation of return. The success of the exchange is dependent upon some mutual benefit to the participants. The benefit may not be direct, or in kind, as in the exchange of goods, but may be some other satisfaction, either immediate or delayed, or indeed to some other person or group in the social network. Challis et al (1988) consider there to be some element of self-interest in all instances of social exchange, with bargaining, negotiation and exchange as necessary functions of interdependence.

Challis et al (1988) report that the medium of exchange between practitioners, managers, and policy makers in inter-professional and interagency collaboration are all the elements which give their work purpose and meaning, especially resources which include people in receipt of services, information, influence, esteem and power. The demand for such exchanges may be threatening, especially

if they are perceived as the likely loss of power or control. The loss of resources or threats to a sphere of influence will be seen as costs of collaboration.

Challis et al (1988) argue that there will be a slow build up of trust between participants who experience successful exchanges, starting with small exchanges involving small risk, and these will develop into social bonds of mutual commitment. Such commitment makes it possible to take greater risks because of the confident prediction that obligations will be met.

The approach to policy implementation, as reported in earlier chapters, is very much focused upon coercion to collaborate through legislation, public service agreement targets, and policy guidance with incentives attached. However, Kirkpatrick (1999) argues that the benefits of collaboration that are embedded within relationships are qualitatively very different and have been given very little attention from Government. Kirkpatrick (1999) considers that there has also been very little attention to the costs of collaboration and that in certain contexts the process of collaboration can generate more costs than benefits contributing to governance failure.

Insights from social exchange theory are relevant as it would suggest that Governments must recognise that trust cannot be commanded, only slowly built, as resources, structures, skills and rewards are deployed and costs and benefits at all stages, and at all levels, are acknowledged. It is therefore interesting to observe the current Government's approach to collaboration and, in particular, the moves to ensure integrated children's services and Children's Trusts are secured within a

statutory framework. Social Exchange theory therefore provides a further line of enquiry to assist the researcher to predict and to understand the likely outcomes of collaboration if the nature and content of collaborative exchange is not fully explored.

4.8   Cooperation theory

Cooperation theory assumes that parties will cooperate for their own benefit, which becomes a mutual overall gain. Axelrod (1984) identifies three necessary conditions which create the optimum environment for successful cooperation between self-interested parties in a complex world: reciprocity; where there is mutual gain from co-operation; durability of relationships; where the parties are certain in the knowledge that they will meet repeatedly over long periods of time and thirdly, provocability; that is the ability of each participant to have enough power in the situation to make the other realise that if they should pull out of the cooperative enterprise it will be more costly to them than cooperation.

Cooperation theory highlights the recognition that it can be mutually beneficial if parties bring to it, not only the willingness to trust each other but also the power to reciprocate if any party should renege on the agreement. There is safety and confidence in the knowledge that a partner cannot just 'cut and run', but they will continue to be involved in the relationship.

Cooperation theory also facilitates the exploration of in-equitable power relationships between collaborative partners. One of the partners may be in a

significantly less powerful position when considering available resources and/or professional status, however, their role in ensuring the successful delivery of agreed outcomes may be pivotal. As a consequence the application of this theoretical approach allows for an understanding of mutual benefits and how legislation, incentives, shared outcomes and targets may all influence the different groups' analysis of potential benefits.

It is interesting to reflect upon insights from cooperation theory and its application when considering the history of collaboration prior to the approach of the current Government. The volume of 'joined up working' policy guidance with few obvious successes, and without the levers of current legislation and financial incentives, may well impact upon the changing analysis of potential benefits to cooperation, thus changing the dynamics of the operating system. The lack of historical success could reflect a general view taken by agencies and professional groups that the benefits of collaboration did not warrant a change to the status quo. Increased financial incentives and increased costs, or repercussions, may impact upon the cost benefit analysis of cooperation.

The underlying theme that unites the four social theories discussed is recognition of interdependence, which benefits not only people in receipt of services, but also the professionals, their agencies and the effective use of expensive public resources. The theories allow for the legitimacy of calculating costs and benefits rather than a vague notion that 'things will be better if we collaborate'.

This chapter attempts to move beyond a description of the difficulties surrounding

collaboration and attempts to explore the reasons why collaboration has proved to be such an elusive policy ambition. The aim is to highlight the complex combination of factors that potentially or actually undermine attempts at collaboration and affect the relationship between central policy and local implementation. In so doing, this chapter also draws upon theoretical insights that fall broadly under the category of organisational theories. Hatch and Cunliffe (2006:5) report that such insights into collaboration must embrace multiple perspectives because the behaviours of agencies will remain too complex and malleable to ever be summed up by one single theory.

This chapter therefore goes on to review the contribution of policy networks, network management and inter-organisational networks in an attempt to consider how such organisational theories may contribute to an increased theoretical understanding of the underlying conditions required to enact collaborative working relationships across agencies and practitioner groups.

4.9   Policy networks and network management.

It has been discussed earlier in this chapter that it would not be possible, or practical, to integrate all the agencies required to meet the needs of children and young people into one single agency, or similarly to merge all the practitioners into a single team. When, and how, to coordinate, rather than integrate, remains a key challenge for agencies. In the absence of a decision for agencies or teams to integrate, policy networks offer a framework and process for coordination.

Policy networks can be defined as (more or less) stable patterns of social relations between independent and interdependent actors, which take shape around policy problems and policy making (Kikert et al, 1997). Policy network analysis combines insights from policy science, which focuses on the analysis of public policy processes, with ideas from political science and organisation theory around the distribution of power. Marsh and Rhodes (1992) explore policy networks as structured sets of relationships between governments and pressure groups within which policy is negotiated over time. This approach would therefore appear to have something to offer when attempting to understand the dynamics and processes of collaboration.

Policy network analysis argues that a small number of groups enjoy a privileged relationship with the state at the expense of other interest groups. Peters (1986) maintains that the role played by a particular agency, within a multi-agency collaborative framework, will be significantly affected by the nature of its links to wider structures of social, political or professional power. More powerful groups may work to ensure the terms of interagency exchange are such as to protect and enhance their dominance.

The power within networks belongs to a small number of groups and is derived from the centrality of some agencies to the operation of the network, the possession of a lead role in service delivery, or dominance of their service paradigms. It is argued that less centrally involved agencies are less likely to be committed to the objectives of the network and are susceptible to the pull of other agendas where the gains or benefits to the agency are perceived to be greater.

Collaboration (within or between networks) is therefore characterised by tensions deriving from the unequal resources and authority of network members, underpinned by the operation of wider social relations/structures of power.

A policy network approach considers that the achievement of central policy ambitions will depend crucially on the relationship between central policy networks and those responsible for policy implementation at regional and local level. The need for public sector agencies to work together (and with the private and voluntary sector) to deliver shared outcomes reinforces the role of partnerships and policy networks at local, regional and national levels.

At the front line, the implementation of central government policy objectives is undertaken by a series of local provider or delivery networks, for example Children's Trusts are mandated to coordinate activity to deliver shared outcomes. The Children's Trusts must therefore successfully engage with a range of agencies, tasked with delivering children's services that are, in turn, informed by a wide range of policy imperatives.

Rhodes (1997) suggests that governance has become a central concern for Government when considering the analysis of different levels of policy network activity and how it can be successfully managed to ensure the effective delivery of cross-cutting outcomes. The Integrated Care Network (2004b) describes governance as:

> "The procedures associated with decision making, performance and
> control of organisations, with providing structures to give overall direction

to the organisation and to satisfy reasonable expectations of accountability to those outside it." (ICN, 2004b:2)

In this context, governance for Government is about directed influence over policy networks. Rhodes (1997) states that governance of policy networks refers to successfully directing the implementation of policy objectives through self organising, inter-organisational networks with the following characteristics:

1. Interdependence between organisations. Governance also covers the actions of non-state actors as changing boundaries of the state means the boundaries between public, private and voluntary sectors become shifting and opaque.
2. Continuing interactions between network members, caused by the need to exchange resources and negotiate shared purposes.
3. Game-like interactions rooted in trust and regulated by the rules of the game negotiated and agreed by the network participants
4. No sovereign authority, so networks have a significant degree of autonomy from the state and are not accountable to it. They are self organising. Although the state does not occupy a sovereign position, it attempts to indirectly and imperfectly steer policy networks.
(Rhodes, 1997, xi)

It is clear from the above that, as is the case with systems and complexity theories, a focus upon policy networks reinforces recognition of interdependence, relationships and interactions. Sullivan and Skelcher (2002) and Strachan (2005) argue that such characteristics ensure that health and social care partnerships present a challenge to the principles of public sector corporate governance. Without clear governance structures it can be difficult to understand who in the partnership takes decisions, how these decisions can be challenged and where

decisions are reported. Weak governance not only undermines accountability, it also places partner bodies at risk of being held responsible for service failure, or damage to their reputations and possibly large financial liabilities. As a consequence this may inhibit agencies' willingness to depart from some of their traditional ways of doing business and promote reluctance to engage in creative and innovative solutions that may well carry substantial risks.

Strachan (2005) suggests public agencies must ask whether a partnership is the right solution to their problems, or whether bilateral arrangements or improved consultation, coordination and networking would be more effective. To answer those questions, public agencies need to be more rigorous in the evaluation of their involvement in all their partnerships.

Kickert et al (1997) propose that observing, analysing, understanding and directing policy networks presents an opportunity for improved public policy making, implementation and governance. They adopted the concept of policy networks and identify network management as a tangible and practical form of intervention aimed at influencing the mechanisms of collaboration and promoting joint problem solving or policy development through networks consisting of diverse participants. Network management is therefore an activity which involves steering efforts aimed at promoting cooperative strategies within policy networks. Thus network management may also be seen as:

> "Promoting the mutual adjustment of the behaviour of actors with diverse objectives and ambitions with regard to tackling problems within a given framework of inter-organisational relationships." (Kickert et al, 1997:44)

Lupton et al (2001) maintain that the policy networks and network management approaches have some limitations for a focus on inter-organisational collaboration. She argued that the approach does not offer enough attention to the relevance of the relationships between networks operating in their wider environment. There is a tendency for the approach to emphasise structure of networks and internal processes at the expense of processes operating in the wider policy environment.

Lupton et al (2001) recommended a need to examine not just the structure, composition and internal processes of networks, but also the external tensions and conflicts within wider networks and the shifting interests, power and resources of the 'actors' within it. Marsh (1998) acknowledged this problem and the need for a 'more dynamic dialectical approach' which would examine the influence of exogenous factors, not just on the structure, operation and composition of the network, but also upon the relationships and interdependencies between them.

Marsh and Rhodes (1992) concede the limitation of policy network analysis has not been given much attention in the literature. The nature of the impact of dynamics and relationships across public policy environments has received little attention at the macro level; for example between government, economic and political networks, at the meso level; for example, at the level of policy development in health, social care, criminal justice and employment and at the micro level; for example the many agencies within localities that constitute

interagency networks tasked with working together to interpret and implement Government policies.

It is therefore suggested that, to further understand the development of collaboration as a significant policy goal, it is necessary to understand the relationship between policy development, the full range of policy networks interacting at sectoral level and service delivery or 'provider networks' operating at sub-sectoral level. It is argued by Lupton (2001) that this is central to our understanding of the factors affecting the gap between central policy objectives such as collaboration, partnerships, and service integration and policy implementation at a local level.

4.10   Inter-organisational networks

Inter-organisational network analysis is suggested as a theoretical framework to support the study and analysis of the operation of policy networks operating in their wider social, economic and political environment. It focuses attention on the complex web of relationships in which a group or agency is embedded. Such an approach promotes sensitivity to the variety and complexity of interactions that sustain organised activity within the wider policy environment and also within more local service delivery networks.

To understand the nature of local service delivery or 'provider networks' and their relationship to wider regional and national policy making networks, this chapter draws on the inter-organisational network approach as developed by Benson

(1975, 1983). This approach understands a particular policy sector as a mini 'political economy' in which there may be networks operating at a number of different, interrelated levels. The focus of Benson's approach to inter-organisational analysis is on the internal **and** external dynamics of these networks. Its concern is to understand the relationships within and among networks and between those networks and the policy sector.

For Benson (1975, 1983), specific policy sectors such as health, employment and criminal justice, are seen as complex inter-organisational phenomena, involving many different networks and operating on a number of different levels. Within networks, participants are connected to each other by a series of mutual resource dependencies and their relationships may be direct or indirect, consensual or competitive. Such interaction may at one extreme include "extensive reciprocal exchanges of resources or intense hostility at the other" (Benson 1975:230). Benson states that it is important to understand policy networks and their operation as embedded in, and subject to, the operation of wider social, political and economic processes.

For Benson (1975, 1983) then, analysis of the operation of inter-organisational networks centres on patterns of interaction that derive from agencies collaborating to perform core functions. This interaction can be understood in terms of the achievement of equilibrium across the following four key dimensions:

Table 5

Key dimensions of inter-organisational network analysis.

DIMENSION	DESCRIPTION
Domain Consensus	The extent to which there is agreement regarding the role and scope of each partner's contribution to the task.
Ideological Consensus	The extent to which there is agreement regarding the nature of the tasks facing the partnership and how they will be achieved.
Positive Evaluation	The extent to which those in one part of the partnership have a positive view of the contribution of those in another.
Work Coordination	The extent to which autonomous partners are prepared to align working patterns.

(Benson, 1975:235)

Those networks in strong equilibrium are characterised by highly coordinated, cooperative interactions based on consensus and mutual respect. Applying general systems theory, Benson's (1975, 1983) broad hypothesis is that these components of equilibrium are related, so that improvements (or decline) in one dimension will bring improvements (or decline) in others. Significant imbalance in any of the dimensions will affect the successful operation of the network. Such a framework allows evaluation of the four dimensions and the possibility of identifying areas of imbalance.

For Benson, (1975, 1983) three possible states of disequilibrium may follow:

- Forced co-ordination (high on work co-ordination, but low on domain or ideological consensus and positive evaluation)
- Consensual inefficiency (low levels of work co-ordination, but strong on domain and ideological consensus and positive evaluation)
- Evaluative imbalance (High on work cooperation and strong on domain and ideological consensus, but low on mutual positive evaluation).
  (Benson, 1975:237)

To understand why a particular organisational network achieves levels of balance, it is also necessary to examine factors that are operating at the sub structural level. Benson (1975) reports that interactions on the 'surface' (super structural relations) of a network are underpinned by more fundamental processes which influence the behaviour of participating agencies. These underlying factors, operating at a sub structural level, relate to the participants' own agency's objectives such as their own key service delivery objectives, ensuring adequate funding/resources to function, maintaining or defending their agency's paradigm (defending ideological commitment to certain ways of working).

Benson's framework (1975, 1983) goes on to identify the influences of the wider policy environment, the social structures and relations of power within society and, ultimately, the influences upon the rules of society, which are the fundamental ideologies that determine how it is structured and operates.

This research is primarily interested in the operations of interagency teams and is therefore concerned with their 'surface' or superstructural relations. Achieving equilibrium across the four domains will only be possible to the extent that it does

not undermine the 'market position' of the collaborating agency, which is, the actions of the network do not threaten their individual interests. However Benson, (1975, 1983) makes it clear that not all agencies collaborating within an inter-organisational network will possess the same degree of power, resource or legitimacy. Some participants will therefore be in a better position to defend and enhance their wider agency's objectives than others.

Benson (1975, 1983) states that the relative power of agencies within a network derives from two main sources. The first source is from their role within the network whereby certain agencies have more of a central function than others. Second, network power will derive from the organisation's linkages to wider patterns of social organisation. For example, the role of the NHS in inter-organisational networks is likely to be influenced by its linkages to the strong professional power of its professional organisations and from the absence of local political accountability.

Benson (1975, 1983) considers that the relative power of collaborating agencies within a network can be used in a variety of ways, including the ability to reach across into 'weaker' agencies and determine their policies, practices and priorities, or to determine the flow of resources within and between networks. This context provides the basic terms and conditions under which the network operates, affecting the supply of resources, distribution of power, and as a consequence, the structural relationships within the network.

Such an analysis offers a valuable framework for undertaking the task of mapping

out a whole system and its constituent networks. This whole system is conceptualised as a number of separate parts that link together to constitute a holistic framework rather than separate and independently operating agencies or networks. There is a logic and rationale in which the components are related, so that improvements (or decline) along one dimension can be expected to bring about improvements (or decline) in others. More effective service delivery will be associated with higher equilibrium.

The application of Benson's (1975, 1983) framework facilitates an analysis of collaboration and the gap between policy development and policy implementation. It takes the analysis of collaborative activity to another level through avoiding simple do's and don't do's as highlighted by so many evaluation reports and 'off the peg' tool-kits that are designed to enhance partnership working. By allowing for high, medium or low degrees of equilibrium across the various components, the model offers a 'health check' on the whole system relationships.

Lupton et al (2001) applied Benson's (1975, 1983) framework when investigating the operation of child protection networks in the UK. In the case of domain consensus she reported considerable confusion about the respective roles on the part of social workers and health visitors. These tensions surrounding domain consensus were exacerbated by different professional approaches and frames of reference about child protection and how it should be addressed, that is, differences in ideological consensus. The findings in relation to positive

evaluation were variable and the extent of work coordination was reported to be low.

The value of the framework is its application to empirical explorations of specific problems and contexts. D'Amour et al. (2005) found that only three out of seven theoretical frameworks on inter-professional collaboration were based on empirical data. Benson's (1975, 1983) framework is empirically grounded as it facilitates the collation of data that aims to establish the conditions in which greater rather than lesser equilibrium can be secured across a whole system when working collaboratively to achieve a policy implementation goal.

Benson's approach to understanding the operation of inter-organisational networks can be utilised at a number of different 'levels. The applicability of the framework to this research lies at the level of researching individual, local networks, tasked with working together to respond to issues and challenges surrounding policy implementation in family support and child and adolescent mental health services. The framework has therefore been adopted as a key component of this research and associated methodology as described in Chapter Six.

4.11   Summary.

This chapter began by reporting difficulties associated with different practitioner groups and agencies using different language to describe, interpret and understand what it means to collaborate or purposefully work together to achieve a policy

goal or shared outcome. In order to provide clarity, and provide a common frame of reference for research, the need for a shared understanding of the language of collaboration was stated and shared definitions were suggested.

The chapter then went on review some of the research evidence into the outcomes of collaboration for health and social care services, identifying common themes including where some of the successes and challenges lie. However, it is argued that the research is generally scarce when attempting to understand what the findings mean, how they relate to different models of collaboration, and in particular there is a general absence of analysis in relation to different models of coordinating and integrating service provision.

It is argued that it is necessary to explore the essence of collaborative activity, to apply theories and theoretical frameworks that aim to further our understanding. Only in this way can we begin to understand the conditions that will lead to research findings that can be more readily generalized and lead to improved understanding of the conditions required to deliver optimum collaborative outcomes within any given model of service delivery.

The social theories identified in this chapter provide a starting point from which it is possible to understand the contributions of theoretical perspectives from a systems perspective. To comprehend and analyse collaboration, the interactions and inter-relationships between individuals and agencies may be studied within the rationale of, for example, theories that explore complex social interactions

such as systems theory, complexity theory, social exchange theory and cooperation theory.

In addition to social theories, organisational theories, such as policy networks, network management and inter-organisational networks were also reviewed. This approach provides additional insight into the nature of agencies, their behaviours when faced with the need to collaborate in support of policy implementation and the realisation of shared outcomes. The 'policy network' and network management approaches offer a framework through which a specific policy area, such as collaboration and integrated working in health and social care, can be analysed. It allows the researcher to examine the development and implementation of a policy through the identification of the agencies and 'actors' required, participating in 'bringing the policy to life'.

However, the value of the 'policy network' approach as an explanatory theoretical framework is limited by its relative inattention to the wider contextual dynamics of networks and their contribution to policy implementation or delivery. Benson's (1975, 1983) inter-organisational network analysis offers a complimentary model for understanding the policy process, the impact of wider contextual factors and an opportunity to 'diagnose' the dynamics and processes that contribute to the 'health' of networks.

Benson's (1975, 1983) approach provides a practical framework for this research as it allows empirically based study and an analysis of the dynamics and tensions created when integrated teams operate within a wider social, political and

economic environment and how these may impact upon the teams achieving equilibrium across four key domains.

The relevance of this chapter to this research is in the identified need for research into collaboration across health and social care to apply, more rigorously, theoretical frameworks and researched models with assessed effectiveness and outcomes that are testable, subject to evaluation, and the learning transferable. In this way policy makers, managers and practitioners can be supported to develop their understanding of concepts such as partnership, co-operation, collaboration and integration in order to recognise opportunities and overcome barriers to more collaborative working practices. The application of researched models of practice also facilitates discussions in relation to the local arrangements which are necessary to deliver improved services.

This chapter has discussed, in very broad terms, social and organisational theories that, when taken in combination, have much to offer as theoretical frameworks to inform the investigation of local practices, undertaken by local agencies, to collaborate and work in partnership to deliver more integrated services for children and families

The focus of this research is very much at a micro level of inquiry; upon the local arrangements to organise inter-professional and interagency teams tasked with the delivery of services to support children and families. Therefore, it is necessary to review the research literature in relation to the operation of inter-professional and interagency teams. The following chapter enables further preparation for the

fieldwork stage of this research project by focusing in more detail upon the issues

affecting the development and operation of such teams.

5 Understanding collaboration in the context of interagency and inter-professional teams.

The focus of this thesis so far has been upon reviewing and analysing the historical context of Government policy in relation to collaboration in health and social care. Specific attention has been paid to the goal of collaborative working in children's services, and between family support and child and adolescent mental health services. It has been argued that Government's approach to supporting the development of effective collaborative working relationships has been to remove any structural and legal difficulties. However, Armistead et al (2007) noted:

> "Partnerships are often overlain on a palimpsest of previous attempts at collaboration which betray a history of inter-organisational, interpersonal or clan conflict." (Armistead et al, 2007:218)

A general absence of interest from Governments in addressing issues around organisational and interpersonal relations, particularly at a locality partnership level, represents a gap in their approach to supporting policy implementation. Dickenson (2007) suggests that arguably these are the challenges in which local health and social care economies require most support.

The application of theoretical frameworks, highlighted in Chapter Four, enables a more rigorous approach to studying, analysing, and understanding such seemingly intractable difficulties posed by the efforts of agencies to interact, interrelate and

work together more collaboratively. The theoretical frameworks discussed can be utilised to examine collaborative activity at a range of different levels; from relationships between individual practitioners working together in a team, through to agencies collaborating within a locality or Government Departments engaged in policy making processes.

The research aims to develop an understanding of collaboration and integration at the level of individual practitioners and managers and their nature of interactions when working within, or planning, inter-professional teams. Therefore this chapter discusses the literature in relation to interagency and inter-professional team working and discusses the findings in relation to what promotes and what hinders integrated team working. This raises important questions for this research to consider, particularly in relation to the impact of different models of integrated team working upon the nature of relationships and interactions between practitioners and manager.

The terms interagency and inter-professional are preferred in the context of this research and are used to describe a range of integrated models of team working. It is maintained that research cannot be undertaken if the subject of the research is not described and conceptualised. Therefore, this chapter provides a general description of 'types' of integrated teams in terms of their formal organisation, structure and processes. This incorporates the role occupied by a practitioner, the responsibilities of the position, and the working relations of accountability and authority to other positions and groups. It also encapsulates prescribed procedures and policies, for example, supervision and decision-making. This chapter

concludes by applying a general typology for describing teams to the interagency and inter-professional teams participating in this research.

5.1 A review of the research evidence in relation to inter-professional team working.

It is proposed that research activity needs to turn some of the ideology of collaboration into theoretical propositions for testing, and to consider the evidence for and against hypothesis such as:

- People in need of services achieve better outcomes from services which exhibit high degrees of either integration or co-operation.
- Inter-professional and integrated teams reduce duplication of activity

Anning et al (2006) identify a number of challenges to researching inter-professional teams. For example:

> Who should be studied?
> What aspects of their work?
> What sort of data should be collected?
> How should it be collected?"
> (Anning et al, 2006:13)

Research could focus upon, for example, outcomes for people in need of services. Measures would then be required to identify what would constitute an improved outcome for a person in need of a service and then compare those outcomes to people who had received the service in a different way. Alternatively, the focus of research could be upon the service outcomes delivered by inter-professional teams

such as reduced duplication of activities across agencies, improved cost effectiveness or reduced waiting times for a service.

Cameron and Lart (2003) report the findings of a systematic review of the factors promoting, and obstacles hindering, joint working across the health and social services interface. The evidence of collaboration identified three themes: organisational, cultural/ professional and contextual issues. Their tentative conclusion was that there was some association between the type of model of joint working and the factors promoting and obstacles hindering progress. These findings informed the nature of enquiry for this research project; legitimising the study of any relationship between degree of team integration and impact upon the relationships and interactions between practitioners within interagency and inter-professional teams.

In a review of the research evidence into inter-professional team working, Hudson (2006a) identifies a dominant 'pessimistic' model of inter-professional team working. Hudson (2006a) grouped the barriers identified by research into three main themes:

- **Professional Identity:** Being able to identify oneself with a body of knowledge is perceived to be of intrinsic worth; the professional identity, which this generates, can become a valued part of individual personal identity and one which is nurtured and protected by the profession. The implication for inter-professional teams is that where members of a team have different professional backgrounds, agreement among members may be difficult to achieve.

- **Professional status:** The extent to which professions share a similar status has implications for how they may work together. The concept of a hierarchy of professions, differentiated by full and semi professional status, has a particular relevance for health and social care professions which have contrasting histories on matters such as training, legal registration and right to practice. Joint working may be more difficult where there are perceived status differentials between team members.

- **Professional discretion and accountability:** Practitioners have to act at a personal level with service users and at the same time relate to a formal structure or the agency in which they are employed. Typically this will cause some tensions, as the rules governing professionals' discretion and accountability may differ between professional groups. The additional complexity of working in inter-professional teams may be a task which some would wish to resist, especially where it is perceived as threatening understandings of how different practitioner discretion, autonomy and accountability should be applied. (Hudson 2006a:14)

Anning et al (2006) studied the experiences of practitioners working within inter-professional teams. The ways in which the teams developed and functioned confirmed the existence of many of the reported conflicts, tensions and barriers in the discourse of the professionals they interviewed. Research findings into inter-professional team working by Ovretveit (1993) concluded that the idea of staff from different disciplines easily identifying their spheres of competence and dividing up their work accordingly was naïve. It was the experience of many teams that a long and arduous process of experiential learning had to take place before health and social care practitioners would begin to trust each other's respective skills and experience.

Ovretveit (1993) concludes that all team members need to be able, willing and helped to move away from the security of their profession specific skills. For a team to function effectively, he recommends that role clarification is essential for each profession and transparency is necessary, covering profession specific responsibilities, generic or team common responsibilities and management and supervisory responsibilities (Ovretveit 1993:105).

Hudson (2005a) describes the empirical literature on inter-professional and inter-agency team working as remaining limited and cites this as an explanation for a theoretical vacuum in relation to integrated working. He applies Benson's (1975, 1983) framework for analysing and evaluating the operation of locality based and integrated teams for adult care in Sedgefield. He identifies several key elements that contribute towards the success of the inter-professional teams. They include the pooling of resources between Primary Care Trusts in health and social care services, the inclusion of wider local authority services in the establishment of joint operational teams under a single management structure, and the creation of local partnership boards to oversee the arrangement.

Hudson's (2007) review of the evidence suggested that, while some differences in culture were acknowledged, they were not such as to impede a shared approach. A key factor was the greater mutual understanding that arose from co-location. As the team rapidly matured, members felt that there had been an increased understanding of each other's roles and that, as a consequence, service delivery had been enhanced. The acceptance of collective responsibility for a problem was observed, as opposed to the pursuit of narrow professional concerns.

Hudson (2007) concluded that there was no evidence to suggest that any team members saw themselves as having higher status or importance than others; all were seen to have a vital part to play in sustaining team effectiveness and securing better outcomes for service users. He suggested that one of the most tangible signs of a functioning team was that previous professional affinities were seen as less significant than new team based affinities. There was evidence that some team members saw the team and its new membership as their prime professional affinity. Hudson (2007) argued that alternative team models such as 'virtual teams' did not permit the rich networking that underpinned a shared approach to problem solving as adopted by more integrated models of working.

The evaluation was not able to track long-term effects or outcomes of team interventions. However, Hudson's (2005a) research reported that integrated teams were capable of undertaking tasks more quickly, were more flexible due to practitioners' willingness to work differently and were more creative as they exploited the opportunity to think about things in a fresh way. Hudson (2005a) argued that it is important to remember that good outcomes depend upon effective processes for their achievement.

These findings contradict the pessimistic tradition and Hudson's (2005a) study offers some evidence for the articulation of an 'optimistic model' of interagency and inter-professional team working. Instead of asking if the initiative works or not, Hudson (2005a) attempted to develop an understanding of why a programme works for whom and in what circumstances by suggesting that context +

mechanism = outcome. (Hudson 2005a:40).

Frost and Robinson (2007) reported research findings of the MATCh project into five interagency children's teams that were supportive of Hudson's (2005a) optimistic model. They observed that, while inter-professional team working can be threatening, teams developed ways of working together. They addressed tensions while developing common team values. Frost and Robinson (2007) recommended the following:

> "We would argue effective strategies for making multi-disciplinary teams work will combine interagency structural and internal team specific aspects." (Frost and Robinson, 2007:198)

Sullivan and Skelcher (2002) also consider that attention to internal team specific aspects such as the specific skills and roles of individuals is important, but insufficient if it was not supported by a wider commitment to developing and organising for collaboration. This was because the capacity of individuals to act would be partially informed by the organisational context within which they operated. (Sullivan and Skelcher, 2002:51). Therefore, it could be concluded there is value to undertaking research that focuses upon the experiences of both practitioners working within interagency and inter-professional team structures and managers who are more firmly grounded in the organisational or agency context of their development.

So far this chapter has discussed interagency and inter-professional teams as the 'front line vehicles' for delivering more integrated services across health and

social care, highlighting the research evidence into interagency and inter-professional team working. It is clear that there is no such thing as a single model of integrated and inter-professional team working. Anning et al (2006) point out there is no single line of enquiry, and multiple lines of enquiry and research are needed, that enable us to build a more complete picture and understanding of inter-professional team working. It is argued in this thesis that underpinning a study of more integrated and inter-professional team working is a necessary focus upon how structures might impact upon how practitioners inter- relate when going about their daily business.

It is the aim of this research to further build the evidence base of interagency and inter-professional team working by focusing upon the impact of different levels of team integration upon the lived experiences of practitioners and managers working within such complex environments. Ovretveit's (1993) framework for describing inter-professional teams is a useful tool that enables the researcher to begin such an inquiry.

5.2 Interagency and inter-professional teams: a manifestation of collaboration.

Researchers such as Easen et al (2000), Myers (1993), and Webb and Vulliamy (2001), have consistently stated that interagency collaborations across health and social care are hard to achieve and to sustain. Edwards (2004) suggests that practitioners in interagency teams for children and families come from markedly different traditions, with potentially conflicting goals and values. These values

are, in turn, reflected in increasingly tough, and quite different, systems of accountability in each profession.

However, it remains the case that collaboration through interagency and inter-professional teams is the order of the day, and researchers have a role in attempting to improve our understanding of the factors that both promote and hinder the development and operation of more integrated structures for delivering services. Understanding collaboration as partnerships between individuals and agencies provides the basis for further exploration. Frost (2005) suggests a hierarchy of terms to characterise a continuum of partnership working as:

> "Level 1: cooperation – services work together towards consistent goals and complimentary services while maintaining their independence.
> Level 2: collaboration – services plan together and address issues of overlap, duplication and gaps in service provision towards common outcomes.
> Level 3: coordination – services work together in a planned way and a systematic manner towards shared and agreed goals.
> Level 4: merger/integration – different services become one organisation in order to enhance service delivery." (Frost 2005: 13)
> .

This hierarchy usefully summarises the direction of Government policy over the years, through the different levels, towards integration. This would suggest a belief that the most successful public services are those which can respond to people's needs by working together to effectively integrate services and teams. However, integrated and inter-professional teams are but one solution to the problems of collaboration and coordinating activity to meet the often-complex

needs of people in need of support. They may be described as a frontline vehicle for the delivery of coordinated and integrated services. A general definition of an inter-professional team is:

> "A group of practitioners, with different professional training (inter-professional), employed by more than one agency (multi-agency), who meet regularly to coordinate their work with one or more service user group in a defined area." (Ovretveit, 1993:9)

There are many types of team, each with different membership and ways of matching a person's needs to the skills and resources available. Understanding the differences between types of team is important for service planners to decide which type of team is most suited to the needs of a client population, for managers to effectively manage practitioners and the appropriate deployment of their skills, and finally for practitioners to understand their part and roles in the team. Understanding different types or models of teams also enables researchers to contribute knowledge about which team is most effective in a particular situation.

Ovretveit, (1997) identifies four fundamental ways to describe an interagency team:

- Degree of integration
- Membership of a group
- Process (client/patient pathway)
- Management arrangements

(Ovreveit, 1997:5-9).

He utilises the above categories to evaluate the organisation of interagency teams and classify them as one of the following types:

- The fully managed team: a team manager is accountable for all the management of the work and team members.
- The coordinated team: one person takes on most of the management and coordination of the work, but is not accountable for the supervision of practitioners practice.
- The core and extended team: the core team is fully managed by a team leader with extended or associate team members remaining managed and supervised within their parent organisation.
- The joint accountability team: most team tasks are undertaken by the team corporately, usually through a process of delegation. However, team members remain accountable and supervised by managers in their parent organisation.
- The network association: this is not usually a 'formal' team, but comprises of practitioners working with a common client group and meeting together to coordinate activities. Management and supervision remains within their parent organisation.
  (Adapted from Anning et al 2006:27)

Ovretveit's (1997) typology of interagency teams is adopted by this research as a useful framework against which to understand and analyse the organisation of the teams participating in this study.

5.3   Describing the structures of interagency and inter-professional teams.

5.3.1   Degrees of team integration.

The concept of integration is a matter of degree and may be regarded as a

continuum. The first way of describing a team is in terms of the degree of integration. The concept of degree of integration is best described as a continuum. At one end is a loose knit team called a network – some people may not call this a team because membership and linkages are voluntary. This is usually a group of people providing services to a person at a specific time. They usually work for different agencies, have their own referral routes to access their service and they may not all know each other or meet. However, the services they provide contribute to a shared overall goal of meeting an individual's needs.

 A single person may be tasked with responsibility for ensuring that the contributions of all of the different practitioners are coordinated to meet the person's needs. If this way of organising the delivery of a number of complimentary services was found to be effective, it might not be necessary for different practitioners from different agencies to meet together to coordinate their work.

Halfway along the continuum is a more stable grouping of practitioners, usually working for different services and/or agencies and from different locations but who often meet, usually formally, to communicate and to agree shared goals for people in need of services. People might be referred to the separate services, but their needs may be discussed within the interagency group setting. Each service has its own policies, priorities, and procedures, as there is no agreed and binding common policy. Each practitioner tends to be part of another team and is managed separately to each other. Participation in the network is fluid and there is often no formal leader. One practitioner, from any of the agencies, may be identified to

fulfill a coordinating function to meet a person's individual needs.

At the far end of the continuum is the fully integrated team. In this type of team there is 'one door of entry' to all of the practitioners', one team leader and a single line management structure. There is an agreed set of priorities and objectives and an operational policy that governs the activities of all members of the team. Full integration is not possible when team members are employed by different agencies, because team members remain accountable to their different employers. There are many variations of this type of team according to how the team manages its work. Issues include to what degree is 'the team' separate and accountable in its own right and what is the relation to professional membership and accountabilities?

The above examples describe two ends of a continuum. Teams can be located on the continuum depending upon a number of team structural factors that impact upon the levels of integration. Leutz (1999) also recommends that it is helpful to think of a continuum of organisational and professional leaderships passing from autonomy through co-ordination to integration. Government does not impose a model for the integration of services and inter-professional teams, but advocates that the solution will always need to be arrived at in the local context of what people consider best for those they serve. Clarity of vision and transparency of purpose in all localities and services are recommended by Leutz (1999) as key objectives.

5.3.2 Membership of a group.

In addition to the continuum of integration, Ovretveit (1997:14) maintains that the type of team membership is also a defining feature of inter-professional teams. He made a distinction between a collective responsibility team and a coordinated profession team. Network arrangements are referred to as coordinated profession teams and fully integrated teams are referred to as collective responsibility teams.

In coordinated profession teams the different practitioners have their own formally agreed priorities' and are financed and managed to provide specific services. They are essentially self-directing and accountable to their profession managers and those who are employing them.

In collective responsibility teams, the team as a whole has to manage its collective resource to service a client population, and the team is financed in its own right. Even part-time members of the team, in their team-time, must work to the collective priorities of the team and consider their time as a team resource. Being a member of a collective responsibility team means that the team influences practitioners' day-to-day decisions and this is how the team members make sure that resources are deployed to best effect. The needs of the client will determine how the service responds and mobilises its own internal resources.

It is not self-evident that different practitioners with different and complimentary skills should always come together as a fully integrated inter-professional team to coordinate their work. It may be that separate but coordinated services are the most cost-effective way to organise delivery, so long as they can be easily brought

together when a person needs a number of coordinated services to achieve the outcomes identified. Clarifying membership of a team often marks a transition from an informal loose-knit group to a more formal organised structure. Being able to assign different categories of membership, so as to recognise differences in the group and avoid confusion over role and contributions, helps this transition. The most common membership distinction is between 'core' and 'associate' – usually meaning full-time or more loosely affiliated team members.

Further dimensions of team membership are the more personal aspects of each practitioner – not just their profession specific skills, but their experience, status and seniority. This also can have a significant impact upon how practitioners relate to each other and organise the delivery of their work.

5.3.3   Team process.

A third way of describing an inter-professional team relates to the stages that people in need of services must progress through to access the team, and how certain decisions are made at each stage. For example, in some situations, all referrals are made to the inter-professional team and the full ranges of different practitioners take most or all of the work from a service allocation process. The practitioner may then take the 'case' away and work entirely within their profession and skill base, or they may report back to the inter-professional team for supervision or decision making purposes such as when to conclude service provision. Alternatively, referrals may be allocated within the practitioners' agency and the practitioner then takes the 'case' to interagency and/or inter-

professional networks for the purposes of coordination of effort.

5.3.4   Management arrangements.

The fourth way of describing a team is in terms of the management structure for members of the team: Ovretveit (1997) suggests the following:

> "There are two challenges in creating management structures for multi-disciplinary teams. The first is establishing management, which allows appropriate autonomy for practitioners from different professions with different levels of seniority. The second is establishing responsibility for managing the total resources of the team. Team management is a controversial subject, raising issues of practitioner autonomy and control over their time, self-image and status." (Ovretveit, 1997:25)

In a profession managed structure, practitioners are managed by their managers from the same profession - this structure is most common in network teams. In contrast, in a general manager structure, one manager, irrespective of professional background, undertakes all management tasks for all team members. Practitioners may have access to a profession advisor for certain tasks. There are many variations within these two management structures depending upon team purpose and team management. For example, there may be teams where a single manager has responsibility for the majority of 'core' team members; however, they may also receive input, on a part – time basis, from other practitioners who continue to be managed within their own professional structure.

Willumsen (2008) maintains that interagency collaboration also implies

interactions between agencies which require theoretical consideration. This research also explores the experiences of managers working across health and social care to plan interagency and inter-professional teams. Therefore an analysis of the interagency teams within this research extends beyond the immediate management arrangements of the teams to the interactions between more senior managers.

Analysing where a team lies on these four dimensions will assist the identification of different types of teams and allows for a comparison of their activities and the experiences of practitioners. The ability to describe and distinguish a type of team is important for several reasons; supporting the planning, design and identification of which type of team for a particular population and facilitating research into which type of team is effective or efficient, in what ways and in what circumstances. Finally, the ability to describe a team enables staff to understand what type of team they are joining and how it works.

When attempting to understand the value of concepts such as coordination and integration, it is maintained that team members and service planners must understand how decisions are made, how accountability is determined, what is the collective resource, and how are the most effective methods of resource deployment determined. Addressing such issues at the 'micro' or team level mirrors the discussions highlighted by Rhodes (1997) and Strachan (2005) who refer to the centrality of the governance of partnerships and policy networks and the interplay between governance at the micro, meso and macro levels of collaboration .

5.4   Team working: reviewing the interagency and inter-professional teams included in this research.

In 2001, an NHS Health Trust in Northern England provided child and adolescent mental health services to two separate, but neighbouring, localities, each with a different local authority responsible for organising and delivering children's social care services. For the purpose of this thesis the local authorities will be referred to as the Northern locality and the Southern locality.

The NHS Health Trust and Local Authorities incorporated much of the then current thinking into their CAMHS Development Strategies, initially making use of monies allocated through a NHS Modernisation Fund, the CAMHS Mental Health Grant (MHG) and the CAMHS Innovation Mental Health Grant to local authorities.

The Interagency Northern Development Strategy asserted that a satisfactory child and adolescent mental health service required a wide range of promotion, assessment and treatment provision, and that this was only possible when contributions were available from the full range of relevant agencies. The strategy considered CAMHS to be the responsibility of all agencies working with children and young people and identified the following future vision:

> "Mental Health is a cross cutting priority. We have the opportunity to drive the integration of CAMHS services by building on progress which has been made in many areas. This has included professional, organisational, territorial boundaries and tensions that lead to inefficiency

and stranded service users. It is proposed that all CAMHS services for children and adolescents should operate as a single CAMH service network. This will require new patterns of local partnership." (Interagency Northern CAMHS Joint Development Strategy, 2001:6)

Development strategies are valuable as a list of aspirations, but, as highlighted throughout this thesis, without specific models from which to implement the strategies and configure the services, they are likely to experience barriers to successful implementation. It is suggested that only from a careful process of evaluation of the evidence can a model, or models, be devised that will deliver such a CAMHS strategy and take forward a collaborative approach through more integrated health and social care teams.

5.5   The Interagency Northern Service.

The Interagency Northern locality established a steering group consisting of manager representatives from local health, education and children's social care services. They proposed building upon their current CAMHS provision by establishing an interagency and inter-professional child and adolescent mental health service. The service, referred to in this thesis as Interagency Northern, consisted of two teams and comprised children's practitioners from health, education and social care services. The service provided an assessment function and time limited therapeutic interventions for children, young people and their families experiencing difficulties with their mental health and emotional well being. The service was established as a partnership between Northern Local Authority and the NHS Health Trust.

The interagency and inter-professional team approach aimed to ensure that children and their families did not experience multiple referrals to numerous practitioners in different agencies. All children experiencing difficulties with their mental health or emotional well-being were directed/referred to the team(s), in the first instance, to establish their need for support. In this way it was intended to prevent inappropriate referrals to health, social care and educational services and the duplication of practitioner activity across agencies.

It was also expected that children and families would experience a reduction in multiple assessments from different practitioners in different agencies and would not be placed on the numerous waiting lists for services from different agencies. Families in need of support would experience a rapid response from the Interagency Northern Service by receiving an intervention from an appropriate health, social care or education practitioner at the earliest opportunity, or at the very least they would be rapidly directed to a service, or services, considered appropriate to meet their assessed needs. The Interagency Northern service can be described using Ovretveit's (1997) categories for defining types of teams:

5.5.1 Degree of Integration.

Interagency Northern Service was an interagency and inter-professional service, consisting of social workers, family support workers (social care staff without a social work qualification, but who might possess a qualification in a related field), community psychiatric nurses, health visitors, an education welfare officer, and administrative staff. Two teams made up the service covering different

geographical areas, but roughly mirroring each other in terms of composition, number of practitioners and professional background.

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The two teams were based on different sites in order for them to be accessible to the respective geographical area to which they provided a service. However, all core practitioners within each separate team were located in the same office area. The service had an agreed set of priorities and objectives and an operational policy that governed the activities of all members of the service.

5.5.2   Membership of permanent group.

The core practitioners were permanent members of their teams and service. However, the service also had three members who provided part-time input, but were based within their own uni-profession based teams. These practitioners, identified as 'service associates', included a children's community doctor, a consultant clinical psychologist, and an educational psychologist. Each of the associate practitioners offered different amounts of time to the Interagency Northern Service.

5.5.3   Team Process.

The two teams had their own 'single point of access' whereby all children, young people and their families, living within the respective teams' geographical boundaries, were referred for a service. On a daily basis, any practitioner within each team could be allocated responsibility for receiving and reviewing all new

referrals to their team. The referral was then allocated to the receiving practitioner who maintained responsibility to progress an assessment of the needs of the child, young person and their family. If the practitioner considered that an initial assessment of the situation demanded the skills of a practitioner from a different professional background, they would either approach that person directly or discuss the referral at a weekly inter-professional team meeting where they would seek advice.

The practitioners within the team were therefore expected to undertake many common tasks, irrespective of practitioner/professional background. A minor proportion of their day to day work was spent undertaking tasks that related specifically to their traditional professional roles or backgrounds.

This process did not apply to the associates who did not undertake the function of receiving and reviewing referrals to the service/teams. Their function was mainly in a more specialist advisory capacity. At the weekly team meetings they would offer advice and on occasions would either work jointly with a 'core' team practitioner or undertake a specific and profession based, time limited task in relation to the referral and the needs of the child, young person and their family.

5.5.4 Management arrangements.

For day to day management purposes, the service was located within an NHS Health Trust. The operational management, finance and reporting arrangements were all through the NHS Health Trust. However, there was also an interagency

agency steering group, consisting of representatives from all the services that contributed to the finance and resourcing of the service. This group was tasked with responsibility for overseeing the strategic direction of the service as a whole, reviewing progress and agreeing service priorities.

The social care practitioners from Interagency Northern Local Authority were all seconded, on time limited agreements, to the NHS Health Trust. Their salary and employment terms and conditions all remained with Interagency Northern Local Authority. The health practitioners all remained employed by the NHS Health Trust, although they were all seconded, on a time limited basis, from their substantive post, within the NHS Health Trust, to the Interagency Northern Service.

The two teams had a single management structure with all the core practitioners receiving management and practice/clinical supervision from within their team or the service. One team manager was seconded from Northern Local Authority, with a background in social work and the other team manager was seconded from the NHS Health Trust, with a mental health nursing background. The team managers offered both managerial and practice/clinical supervision to all team members. Some practitioners received mentorship from practitioners external to the interagency service, but located within the parent agency from which they had been seconded.

The team associates did not have a secondment arrangement with the interagency service and maintaining supervision within their own profession based service.

Adopting Ovreveit's (1997) typology for describing inter-professional teams, Interagency Northern Service could be described as more closely aligned to a core and extended team. All core team practitioners were fully managed, and received their practice supervision, from within the Interagency Northern Service. All core practitioners would undertake core team tasks, with the work of the associate practitioners being coordinated by the team manager. The team can be visually represented in the following way:

Figure 2

Interagency Northern Service: core and extended teams.
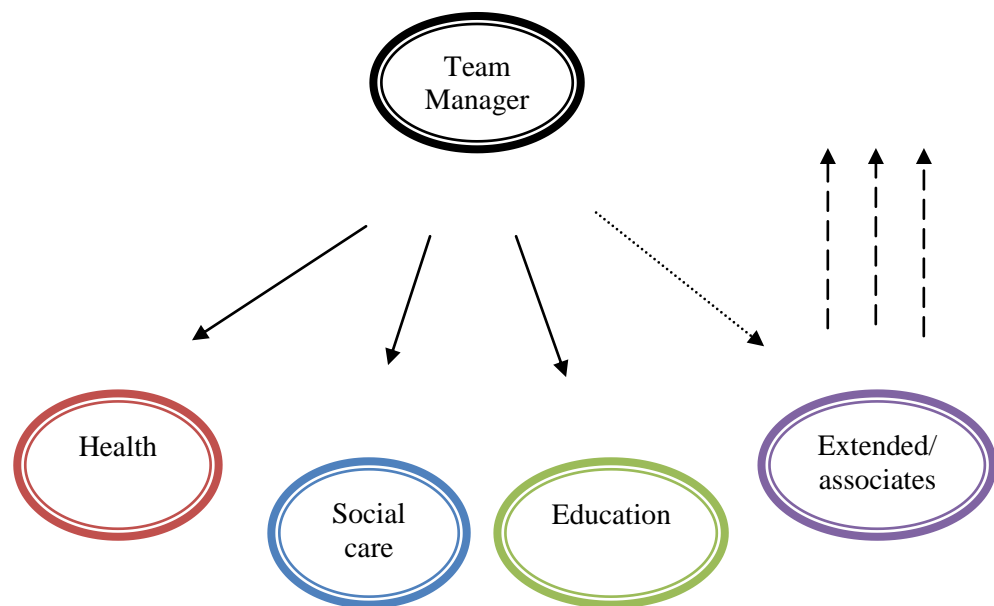
Key for lines of accountability:

——————▶ Full Line Management

– – – –▶ Supervision/practice support

········▶ Coordination of work

**5.6	The Interagency Southern Service.**

In parallel to developments between the NHS Health Trust and Interagency Northern Local Authority, the NHS HealthTrust also provided a CAMHS service for the Southern Local Authority. The NHS Health Trust and Southern Local Authority adopted a different approach to delivering more integrated support services to children and families.

Interagency Southern Service was developed at the same time as Interagency Northern Service and consisted of three teams, based in three different geographical areas within Southern Local Authority. The function of the service was somewhat wider in scope than that of the Interagency Northern Service. It was established to provide more coordinated and integrated family support to children, young people and their families, including child and adolescent mental health services.

Emotional well being and mental health difficulties were not the primary criteria for access to the service. It was established to undertake assessments of the needs of children, young people and families and also to provide a full range of interventions to support families experiencing a wide range of social, housing, financial, emotional and health difficulties.

It was the intention of the service to ensure that families could receive support and guidance from a single, more integrated service, thus avoiding the experience of being 'passed around' different agencies before receiving a service they required.

Families would therefore avoid the experience of multiple assessments, being placed on multiple waiting lists and experiencing contact with multiple practitioners from different agencies.

5.6.1   Degree of integration.

Interagency Southern Service consisted of qualified social workers, family support workers, health visitors, community psychiatric nurses and benefits advisors. The three teams did not consist of exactly the same mix of practitioners, but roughly mirrored each other in terms of composition and size. All the practitioners in each separate team were co-located in the same office but within their separate geographical areas within the Southern Locality. The service had an agreed set of priorities and objectives and an operational policy that governed the activities of all members of the team.

5.6.2   Membership of permanent group.

There was a core membership of social care practitioners who were permanent members of the teams and who would undertake all core team tasks. The team also consisted of health practitioners, including health visitors and community psychiatric nurses, who were located within the team. The health practitioners received management supervision from the team manager, primarily for the allocation of their work. However, practice or clinical supervision was provided from a health practitioner within their parent or seconding agency.

The health practitioners did not usually undertake all the team's core tasks, with a tendency to focus upon working within their own specific and professionally based skill set. The service also comprised of associate members who were located within different teams or services, but provided an amount of 'sessional' time to the Interagency Southern teams. The team managers had varied professional backgrounds including social work and health visiting.

5.6.3 Team process.

The three teams operated a 'single point of access' through which a full range of agencies could refer children, young people and families for support. Similarly, the teams offered a single point of contact for children, young people and their families so they could approach the team directly for advice and support in relation to a full range of health and social care needs.

However, in contrast to Interagency Northern Service (receiving all referrals for children young people and their families in need of support for mental health and emotional wellbeing issues), it remained the case that children and families experiencing mental health difficulties were referred by agencies to the local Child, Adolescent and Mental Health Service provided by the NHS Health Trust.

Social care practitioners were mainly responsible for the 'core' tasks of the service. The social care practitioners would receive referrals to the team on a daily basis. The social care practitioners would then progress an assessment of the

needs of children, young people and their families, and maintain continued responsibility for supporting the children and families allocated to them.

The community psychiatric nurses in the teams did not undertake the 'core' tasks of the service, such as receiving and progressing initial assessments of referrals, and they did not hold allocated responsibility, on behalf of the team, for progressing the overall plans to deliver support to the children young people and their families. Their role was specifically to provide advice and guidance to the rest of the team in relation to child and adolescent mental health or issues associated with promoting emotional health and well being. They would work jointly with children, young people and their families alongside other members of the team who had been allocated 'case' responsibility for the child, young person and their family.

There were variations in function of some practitioners across the three teams. For example, in one team, the health visitor operated very much like the social care practitioners, undertaking many of the core team tasks. In another team, the health visitor did not undertake core tasks such as receiving referrals to the team, but was allocated 'case' responsibility for children and young people in need of their profession specific skills only.

Interagency Southern Service did possess a number of associate team members. They provided a specific input to the teams that related to their area of professional expertise. Examples of associate members included practitioners providing benefits advice, youth employment and career advice and education

welfare advice. They offered sessional input to the teams and were located within other uni-professional teams, usually in different agencies.

At the time of undertaking this research, Interagency Southern Service was in the process of expanding the inter-professional nature of provision by seeking to recruit practitioners who could offer advice around services available for children with disabilities and youth offending issues.

5.6.4 Management arrangements.

For the purpose of service management, Interagency Southern Service was located within Southern Local Authority Social Services Department. This was in contrast to Interagency Northern Service where management arrangements were located within the NHS Health Trust. Interagency Southern Service also had a multi-agency steering group, consisting of representatives from the different agencies contributing resources to the service. This group was tasked with responsibility for overseeing the strategic direction of the service as a whole, reviewing progress and agreeing service priorities.

The social care practitioners in the service were all employed by Southern Local Authority. Their salary and employment terms and conditions all remained with the local authority social services department. The health practitioners were all seconded from the NHS Health Trust on time-limited contracts. Their salary and employment terms and conditions all remained within the NHS Health Trust from which they were seconded.

The service had a single management structure, with all core practitioners receiving management supervision from within the teams and service. There was a clear distinction made between management supervision, concerned with the deployment of resources, and practice or clinical supervision, concerned with professional practice. The health practitioners considered it necessary to receive clinical supervision from persons within their own profession and from within their parent organisation, that is, the NHS Health Trust.

One team manager, with a background in health visiting, was seconded from the NHS Health Trust and the other two team managers originated from Southern Local Authority social services department with a background in social work. All the team managers were accountable to the Southern Local Authority Social Services Department.

Adopting Ovreveit's (1997) typology for describing inter-professional teams, Interagency Southern Service could be described as more closely aligned to a coordinated team, with the work of the health practitioners being fully managed by the team leader but not their supervision/practice. The work of extended or associate team members was coordinated by the team leader but not their supervision/practice. The team can be visually represented in the following way:

Figure 3

Interagency Southern Service: coordinated teams.
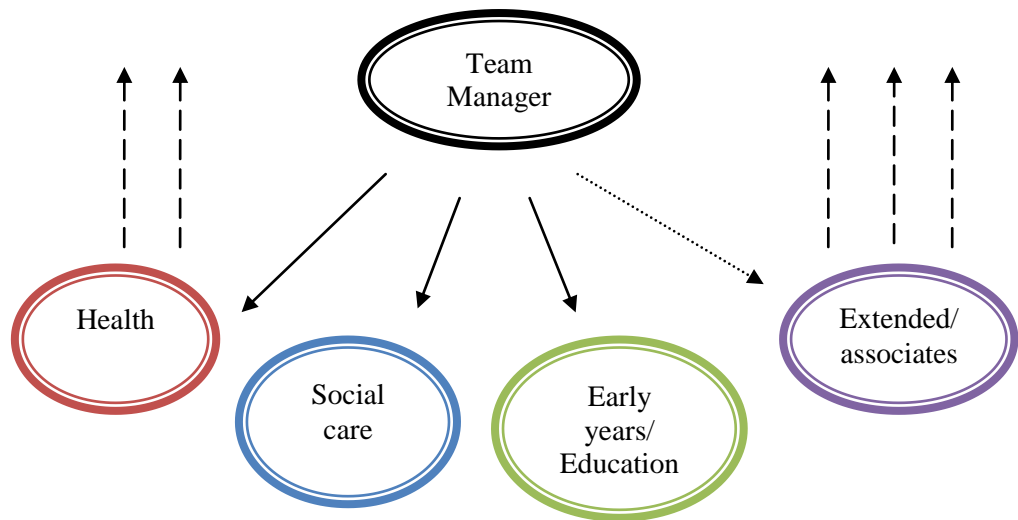
Key for lines of accountability: ———————▶ Full Line Management

　　　　　　　　　　　　　　　　　　　　 – – – – ▶ Supervision/practice support

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The following table represents a comparison of the different functions, locations membership and organisational structures of Interagency Northern and Interagency Southern Teams:

Table 6

 Comparing Interagency Northern Service and Interagency Southern Service

team types.

Service	Client group needs	Team membership	Lead agency	Agencies represented	Governance	Team type
Interagency Northern	Children and families in need of support from Child and adolescent mental health services and promoting emotional wellbeing	Core practitioners co-located in a community setting. Associate practitioners providing sessional input.	NHS Health Trust	Health, Social Care, Education	Senior stakeholder/ partnership steering group	Predominantly core and extended Team type*
Interagency Southern	Children and families in need of support in relation to social care needs, including mental health and emotional well being	Core and coordinated practitioners, co-located in a community setting. Associate practitioners providing sessional input.	Local Authority Social Services	Health, Social Care, Education, Benefits Agency	Senior stakeholder/ partnership steering group	Predominantly coordinated team type*

* Team types are not intended to represent 'pure' categories and different teams

can contain different elements of different categories.

(Adapted from Anning et al 2006:31)

Table 6 illustrates the main differences between the teams that comprise the two

interagency services. It can be seen that the main differences pertain to the team

membership and the lead agency for the service; resulting in the different team

type categories assigned. Although not strict categories, Interagency Northern and

Southern Services have been analysed as conforming to two different team types;

a core and extended team and a coordinated team respectively.

To summarise, the differences between the organisation of the teams within the

two services are reviewed: both services were inter-professional consisting of core

groups of practitioners, based in single teams, and with a single line management

structure. Managerial supervision remained within the services, although, for

Interagency Southern Service, the health practitioners received clinical or practice

supervision from professionals from the same discipline and from within their

seconding or 'parent'agency, that is, from outside of the 'host' agency for the

service.

There were different levels of integration between the services in relation to

practitioners and the tasks or functions they were expected to fulfill. Interagency

Southern Service displayed greater differentiation between practitioners and their

roles and tasks, these being more closely aligned to their profession specific

background and skills. In contrast, practitioners within Interagency Northern

service displayed a greater level of integration through devoting the majority of

their time to undertaking core team tasks.

The differences between the services were most clearly illustrated when the roles

and tasks of the Community Psychiatric Nurse were compared. Interagency Southern Service defined their roles and tasks as more clearly, aligning them to their professional background. Their clinical supervision remained outside the service and within the NHS Health Trust's Child and Adolescent Mental Health Services.

Both services comprised a similar practitioner mix of health and social care staff. Interagency Northern Service was hosted within the NHS Health Trust, with local authority practitioners seconded into the service on temporary contracts. In contrast, Interagency Southern Service was hosted within Southern Local Authority, with health practitioners seconded into the service on temporary contracts.

Each of the two services possessed associate team members, offering sessional input to the teams and focused around their own professional expertise. The associates were not usually physically located within the teams, belonging to other uni-professional teams located within other services or organisations.

Interagency Northern and Interagency Southern Services both developed a single referral process for children, young people and their families. As already reported, the differences in levels of integration between the services pertained to the ways in which core and more specialist tasks were undertaken by the different practitioners, depending upon their professional backgrounds.

Interagency Northern and Interagency Southern Services were both physically

located within single agency settings; a health and a local authority setting respectively. Practitioners were seconded from their 'parent' agencies to the interagency services on time limited contracts. As a consequence, there were differences in both services between practitioners' employment terms and conditions and their salaries.

Both services had single line management structures, although practice/clinical supervision in Interagency Southern Service was more closely aligned to professional/practitioner background from their 'parent' or seconding agency. Team associates operating within both services received completely separate management and supervision arrangements within their own uni-professional service and agency setting.

Each service reported activities and progress to a senior management steering group consisting of representatives from different health and social care agencies. The groups had strategic oversight of the progress of the services rather than a day to day operational management role.

Utilising Ovretveit's (1997) typology for describing and classifying interagency teams, it can be concluded that Interagency Northern Service was more integrated than Interagency Southern Service. There is no value statement associated with this analysis of the teams: however, it is maintained that it is useful to understand the structural differences between services and where they sit on the cooperation – integration continuum. Such an analysis offers the opportunity to study the impact of different interagency structures and processes upon collaboration and

the context within which interpersonal and inter-professional relationships develop.

5.7   Summary.

This research is concerned with interagency collaboration at the level of integrating inter-professional teams in children's services. It addresses collaboration on two levels: between practitioners working within integrated teams at an interpersonal level, as well as between managers on an interagency and interpersonal level.

This chapter has reviewed the research literature into interagency and inter-professional team working. Factors are identified that both support and hinder the attempts of practitioners from different professional backgrounds and from different agencies to work collaboratively within an inter-professional team. Ovretveit's (1997) typology for describing inter-professional teams is reviewed and applied to the teams that comprise the interagency services participating in this research.

The teams within the two interagency services are then compared in relation to the degree or level of integration of working practices. It is suggested that such a detailed description of the structure and processes of the teams, and an analysis of their levels of integration, will enable a more developed understanding of the context within which practitioners and managers express their experiences of interaction. It will then be possible to consider 'degree of integration' as a

potential factor that influences managers and practitioners experiences of interagency working and inter-professional teams.

The following chapter discusses the methodology by which this research project elicits the experiences of practitioners and mangers when collaborating to deliver interagency services through inter-professional team working.

6.   Determining the research methodology.

This chapter aims to describe the rationale for undertaking this research and describes the chosen methodology. The research process begins by asking a research question: that is, what do you want to find out? Once this is established, the research methodology and the research methods can be determined.

The desire to undertake this research project was influenced by the researcher's employment as team manager within Interagency Northern Service. Very soon after taking up employment in the post, the challenges of managing such a team became apparent. Issues requiring attention included, for example, managing relationships and roles between practitioners who had never worked within such an integrated operational setting. Further examples included managing relationships between, and with, senior managers from the different agencies, all with an interest in the work of the service and how it would impact upon their own agency's delivery of services.

The researcher was also aware of service developments within a neighbouring authority, Interagency Southern Service. Having established contact with colleagues managing teams within Interagency Southern Service, it was apparent that they were experiencing similar challenges. However, there were also differences between the services and how they were organised, particularly in relation to levels of integration as described in the previous chapter.

A review of a broad range of literature documented many of the challenges of

interagency and inter-professional team working, but there was little research or guidance that answered the following question:

Does the organisation and levels of integration of inter-professional and interagency teams have an impact upon the experiences of practitioners and managers working within them?

This emerged as an area of research interest for the researcher and was identified as the overarching question guiding this research project. In order to respond to this question, the following sub questions are identified as specific areas of interest for this research:

- What are the benefits and challenges for practitioners and managers working within interagency and inter-professional teams?
- Are the benefits and challenges influenced by the different models of integration?
- How can theory be used to develop understanding of the underlying issues that prevent or promote the delivery of more integrated children's health and social care services?
- What are the practical strategies that will improve practitioners and managers experiences of collaborating, organising and delivering more integrated services for children and families?

It was anticipated that the outcomes of this research would have a practical application to the real world by contributing knowledge to further develop an understanding of the challenges of, and opportunities for, service integration, and

the impact of different organisational team structures. This understanding could then be utilised to inform a wider body of knowledge aiming to develop strategies in support of reducing the enduring gap between policy aspiration and more successful policy implementation in the field of collaboration and service integration across health and social care.

The discussion of methodology is important to any research project because it is the framework through which data is collected, presented and analysed. This framework guides the researcher throughout the entire process and the logic of its design will inevitably influence the validity of the findings. Issues such as appropriateness, justification, and replication are of key importance to any research project.

Punch (1998) argued that to be appropriate and innovative at the same time, the chosen methods need to reflect the relationship between the objectives of the study and the actual methodological tools used for collecting and analysing the data. It is therefore necessary to justify the approach based on their stated merits in preference to other possible approaches.

To be innovative poses significant challenges to the researcher. To be innovative and contribute new knowledge to the field of inquiry does not always mean a paradigm shift in terms of method. It more often than not entails a more realistic examination of data in different ways. For example, the manipulation of existing methodologies can confirm the findings and increase the validity of existing data. It can yield new and richer data that adds different insights into the phenomenon

under study. However, the limitations of the approach must also be made explicit.
It will then be possible to assess if the methodological innovation and associated
findings are useful and, by extension, if any additional contribution was made to
knowledge in the field of inquiry.

6.1   Utilising quantitative and qualitative methodologies.

Punch (1998) argued that scientific enquiry has two essential parts: Part one is the
collection of empirical data and part two is the role of theory, particularly theory
which explains empirical data. The building of theories in the physical sciences
usually results from carefully managed and restricted observations and
measurements. In the social sciences, attempts at understanding human
interactions and behaviours are often based on observations and data collection in
relatively less well controlled circumstances. Black (1999) viewed quantitative
and qualitative research in social science as an ongoing process of refining models
and consequently any explanation is the best possible at any time, based on
available information.

Black (1999) states that a hypothesis can be explained as an expression of the
anticipated outcomes, as predicted by a given theory, or the expected
consequences, of an application of principles to a situation. Statistics can tell us
whether the outcomes we see would have happened due to some causal
relationship or simply by chance alone. The null hypothesis simply states that no
significant difference is expected between what we observe and what would
happen by chance alone.

There is a general deficiency of research findings to determine the existence or nature of the relationship between the stated experiences of health and social care practitioners and managers and the extent of integration of the teams within which they were working (extent of integration is defined in chapter five and is based upon a number of descriptive, structural and organisational factors). Therefore this research project asserts the following null hypothesis:

> "There are no differences between the stated experiences of health and social care practitioners and managers and the extent to which the teams or services they are working in are integrated."

The following diagram illustrates how this research project could build knowledge of relationships between variables and provide further lines of enquiry.

Figure 4

Researching interactions and their relationships with variables.
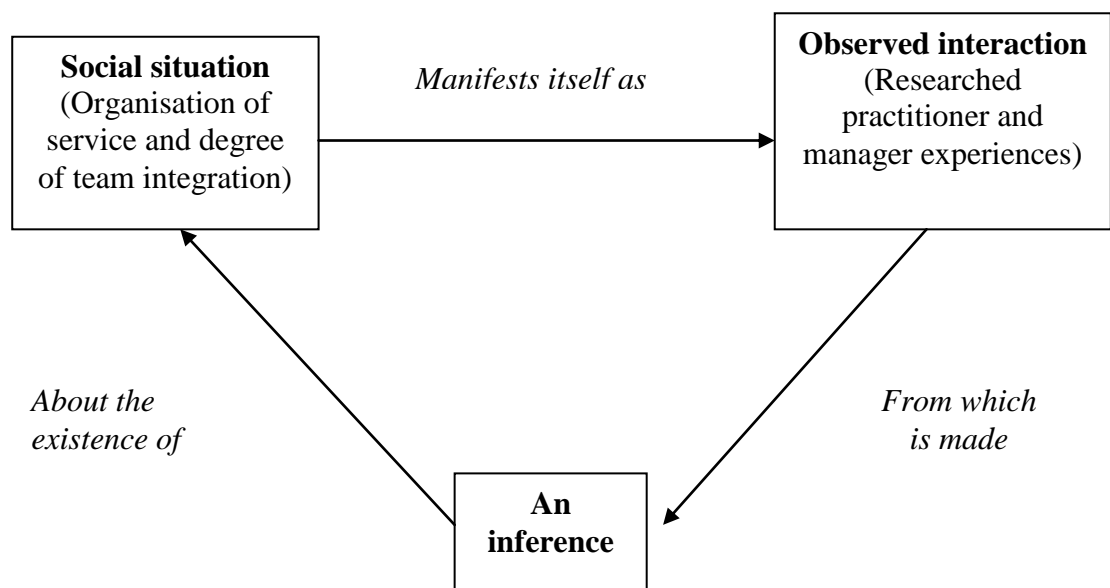
(Adapted from Black, 1999:34)

When researching an observed interaction between variables, a distinction is usually made between two approaches to data collection and analysis: the quantitative and the qualitative. Clarke (2001) states that it is common to find these two approaches presented as representing divergent and opposing research traditions in the social sciences. Emphasis is placed on the differences in philosophical assumptions made about the nature of reality and the relationship between the researcher and the researched. The debate is characterised as positivism versus interpretivism. Clarke (2001) states that:

> "According to the positivist tradition there is an objective external world that exists independently of human perception, which is amenable to quantitative measurement." (Clarke, 2001:32).

The positivist approach maintains that the aim of research is to develop valid and reliable ways of collecting facts about society, which can then be statistically analysed in order to produce explanations about how the social world operates. The researcher must adopt methodologies that safeguard against bias by limiting the amount of contact between the researcher and the researched and by controlling, as far as possible, the 'experimental conditions'. Quantitative data is utilized to build up a picture that constitutes unassailable evidence of the 'truths' of the external world.

Qualitative research is based within the interpretivist tradition and adopts a different set of philosophical assumptions concerning the nature of reality and the role of the researcher. The qualitative researcher therefore does not attempt to uncover objective 'truths'. Instead, attempts are made to discover the subjective

worlds of individuals and their constructions of reality through the use of methods that enable them to get close to their subjects in their natural surroundings.

Punch (1998) considers that the distinction between qualitative and quantitative methods is one of emphasis, not of discrete differences, and offers practical suggestions for dealing with the choice of qualitative or quantitative methods (or both):

- Examine the research question and the way it is phrased - what are the implications for data?
- Are we interested in making standardised comparisons, quantifying relationships between variables and accounting for variance? Alternatively, are we more interested in studying a phenomenon in detail, holistically and in context, focussing on interpretations and processes?
- What guidance do we find from the literature about this topic on this methodological question?
- What are the practical consequences of each alternative (including resources)?
- Which way would we learn more?
- Which sort is more 'my style'?

(Punch 1998:52)

In order to clarify the nature of inquiry and data collection, the suggestions made by Punch (1998) were considered in relation to the research question identified earlier in this chapter. The researcher was in a position to gain access and meet with practitioners and managers within both Interagency Northern and Interagency Southern Services. This access to local networks offered the opportunity to explore the thoughts, attitudes and feelings of health and social

care practitioners and managers working within teams offering family support services, including services to promote child and adolescent mental health and emotional well being.

The additional value of this research to the research literature was to undertake the study within a single methodological framework and analyse the findings in relation to assessed levels or degree of service/team integration, which is locating them in different places along the continuum of coordination to integration. The methodology demanded by the research question which focuses upon practitioners' attitudes, experiences and views is essentially subjective and qualitative in nature, demanding a qualitative approach to data collection. The interviewing of health and social care practitioners and managers, from two separate children's services and their associated teams, was therefore chosen as the preferred research methodology to add in-depth knowledge and practical research information to the current collaboration and service integration agenda.

Such an approach is considered to be appropriate as it offers the opportunity to add to the field of knowledge in this area by making qualitative comparisons between the experiences of practitioners and managers working within similar service models but within structures and processes that allowed identification of different levels of integration. This research was also undertaken in the context of children's services working to promote mental health and well-being where research into the experience of integrating teams is limited, Salmon (2004), Anning et al (2006). Knowledge of theoretical frameworks in relation to both interpersonal dynamics and interagency structures and processes, as outlined in

Chapter Four, would also seem to be an essential component of this research.

6.2   Reliability, validity and the reporting of outcomes.

Reliability and validity are key methodological concepts used in positivist research**.** Reliability is about whether a measure works in a consistent way and validity is about whether the right concept is measured (May, 1997). Both of these concepts are used to measure objective truths. However, in qualitative research it can be argued that there are no objective truths.

Black (1999:29) states that it is frequently assumed that all research only aims at establishing cause and effect relationships between variables. Using a scientific/positivist approach to resolve the validity of a hypothesis suggests not only the need to understand the relationship among variables, but also to extend the relationship to a wider population. However, in the social sciences, causality is extremely difficult to establish. Black (1999) maintains that in the multivariate world of human activity there are many non-causal relationships among variables such as correlations. Such correlations may provide clues to the eventual establishment of causal relationships. Social science theories therefore can help to provide possible explanations of tendencies or actions of groups with common characteristics.

As already stated, the focus of this research is the individual attitudes and experiences of health and social care practitioners and managers working within interagency and inter- professional services. Therefore the independent variable

identified is the work location of the practitioner and manager, that is, Interagency Northern Service or Interagency Southern Service and the dependent variable is practitioner or manager background (health or social care). Both are nominal variables based upon the personal circumstances of the respondents. The variables are represented in the table below.

Table 7

Representing the key variables of this research.

	Health practitioners experiences	Social care practitioners experiences	Health managers experiences	Social care manager experiences
Interagency Northern				
Interagency Southern				

At the conclusion of the research it is anticipated that it will be possible to assert the existence of a relationship, or not, between the variables. Therefore, this research is concerned with observing relationships and constructing a theoretically based explanation of the nature of such relationships, that is inductive in approach. However, a causal relationship between practitioner and manager professional background and degree of team integration will not be attempted due to the possible presence of intervening variables. Examples of other intervening variables might include practitioners' previous work experience and the amount of time spent working within a team.

Flick (1998) suggests that reliability and validity as key concepts must be redefined. He argues that trustworthiness and credibility should replace reliability and validity. The rigour of the research process is defined in terms of the transparency of reflection and presentation of methodological proceedings. Thus, the reporting of the research is a crucial activity and its rigour is essential to the evaluation of the research outcomes.

The task then becomes how to report qualitative research findings. In the traditional model of research writing, the 'write up' does not 'get done' until the research is completed. A different view sees writing as a way of learning, a way of knowing, a form of analysis and inquiry. Writers interpret, so writing is a way of learning, through discovery and analysis. Thus writing becomes an integral part of research and not just an 'add on' once the 'real' research is completed. This is 'writing to learn' (Punch, 1998:279). Flick (1998) states that only through such a rigorous approach to reporting can we learn, generalise and generate knowledge.

6.3   Undertaking qualitative research methods in the context of this study.

Coghlan and Brannick (2001) argue that the purpose of academic research is not just to describe, understand and explain the world but also to change it for the better. There was an expectation from both the researcher and their employer that any research would make a useful contribution to the agency. It was therefore necessary for the researcher to negotiate with the employing agencies a research project that would explore a research question that would be of practical, real world benefit and would meet both their own, and the agency's needs.

The researcher's discussions with practitioners and managers from Interagency Northern and Interagency Southern Services had revealed tensions emerging from attempting to integrate the teams within the services. It was agreed by both the NHS Health Trust and the two local authorities that such a study could contribute insight into the underlying issues that jeopardised the success of the services. Therefore, the potential of the research to meet both the agencies' and researcher's needs was acknowledged.

The decision to interview practitioners and managers from different employing agencies would require the consent of both the individuals who were to be interviewed and of their employing agencies. Therefore, the research proposal was placed before the local NHS Health Trust research ethics committee and was compliant with their *Framework for Research Governance in Health and Social Care.* In addition, the social care senior managers from the Northern and Southern localities received a letter requesting that their agencies give permission for social care employees to take part in the research.

Approval was obtained from the NHS Health Trust's Ethics Committee and the senior managers representing the social care organisations. An information sheet was subsequently devised for prospective interviewees, describing the purpose of the study and why they had been invited to participate. The sheet went on to outline the process that would take place and what was required of the interviewees should they agree to participate (the sheet is included in Appendix A).

Confidentiality was assured as all interviews would be transcribed by the researcher only, assigned a code, and any quotations utilised in any report would not include information that would allow it to be traced back to an individual. In addition, an informed consent sheet accompanied the information sheet and was supplied to all those who agreed to participate (refer to Appendix B). Each participant then signed their agreement to take part in the research.

6.4   Choosing the research participants.

The aim of most research is to make the sample representative of the population from which it was selected. All empirical (quantitative and qualitative) research involves sampling and it is necessary to ask the question who or what will be studied? The appropriate sampling plan for a study depends very much on what the study is trying to find out, and on its strategy for achieving that. For quantitative research, care needs to be taken to indicate whether the sampling strategy is probabilistic (if representativeness is important) or purposive (to describe the relationship between variables).

A sampling frame is the list of people within the population under investigation and is used to select the sample. However, small scale qualitative research is often based upon small samples drawn from local areas, and therefore using a probability sample is often unrealistic. Within the context of this research, purposive sampling involved the selection of all practitioners and managers working within Interagency Northern and Interagency Southern Services, with a total of twenty five practitioners and managers, out of a possible thirty four,

agreeing to participate.

Of the twenty five people, six managers participated. Two health managers and one social care manager represented Interagency Northern Service and two social care managers and one health manager represented Interagency Southern Service. The remaining nineteen participants consisted of the following:

Interagency Northern Service:

Six health practitioners (community psychiatric nurses, health visitors and a psychologist)

Four social care practitioners (social workers a family support worker and a practitioner with a background in education services)

Interagency Southern Service:

Five health practitioners (community psychiatric nurses and health visitors)

Four social care practitioners (social workers and family support workers)

The request for participants was through an open invitation to all practitioners and managers working within the teams that comprised both Interagency Northern and Interagency Southern Services. There was no follow up by the researcher to establish the reasons for nine participants not responding to the invitation to participate.

6.5   Undertaking research interviews in the context of this research project.

The purpose of most qualitative interviews is to derive interpretation, not facts or laws, from the respondents' words. Qualitative interviewing is considered to be a kind of 'guided conversation' (Arksey and Knight, 1999) in which the researcher carefully listens. The researcher then uses their interviewing skills in an attempt to uncover explanations, understanding and meanings. Fielding & Thomas (2001) state that:

> "Sociologists have always been interested in the attitudes and beliefs of social groups, and much methodological refinement has come about by engaging with the problems posed by trying to get at other people's feelings. A key method of attitude research is the interview". (Fielding and Thomas, 2001:123)

Arksey and Knight (1999) maintain that research has the most power when the choice of methods is deliberate, and where interviews are one of the chosen methods, where full thought has been given to the goals and to the type of interviews that will be used.

> "Interviewing, we suggest, is not a research method but a family of research approaches that have one thing in common – conversation between people in which one person has the role of researcher. Choosing the most appropriate interviewing approach is a skilled activity, one that involves taking a stance on some complex and important debates about the nature of research in the social sciences" (Arksey & Knight, 1999:2)

The choice of interviewing methods was therefore made by reviewing the options available. Unstructured interviews are when the interviewer simply has a list of topics they wish to explore. The interviewer is free to phrase the questions as they

wish, ask them in any order and even join in the conversation by discussing their views. Such an approach is very much suited to more exploratory research.

Semi-structured interviews, as opposed to unstructured interviews, were chosen as the preferred research method to generate qualitative data. Research literature into collaboration, service integration, and interagency and inter-professional team working has been discussed in earlier chapters. The literature provided a basic framework through which topic areas and themes could be identified and formulated into questions that would focus the path of the interview. Such an approach guides the respondent to the area of investigation and avoids a more general conversation that might not actually address the topic of concern for the research.

The benefits of a semi-structured interview format are that it also offers a framework that allows for some comparability of participants' responses. Therefore, separate interview schedules for both the practitioners and managers (reflecting their different working context/environment) were developed by the researcher that contained key questions and prompts based upon themes that had emerged from a review of the research literature (refer to Appendices C and D). Such a format allows the interviewer to follow up ideas, probe responses and seek clarification and further elaboration, but within a consistent framework for analysis.

It is important for the interviewer to allow the participants to respond freely to the questions posed and to only utilise prompts with care and in a consistent manner,

which is, adopting the same phraseology within each interview situation. Allowing participants to choose what they want to say in response to a particular question, irrespective of the research literature findings, enables the researcher to identify and develop any new emerging themes that existing literature has not already established.

Such a qualitative approach concentrates on understanding the thinking and behaviours of individuals and groups in specific situations. Qualitative research recognises that accounts of human thought, feeling and experience do not apply to all people at all times and that they do not necessarily allow predictions to be made in the way that they are made in the positivist natural sciences.

The questions were also formulated to facilitate an analysis of responses across all four domains identified from Benson's (1975, 1983) approach to inter-organisational networks (as discussed in Chapter Four). Benson (1975, 1983) focused upon the patterns of interaction that derive from agencies collaboration in the performance of their core functions. For Benson (1975, 1983), the interaction can be understood in terms of achievement of equilibrium across four key dimensions: Domain Consensus (agreement regarding the appropriate role and scope of each agency); Ideological Consensus (agreement regarding the nature of tasks faced and the most appropriate way of approaching these tasks); Positive Evaluation (by workers in one agency of the work of those in others); and Work Coordination (alignment of working patterns and culture).

For example, a question within the practitioners semi-structured interview

schedule asked the interviewee:

"Can you describe the structure of the team that you work in?"

This question is underpinned by Benson's (1975, 1983) Work Coordination dimension, and is designed to elicit responses that would explore the extent to which there is agreement regarding how the team organised their work. In this way the semi-structured interview schedule was designed to ask questions that would facilitate analysis across all four of Benson's (1975, 1983) dimensions. Such an approach would then allow the researcher to review the data within a framework that considers different aspects of interagency and inter-professional team working and levels of equilibrium achieved within the different interagency teams.

The interview schedules were piloted on three people who were not participating in the research – a mental health practitioner working in an inter-professional young peoples support service, and a social care practitioner working within the same team. The third person was a manager of an interagency and inter-professional project for sexually aggressive young people.

The pilot interviewees were chosen because of the similar nature of their professional background to the participants in the research project; that is a children's community psychiatric nurse, social worker and a manager of an interagency service for children. The research interviews with the three people revealed remarkably similar themes emerging in relation to the research literature

and to the experiences of the researcher. Feedback regarding the interview schedule and sequence of questions was sought from the pilot interviewees and the interview schedules were altered accordingly. For example, one of the pilot interviewees considered it difficult to know how to respond to the question "can you describe your contribution to the work of the team?" She suggested clarity would be improved if the question asked the interviewee to identify their role in the team, and the schedule was altered accordingly.

Having established the interview schedule, a date was agreed with each research participant to undertake the interviews in a confidential environment. All participants chose to be interviewed within their workplace during their normal working hours. All interviews with the twenty five participants, across the two interagency services, were then undertaken by the researcher, recorded on a tape recorder and transcribed by the researcher. Notes were taken with observations to supplement the interview process – this included a general reflection at the end of each interview regarding the flow of the interview and perceptions of how the interviewee had responded.

The limitations of the methodological approach, highlighted by Arksey and Knight (1999), are that qualitative methods reflect views that knowledge in social sciences is provisional, uneven, complex and contexted. They point out that what people claim to think, feel or do does not necessarily align well with their actions. Therefore it is important to be clear that interviews capture what people say, however sincerely, and not necessarily what they do. The general point is that a verbally expressed attitude will not be the sole determinant of either the verbal or

non-verbal behaviour, and strong relationships can be expected only if the entire situation is analysed. Proctor (2001) states:

> "A verbal statement is therefore only a behavioural indicator of an attitude and the attitude-behaviour problem is really just one aspect of the more general one of imperfect relationships between different behaviours." (Proctor, 2001:107).

One implication is that in order to know what people do, observational methods could be deployed in addition to interview methods. Consideration was given in this research to adopting more quantitative methodological approaches, for example the use of observational methods, surveys or questionnaires to supplement the qualitative interview data. However, different methodological paradigms have different perspectives in relation to the reduction of qualitative data into quantitative data and positivist interpretations. Krueger (1998c) advises that statistical procedures cannot compensate for ambiguity in questions or responses:

> "Surveys that reduce reality to numbers have inherent flaws in communication – some more than others. This does not mean that we should abandon statistical analysis but, rather, that we should recognise the inherent assumptions and treat all data that measure human experiences with adequate humility." (Krueger 1998c:6)

Rosenblatt (2002) explores the value of qualitative research if the outcomes are so subjective and situational. He states that conducting interviews enabled him to get at something like the truth. When, for example, bereaved parents told him about their grieving process, he was not simply hearing each single story in isolation. He

heard similar stories from many bereaved parents and concluded that he was learning something about parental grief. Rosenblatt reported:

> "Every person I have ever interviewed seemed to believe in truth and to try hard to deal with the truth. They all talked as though there is a reality to be known and told (or withheld). So even if we as interviewees are postmodernists, the social construction of our interview interactions is to some extent driven by truth and essentialism." (Rosenblatt, 2002:895)

It is not the intention of this research to establish 'the truth' behind each participant's responses, or to make standardised comparisons, quantifying relationships between variables and accounting for variance. This research focuses on the qualitative and varied responses of individual practitioners to the circumstances in which they found themselves to be working. Therefore, to add methodological rigour, an alternative qualitative methodology was considered by the researcher to be appropriate.

6.6   Developing a strategy for data triangulation.

Arksey and Knight (1999) suggest that the charge of relativism of an embedded subjectivity, which is contrasted to the supposed neutrality of positivist research, can be met when the interviewer can warrant that the research is systematic enquiry and that the picture that is presented is authentically grounded in a careful study of a social phenomenon or situation. Macdonald (2001) describes triangulation as the process of using multiple perspectives to interpret a single set of data. It is useful because it tests one source of information against another to strip away alternative explanations and prove a hypothesis. It helps the researcher

to refine the hypothesis and explanations by seeing or hearing multiple instances of the phenomenon from a variety of different sources, using different research techniques and methods.

Denzin, (1990) proposes four kinds of triangulation. The first is data triangulation, where data are collected at a variety of times, locations and from a range of sources. The second is investigator triangulation involving the use of multiple researchers to explore the same data. The third is theory triangulation, consisting of the application of several theoretical approaches to generate the categories of analysis, and finally methodological triangulation involving the application of different research methods to generate data within a study.

Triangulation of data within this research study was attempted through the utilisation of individual *and* focus group interviews with all the research participants. In addition, interviewing both managers and practitioners would allow for a more systematic approach through the comparison of data from different sources within the same methodological framework. Therefore both data (different sources) and methodological (different qualitative methods) triangulation was built into the study design in order to provide a more rigorous method for testing any emerging theory or themes.

6.7   Using focus groups as a qualitative research method.

Morgan (1998a) provides the following definition of focus group interviews:

"Focus groups are group interviews. A moderator guides the interview while a small group discusses the topics that the interviewer raises. What the participants in the group say during their discussions are the essential data in focus groups." (Morgan, 1998a:1)

As with the semi-structured individual interview, the focus group discussion involves the exploration of ideas and interpretation and analysis of what people say. However, it differs from the individual interview in that the focus group relies upon the interactions and insights generated between the participants. Marshall and Rossman (1999) report that this method assumes that an individual's attitudes and beliefs do not form in a vacuum; people often need to listen to others' opinions and understandings in order to inform their own. It is necessary for the researcher to consider how the data obtained from the group discussion was qualitatively different from the semi-structured interviews.

Focus group interviews were planned to further develop the data obtained from the semi-structured interviews, and to give the participants the opportunity to explore their thoughts and feelings within a group setting. It was anticipated that the focus groups would create a richness of data through creating a group dynamic that could be triangulated against the information emerging from the individual research interviews.

Three focus groups were organised to comprise of the following participants:

- All of the health practitioners coming together from both Interagency Northern (six people) and Interagency Southern (five people) Services.

- All of the social care practitioners coming together from both Interagency Northern (four people) and Interagency Southern Services (four people).
- All the health (three people) and social care (three people) managers from Interagency Northern and Interagency Southern Services.

The groups were organised in this way as it was anticipated that the focus group format would enable practitioners to openly explore their experiences of interagency and inter-professional team working in a single practitioner/ professional group setting, without the potential influences of colleagues from different practitioner / professional groups. For the purposes of this research, educational and early years' workers were grouped as social care practitioners as they were both minority groups (a total of two people) derived from a local authority setting. However, it is acknowledged by the researcher that different practitioner groups from within local authority services may well have different professional and cultural backgrounds that are worthy of study in their own right.

The third focus group included all the health and social care managers from Interagency Northern and Interagency Southern Services. The limited numbers of managers participating in the study meant that it was not practical to separate out the health and social care managers into two separate focus groups. However, the focus group arena would facilitate the opportunity for managers to further explore their views and opinions in the presence of colleagues occupying similar employment positions, with similar roles and responsibilities and experiencing similar challenges. It is recognised that this difference in structuring the focus group interviews may well have had an impact upon the dynamics of group discussions, thus influencing the expressed experiences of practitioners and

managers.

Preparation for the practitioners' focus groups used a similar format to that adopted for the individual interviews, with participants receiving a written explanation of what a focus group entailed. Participants were aware that the interviews were to be tape recorded and transcribed by the researcher and they were requested to respect the confidentiality of the group discussion. The researcher also assured the group of the confidential nature of the discussion, confirming that the transcript would not allow for the identification of individual participants.

The researcher produced a separate focus group schedule for the practitioners and managers and facilitated all the focus groups around four questions (refer to Appendices E and F). Each questions was based upon a key emerging theme identified from the analysis of the semi-structured interviews and were designed to capture responses that would facilitate analysis across at least one of the four dimensions identified from the work of Benson (1975, 1983) and his study of inter-organisational networks. For example, in relation to Benson's (1975,1983) Domain Consensus, the semi-structured interviews revealed significant levels of variation across the two interagency services regarding levels of understanding of the role and contributions of practitioners, from different professional backgrounds, to the work of the teams. Therefore, the practitioners' focus groups were asked the following question:

> "Discuss the role and contribution of the different practitioners to the work
> of the team".

One of the difficulties of focus group discussions is the risk of some individuals dominating the group conversation, with only their views being 'heard'. It is the task of the facilitator to encourage all participants to speak. To facilitate the opportunity for all individuals to make an independent contribution and ensure their perspectives were captured, at the conclusion of each of the four questions, each participant was individually requested to provide a rating of their views in relation to the question asked.

This approach required participants to individually respond by assigning a numerical rating of their considered attitude on a five point scale, with five representing high level of agreement, four representing strong agreement, three representing agreement, two representing can't decide and zero representing no agreement. For example, the question cited above pertains to Benson's Domain Consensus. After concluding the discussions in relation to the question, the participants were individually asked to rate their considered opinion in relation to the following:

> "What level of agreement is there within the team in relation to what are the tasks to be undertaken?"

Such an approach allows the views of individuals to be captured following a group discussion and to counteract the potentially dominating influences of others. This approach also enabled focus group members to provide a direct response that was commensurate with questions designed to elicit analysis in relation to Benson's (1975, 1983) four domains within the context of their experiences of interagency team working.

It is stressed that the application of this approach is not intended to add a further quantitative research methodology, designed as an explicit attitude measurement model and to meet statistical criteria for a good scale. The application of this approach was designed to offer no more than a complementary method, within the focus group discussions, for obtaining qualitative information in relation to the participants' experiences of interagency working.

6.8   Researching one's own employer: dilemmas for the researcher.

An additional factor to consider in the design of this research pertains to the fact that the researcher was, 1) an employee of one agency, 2) a manager of one of the interagency teams, and 3) managed by one of the senior managers participating in the research interviews.

As a manager of prospective interviewees, it would be necessary to be sensitive to the possibility of influencing their responses, for example they might be reluctant to identify dissatisfactions that implied some managerial responsibility. The researcher also needed to be aware of how his own attitude, as a result of working with and observing colleagues for several years, might influence the objective interpretation of data. For example, interpretations might be dismissed as not congruent with his beliefs about observed behaviour in the work environment.

Handling interpretations or outcomes which could be perceived negatively by the agencies, is a particularly sensitive issue. Coghlan and Brannick (2001) maintain

that if your job is that of manager, then there could be additional dilemmas to resolve when taking on a researcher's role. In this study, the researcher was required to manage multiple roles – manager, researcher, and employee, leading to the potential for the distortion of data and role confusion.

An alternative perspective to counteract such difficulties suggests that the researcher, as an 'insider', can enhance interpretation and analysis of meaning by having a more in-depth understanding of the subject, the subjects and the social context in which the research was taking place.

Gummeson, (2000:57) refers to a researchers inside knowledge as 'preunderstanding' which includes both explicit and tacit knowledge of the workings and culture of an organisation. Gorinski and Ferguson (1997) identify positive aspects of insider research that include accessibility, credibility, trustworthiness, commitment and familiarity with the research context and personnel. The onus is upon the researcher to maximize such insight through avoiding assumptions based on previous experiences and reflecting upon content, constantly challenging the analysis of meanings and internal subjective influences.

Coghlan and Brannick (2001) describe doing research in one's own agency as a complex process with distinctive elements. It involves undertaking research in and on an agency while continuing to be a 'complete member'. Adler and Adler (1987) advise that, as the researcher is familiar with the organisational setting, they have to create the space and character for their research role to emerge. It is necessary to look at the familiar through a fresh perspective, change the nature of

pre-existing relationships and become involved with the setting more broadly than hitherto in the researcher's functional role with the organisation. Therefore, in this instance, the researcher had to balance a membership role with a service, while assuming an additional role of inquiry and research.

Coghlan and Brannick (2001) state that reflexivity is the social sciences concept to explore the relationship between the researcher and the object of the research. Johnson and Duberley (2000) identify two forms of reflexivity; epistemic and methodological. Epistemic reflexivity focuses upon the researcher's belief system and is the process for challenging our existing assumptions. Methodological reflexivity pertains to the monitoring of our behavioural impact upon the research setting as a result of carrying out the research. This research requires the researcher to consider each form of reflexivity and how such reflections can inform the design, application and analysis of this research

The researcher deployed several strategies in an attempt to build reflexivity into the research. The participants information sheet (Appendix A) openly acknowledges that the researcher may be a line manager or be line managed by the participant. The distinction between the role of the researcher and their role in the organisation is made along with the commitment to keep the roles separate. At this point of the research process, the option not to progress is available to the participants'.

Participants were offered the opportunity to acknowledge the potential impact of the researcher upon their responses. The researcher concluded each individual

interview by asking the participant if their responses had been influenced by their employment relationship with the researcher. In only one instance did a participant acknowledge that they had been conscious of the relationship, but stated they did not feel it had compromised their abilities to be as open and honest as they had wished.

This chapter discusses the use of focus group interviews as an attempt to introduce a further qualitative method for the triangulation of any emerging themes in the data. Morgan (1998a) considers that, as a method for interviewing participants, focus groups have the benefit of reducing the potential impact of the presence of the interviewer. A skilled facilitator of focus group is able is able to ensure that a group discussion and dynamic ensues between participants', rather than a dynamic that is strongly influenced by the relationship between the researcher and individual interviewee.

Through adopting focus group interviews as a research method, the researcher was able to mix groups of participants who may or may not have any employment connection with him. It would therefore be incumbent upon a reflexive researcher to ensure their analysis of emerging themes from the individual interviews and from the focus groups included a comparison of responses across participants known and not known to them through their employment.

In an attempt to introduce a degree of epistemic reflexivity, the following section discusses how a person, independent of the research, offers a review of the researchers thematic coding of an initial four individual interviews. A further

strategy identified was to effectively utilize PhD supervision. The supervisor

offered feedback to the researcher's reflections in relation to their interpretations

and emerging themes. These two approaches combined offer a level of support

and challenge to the researcher in relation to their interpretation of the data, thus

building in objective challenge to the process of data analysis.

It can be concluded that doing research in one's own organisation presents both

challenges and opportunities for the researcher. The key is to ensure a rigorous

approach, accept that qualitative research is about the subjective interpretation of

data, to be open about this in writing and to put in place strategies that will

minimize the potential influences of the researcher upon the researched.

6.9   Strategies for analysing the data.

Webb (1999) argues that it is preferable for the researcher to use manual methods

to learn the process of data analysis. He argues that qualitative data analysis is a

creative endeavour involving intuition and empathy and cannot be reduced to

mechanical process. It is the thinking part of the analysis and process that is

paramount. Therefore, data analysis in this research adopted an approach that

focused upon the researcher becoming familiar with the analytic approach rather

that the use of computerised qualitative data analysis packages.

Having determined the research methodology, systematic steps were required to

plan for analysis of the interview data. Denzin and Lincoln (2000) define data

analysis as:

"The operations needed for a systematic, coherent process of data collection, storage and retrieval." (Denzin and Lincoln, 2000:429)

Content analysis allows the production of detailed and systematic recording themes and issues addressed in the interviews to link the themes together under a reasonably exhaustive category system. The transcription was essentially of content and not of process and therefore did not include features of speech such as pauses or difference in volume of speech - unless considered by the researcher to be a significant factor as part of data interpretation and analysis.

Coding is the first analytic step that moves the researcher from description towards conceptualisation of that description. Concepts or codes are attached to the empirical material. The codes reflect the researcher's interests and perspectives as well as the information in the data. Charmaz (2002:683) argues that researchers already possess a set of sensitising concepts that inform the empirical inquiry and spark the development of more precise concepts, and that interpretation of data cannot be regarded independently of their collection. This research was informed by existing research literature, which in turn influenced the content of the interview schedules.

Researchers therefore need to be reflexive about their constructions, including preconceptions and assumptions, and this activity should be incorporated into the analysis of the data. However, grounded theory (Strauss and Corbin, 1998) also shaped the approach to analysis in that new categories were created by the researcher as themes emerged from the interviews and focus group discussions.

Bryman and Burgess (1999) recommend indexing data in batches, in this way it is possible to make connections between things said in different interviews and to code the different ways of saying the same thing more comprehensively: All the research interviews were coded by the researcher identifying a theme and then assigning codes to the themes. This approach facilitated the analysis of information as it allowed the researcher to fracture the data and then to re-assemble it in new ways that demonstrated frequency of a theme or issue. It also enabled the researcher to match themes against other variables such as practitioner/professional background and the service within which the interviewee was located, that is Interagency Northern or Interagency Southern Services.

After conducting an initial four individual interviews, the task of identifying themes and analytical categories commenced. The following diagram represents the process adopted by the researcher to analyse emerging data:

Figure 5

A diagrammatic representation of strategies for identifying emerging

research themes and analytical categories.

Draft Interview schedule developed

Ideas about analytical categories gained from the research literature and informed the content of questions

Interview schedule piloted   Interviews transcribed

Review pilot interviews and re-draft interview schedule based on interviewees' feedback

Conduct first four interviews with participants

Analytical Category Tree organised from emerging themes

Categories applied to the analysis

Modify by adding or removing categories   Check fit of themes and categories with further interviews conducted.

Adapted from Arksey & Knight (1999:161)

Arksey & Knight (1999) state that text can contain a variety of meanings and

therefore all the participants were provided with a transcript of their interview and

asked to provide feedback regarding the accuracy of content and emphasis of

meaning and/or any possible mis-interpretation of the data. This process allowed the interviewee to reflect upon the written data and consider if the words reflected or captured the meanings they intended. None of the interviewees provided feedback identifying problems with the accuracy of the transcriptions.

Applying such a systematic approach to the analysis of the interviews supported the task of considering the thousands of words expressing opinions, attitudes and thoughts, categorising them into common themes and turning them into a succinct account that offers an answer to the research question. In this instance, data analysis was guided by the recommendations of Cresswell (1998:32) and the following tasks were undertaken.

- Read all descriptions in their entirety
- Extract significant statements
- Formulate into meanings
- Integrate the themes into narrative description.

Arksey and Knight (1999) advise that it is desirable to check that your coding and indexing of data is not eccentric by getting others to use your rules to index a sample of transcripts. After completing the initial four semi-structured interviews, the researcher identified emerging themes, coded and indexed them. The interviews were reviewed by a colleague who worked within an interagency service and had participated in the piloting of interview schedules. The colleague identified very similar emerging themes to the researcher – thus demonstrating the trustworthiness of the research to a level that was reasonable to expect given the resources available. This approach also guarded against the potential influences

(highlighted earlier in this chapter) of the researcher's role as an employee and their potential bias in the interpretation of the data.

After coding and indexing approximately twenty interviews, it was recognized by the researcher that a stage had been reached where the text was being read and codes allocated without giving much thought to the subtleties of the conversation flow and how meanings in the text followed or preceded each other. What prompted the researcher to notice this was that the time taken to code the interviews had dramatically reduced. Therefore, several coded interviews were revisited by the researcher to review the accuracy of the coding.

Several of the themes were identified to have similar meanings, and therefore they were grouped and redefined into further themes that were either changed to accommodate a more accurate reflection of the meaning. Eventually the grouped themes were analysed and assigned to a category that attempted to capture an overarching meaning that aimed explained the theme. Sub categories were also added to capture the subtle differences within a defined category.

For example, one category identified how practitioners considered interagency and inter-professional teams had affected their professional identity (refer to Chapter 7). Further examination and analysis of the text and coded themes revealed sub categories that captured: 1) the impact upon professional identity of working outside of the practitioner's parent agency, and 2) the impact upon identity of working with others in a single inter-professional and interagency team.

The coded themes and categories were constantly checked for adequacy against the new data coming in. It was necessary for the researcher to ask: Are new themes and categories needed? Do existing categories split into sub-categories? In this way the categories are 'grounded', rooted empirically in the data and conceptually in the research issues.

Axial coding is the process of relating categories to their subcategories, termed "axial" because coding occurs around the axis of a category, linking the categories together through their relationships (Strauss and Corbin 1998:124). The purpose of axial coding is to begin the process of reassembling data that were fractured during open coding. Analysis therefore occurs at two levels: the actual words used by the respondents and the researcher's conceptualisation of these into themes, categories and an interpretation of the inter-relationships.

When analysts code axially, they look for answers to questions such as why, or how come, where, when, how, and with what results, and in so doing uncover relationships among categories. Strauss and Corbin (1998:129) state that it is important to realise that the researcher needs to capture the dynamic flow of events and the complex nature of relationships that, in the end, make the explanation of phenomena interesting, plausible and complete.

Briggs (1986:116) states that data retrieval presents information taken out of context and maintains that this is a major problem, arguing that interviews are special social situations whose meanings are intelligible only in that social context. That social context also requires the researcher to observe and interpret,

for example, body language, the emphasis placed upon words, the use of pauses, the age and gender of the participants. Briggs (1986) argues that failure to pay such detailed attention to the interview environment will lead the researcher to misconstrue the interviewees' meanings and to mis-interpret any emerging themes.

Arksey and Knight (1999:168) are less convinced that it is necessary to transcribe tapes and capture, in detail, hesitations, pauses and false starts and, while it is ideal to use video recordings to capture participants' body language, they are not convinced that it adds much significance to many research projects. Arksey and Knight (1999) consider the "decontextualisation" issue is not a pressing one, always given that the researcher is alert to the subcultures and cultures from which respondents are drawn and has an understanding of the interviews as complete texts as well as a cut and paste assemblage of fragments.

As noted above, the framework for analysis was informed by existing research literature and overall the research objectives. Therefore, information that was considered to be irrelevant to the research objectives was not included – unless it became a clear theme across the interviews. For example, a theme emerged across all practitioners' interviews regarding children, young people and families' often negative perceptions of social workers. Initially this was not coded as a theme as it had not been identified in the research literature. However, within the context of this study, the frequency of this issue being raised demanded the creation of a category that captured this theme.

Chapter Nine of this thesis is concerned with the interpretation of the data and the synthesis of categories into an overarching concept that can be understood and further developed through the application of theories. Clearly, the coding of data into themes must not hinder the recognition and importance of new and emerging themes, and the need to create new linkages between the emerging data and how they could be analysed in relation to the formulation of categories and theories.

This research applies a modified version of the grounded theory methodology as discussed by Strauss and Corbin (1998). A grounded theory approach is concerned with the discovery of theory from data. Miles and Huberman (1994) state:

> "The researcher is faced with the task of trying to reduce the amount of data taken in while still gathering more. The idea is to focus much of the data on emergent themes or constructs yet still collect additional data. Ongoing data analysis is inflationary. Typically the more one investigates the more layers of the setting one discovers." (Miles & Huberman:1994: 431)

When a theme, hypothesis or pattern is identified inductively, the researcher then moves into verification mode, trying to confirm or qualify the finding, this then initiates a new inductive cycle. Grounded theory is a process of systematic inquiry into a phenomenon, which allows theory to emerge from the data that is collected. As data is collected it is used to inform the next steps of the research process. Strauss & Corbin (1998) claim that grounded theory permits the investigation of

interaction in a social environment and promotes the development of theories to account for social behaviour. It allows the exploration of patterns of action and interaction between and among people and is therefore appropriate to this study. Charmaz (2006) states that grounded theory provide researchers with the opportunity to analyse data at several points in the research process, not simply at the "analysis" stage.

However, this research did not apply a 'pure' grounded theory methodology as the content of the interview schedules, for both the semi structured and focus group interviews were informed by existing research literature and theoretical perspectives. Therefore the approach is not entirely inductive, but this research did adopt a grounded theory approach in so far as the semi structured interview schedule was further developed as a result of coding the emerging themes from an initial four semi-structured interviews. In addition, the focus group discussion was based on the findings of the semi-structured interviews as well as utilizing Benson's (1975, 1985) framework for analyzing the 'health' of inter-organisational relationships as discussed in Chapter Four.

The final stage of data analysis is the interpretation of the data. When interpreting the data, identifying, sifting through and sorting through all the possible factors showing the nature of relationships, does not result in a simple "if …. then…. statement". Strauss and Corbin (1998:130) believe the result is much more likely to be a complex path of inter-relationships, each in its own patterned way that explains what is going on. Phenomenon is the term that answers the question "what is going on here?" In looking for phenomenon we are looking at repeated

happenings of what is going on, events or actions/interactions that represent what people do or say, alone or together in response to the problems and situations in which they find themselves.

Any interpretation of the data must therefore explore the relationships between the content analysis and the variables. The main variables as identified earlier in this chapter include:

- Health or social care practitioner
- Health or social care manager
- Interagency Northern of Interagency Southern Service.

The task of the researcher at this stage of data analysis is therefore to develop a set of inter-related concepts and not just present a list of themes extracted from the data. However, because they are interpreted abstractions and not descriptive details of each case (the raw data); they are constructed out of the data by the researcher.

This research identified themes extracted by the researcher from the raw data, grouped into descriptive categories or concepts and analyzed in relation to the impact of the different variables. In this way it was possible to integrate the categories to form a larger theoretical scheme to describe phenomenon. This final stage of data analysis is covered more comprehensively in Chapter Nine, where phenomenon are described on the basis of discussed theoretical constructs that emerged from the researcher's interpretation of the data.

.6.10   Summary.

This chapter has reviewed the researchers' reasons for choosing this field of study. The real world challenges posed by interagency and inter-professional team working influenced the researcher to formulate a research question that aimed to provide additional insight into the impact of the degree of integration of inter-professional teams upon practitioners' and mangers' experiences of both the challenges and benefits of inter-professional team working.

The fact that the researcher is employed within the field of research will have an impact upon the chosen methodology, the construction of the interview schedule and interpretation and analysis of data (Coghlan and Brannick 2002). Marshall and Rossman (1999) state that reflexivity denotes a style of research whereby the researcher addresses how the research process affects the results. It emphasises the researcher's own assumptions and beliefs through explicit statements of how the researcher's very presence affects what they are investigating. This chapter attempted to demonstrate how reflexivity has been built into the methodology through, for example, building upon existing research literature, piloting the interview schedule and seeking external verification of the coding themes.

The emphasis of this research is upon a qualitative methodology and is very likely to be a reflection upon the researcher's preferred style as much as the rigour of the chosen research methodology. As Denzin and Lincoln (2000) state:

> "Research strategies locate researchers and paradigms in specific empirical, material sites and in specific methodological practices" (Denzin and Lincoln 2000:371).

The positivist and interpretivist traditions are based upon underlying philosophical assumptions that are not only different but potentially mutually exclusive. However, polemical debates are often unhelpful and prevent a more constructive and pragmatic approach to research and research methods. Although a predominantly qualitative methodology was adopted for this research project, approaches from the quantitative and positivist tradition were utilised, such as assigning a numerical rating to the measurement of attitudes, and coding through the quantification of the frequency of statements in relation to emerging themes. However, it is argued in this thesis that sociological research is essentially pluralistic as researchers use the strengths of each tradition and combine quantitative and qualitative methods to increase the reliability and validity of essentially subjective data.

A central challenge for a qualitative research project would seem to be the transformation and interpretation of data in a rigorous and scholarly way in order to capture the complexities of the social worlds in which interagency and inter-professional teams operate. How to be subjective, interpretive and scientific at the same time?

It should also be emphasised that this research is a compromise. It is a compromise between what the researcher wished to do and what could pragmatically be done by a single researcher; between ideals and the need to get

work done; and between the search for the best possible interpretations and the ethical need to be mindful and respectful of research subjects. Where these compromises mean that what is completed falls short of what would have been preferred, then it is good practice to address this in the thesis.

For example, the limited numbers of managers participating in this research resulted in the decision to hold a single health and social care managers' focus group, rather than separate health managers and social care managers' focus groups. In addition, interviewing a larger sample and utilising observational and documentary analysis methods would have contributed to a more robust framework of inquiry and analysis. However, the size of the task for a single researcher, in full time employment, simply did not allow for such a comprehensive approach.

Despite the limitations identified, this research has adopted a systematic approach to the field of study. The findings of this research are expected to add real world and practical value to practitioners, and operational and service managers who continue to be required to work collaboratively in support of policy implementation. The following two chapters identify the findings concerning managers' and practitioners' experiences of interagency working captured as a result of implementing the methodology outlined in this chapter.

7.   The practitioners' views and experiences.

The previous chapter discussed the chosen methodology for undertaking this research. This chapter presents the findings from the individual semi-structured interviews and focus groups with health and social care practitioners. Quotations from both semi-structured interviews and focus groups are utilised to illustrate emerging themes that were common to the health and social care practitioners.

The reasons for reporting the findings in this way were to allow an integrated comparison of the themes as they emerged from the interviews and the focus groups. The managers participating in the study did not work within the inter-professional teams and it was anticipated that, as a group, their experiences of interagency working might be very different to those of the practitioners. Therefore the findings of the interviews and focus group discussions with the managers from the interagency services are presented separately in the following chapter.

Interagency Northern and Interagency Southern Services were established in 2000 and this research commenced in 2003/4. The majority of practitioners had therefore been working within the teams for three to four years. Only two practitioners had not been with the teams since their inception, both joining their interagency team within the previous twelve months.

To ensure practitioner confidentiality when utilising quotations, all practitioners were allocated an individual code. For example, a total of ten practitioners were

interviewed from Interagency Northern Service and each practitioner was allocated a number from one to ten, depending upon the order in which they were interviewed. For the purpose of reporting the findings, each quotation is preceded by the name of the service; Interagency Northern , the designation of the practitioner; health or social care and their unique practitioner number. The same coding system was applied to participants from Interagency Southern Service.

To enable the identification of research interview method, the initials FG (focus group) or II (individual interview) are used at the end of each quotation to represent the source of the data. The themes identified from the research interview methods were grouped into the categories listed below and classified as representing either benefits or difficulties of interagency working.

The benefits of interagency working:
- Promotes ease of communication.
- Promotes understanding of different professional roles and perspectives.
- Enhances practitioners' skills and knowledge.
- An improved service for children and families.

The difficulties of interagency working:
- High demands and expectations placed upon the services.
- The challenges to professional roles, responsibilities and identity.
- Physical, emotional and professional isolation.
- Addressing the influence of professional and agency cultures.
- The impact of structural and agency issues.
- Children and families' antagonism towards social care staff.
- A lack of support from senior health and social care managers.

The above categories then form the basis for further analysis of the data as they are related into central explanatory phenomenon.

The previous chapter described how Benson's (1975, 1983) theoretical framework for exploring the 'health' of interagency relationships was utilised to structure the questions in the semi-structured and focus group interviews. Such an approach supported the collection of research data within a framework that facilitates analysis in relation to the degree of consensus achieved across the four domains of ideological consensus, domain consensus, positive evaluation and work coordination.

This chapter then presents an initial analysis of the research categories and any impact upon them of variables such as the practitioners' background (health or social care) and the interagency service they were located within. Such an approach allows the framework to be utilised as a comparative tool for assessing the 'health' of interagency services based upon the expressed experiences of health and social care practitioners.

7.1   The benefits of interagency working.

The findings of the semi-structured interviews and focus group discussions revealed a general consistency of themes identified by all practitioners, irrespective of their professional background or the interagency service within which they were employed. There was an overwhelming message from practitioners communicating their support for interagency and inter-professional team working:

Interagency Southern, Health Practitioner 1: "It's good to work in that environment and I wouldn't want to particularly return to not working in that environment, it's very healthy." (II)

Interagency Southern, Social Care Practitioner 2: "I feel this is the way forward and the way I want to work personally. We need to be bringing in other agencies; we need to be looking at being more creative in the work we're doing with families." (II)

During the course of the focus group discussions, the practitioners reiterated their support for interagency working. They believed that the interagency and inter-professional teams were the way forward for practitioners and organisations to deliver services, and for families to receive improved services.

The participants cited several reasons for their beliefs and these were based upon their direct experiences of working within the Interagency Northern or Interagency Southern teams. The main reasons given for their support of interagency working were categorised under the following themes:

7.1.1   Promoting ease of communication

Health and social care practitioners identified significant benefits that resulted from their ability to talk to different practitioners from different professional backgrounds within their own interagency teams. They valued the opportunity to rapidly discuss their thoughts and ideas with the different practitioners:

Interagency Northern, Health Practitioner 7: "I can go out and do an assessment and think, right I need to know x, y and z and that is social services family support issues, or whatever, and I can come back to the team immediately and get that piece of information without having to make loads and loads of phone calls, and that means I can get that information to my client as fast as possible, which is great." (II)

Interagency Southern, Health Practitioner 6: "An issue would come up and you could just go into the office and speak to the health visitor, or speak to the social worker, and you could set something up." (II)

The practitioners reflected upon the improved quality of their work as a result of being able to consult with others on an ongoing basis:

Interagency Southern, Social Care Practitioner 9: "You can discuss it with someone else from the social services and they will have a similar opinion to you, but discussing it with a worker who has specialist knowledge and looks at it from a different viewpoint will just make you re-examine what you are doing and make you look at it from a different viewpoint. And sometimes it is just about the reassurance that you are on the right track." (FG)

Interagency Southern, Social Care Practitioner 5: "I think the beauty about this service is that we've got a multi-agency approach and we have those other agencies inputting into the service and it's cutting down on communication problems. It's nice to be able to assess a family's needs and have those people on site so we can co-work and hopefully resolve situations." (FG)

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The focus group discussion reported how they would actively utilise the skills of different practitioners within their inter-professional team. Social care practitioners described in the individual interviews how they could communicate more easily with their health colleagues by being co-located within the same teams. They acknowledged the benefits of being able to seek not only the informal views of colleagues, but also constructive discussions within a more formal peer group supervision arena, as illustrated by the following:

Interagency Northern, Social Care Practitioner 5: "We have a lot of informal discussion with other members of the team who are in different professions." (FG)

Interagency Northern, Social Care Practitioner 4: "Sometimes, say if it was me as a social worker doing the assessment and we have got a CAMHS worker in the team meeting or a health visitor, then they might have a different perspective and say well, have you thought of this, its another angle." (II)

Practitioners from Interagency Northern and Interagency Southern Services reported utilising and valuing peer group supervision as a means of sharing perspectives. Practitioners described attempting to match the allocation of a referral, based upon the initial information, to a practitioner who may have the appropriate skills. The focus group discussions reported how both interagency services would actively utilise the skills of different practitioners within their inter-professional team:

Interagency Northern, Social Care Practitioner 3: We have peer group supervision every other week and we tend to bring cases that we are stuck

with, the more complicated ones." (II)

Clearly, the experience of being co-located within single interagency teams had a positive impact upon practitioners' opportunities to effectively communicate with each other. This finding is reflected in a research study of the Sure Start Programme, conducted by Tunstill and Allnock (2007), who concluded that co-located teams resulted in improved levels of work coordination between practitioners.

7.1.2   Promoting an understanding of different professional roles and perspectives.

The practitioners considered that there had been an improvement in their understanding of the roles and functions of different professionals and different agencies:

> **Interviewer:** "Do you feel that being part of the team has had any effect upon your understanding of what other people do and how they work?"
>
> **Interagency Northern, Social Care Practitioner 6**: "I didn't have much idea of what social services or health roles entail. In order to work I have had to learn a lot more about what people do so I can find the right people."[1]
>
> **Interviewer:** "Has it dispelled any myths?"
>
> **Interagency Northern, Social Care Practitioner 6**: "Yes. Probably the biggest one is social work and not having an understanding of what their

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[1] The social care practitioner had been previously been employed within an education services.

role…what their restrictions were and resourcing and everything like that. A lot of the pressures that everyone is under really." (II)

As a consequence of improved understanding of different professional roles and perspectives, the practitioners reported a breaking down of negative stereotypes and more realistic expectations of other practitioners and agencies. As one practitioner explained:

Interagency Northern, Health Practitioner 10: "They work as part of a team. That was, in my opinion, one of the benefits of developing the service. It was the fact that practitioners could break down some of the boundaries and create a better understanding of roles and responsibilities, their skills and knowledge base could be brought together. And working as a team, I think it has facilitated that." (On being located within an interagency team). (II)

Two of the practitioners interviewed discussed how single profession and single agency staff groups tended to become very insular and critical of other services. On the basis of their previous experiences of working in such settings, they reported that practitioners tended to resist looking at the pressures and strengths of other services. The practitioners explained that they had developed a much clearer understanding of the pressures upon social services and what social services could deal with:

Interagency Northern, Health Practitioner 2: "Thinking of myself, when I came into this team you were quite insular when you thought of working with families, when you didn't think you were. There was very

much stereotypes around different agencies. Working in this team has broken those barriers and stereotypes and that has been so useful in that we are all doing the same job and wanting to work with families. It has also broadened my knowledge base about other agencies and how they work. That has been invaluable." (II)

Interagency Southern, Health Practitioner 3: "What we do as professional groups is become very isolated and insular and critical of other services instead of looking at the pressures and strengths of other services." (II)

The practitioners also acknowledged there were difficulties as a consequence of working with people from different professional backgrounds:

Interagency Northern, Social Care Practitioner 5: "Other professionals (within the team) have different points of view, but I don't think there is any harm in having healthy discussion. Sometimes it might be difficult for another professional to see your point of view and it can get quite heated." (FG)

Practitioners recognised that they would often come up against tensions as a result of airing different perspectives within the work place. However, practitioners reported this to be a positive feature of interagency working as it encouraged creative debate and reflective practice.

As a single group, the practitioners were almost unequivocal about their respect for each other. They valued the skills and contributions that the different

professions brought to the work of the services. Their mutual satisfaction with the work of their colleagues was an overwhelming factor in their support of interagency and inter-professional working.

7.1.3 Enhancing practitioners' skills and knowledge.

There was a strong belief expressed that working within an interagency and inter-professional team enhanced practitioners' knowledge and skills. Participants reported learning from the different perspectives of others and this contributed towards a positive improvement in their own practice skills:

> **Interagency Northern, Health Practitioner 9:** "I think we learn things from each other all the time. Certainly from doing joint pieces of work it is really nice to be able to watch somebody else from a different background doing essentially the same thing but obviously from a different way, like an assessment, we would maybe ask slightly different questions or in a different manner." (II)

They considered their outlook had been widened and that they were more able to address the wider health and social care needs of their clients. One of the health practitioners reported that working within an interagency team avoided the pitfalls of practitioners from different agencies saying 'it's not my job to do that because it is their job to do it'. A social care practitioner stated:

> **Interagency Northern, Social Care Practitioner 5:** "We are getting a

holistic view and, plus, we can advise each other when working with different professionals (outside of the team). You know, there might be a problem with child protection work and another professional (within the team) can access me for support, and likewise I could ask a health professional if I am unsure about something else, so the interagency part of it has worked within the team, you are learning all the time basically. I have gained a lot of knowledge of children's mental health and I think I can give a lot to clients because of that knowledge." (II)

Practitioners reported feeling more willing and more able to continue working with a child and family in need of support, in the knowledge that they could receive ongoing advice from a colleague rather than feeling the need to refer the child and family to another service or agency. Health and social care practitioners in each focus group discussed how their skills had been enhanced through working within interagency teams.

Interagency Northern, Social Care Practitioner 6: "I feel like I really value other professionals in our team because they share their skills and experience and we all do the same job, all take part in duty. To me everybody helps each other; they are always available to talk to." (FG)

Interagency Southern, Health Practitioner 3: "I've certainly learned what I need to look out for. I think my assessment skills have improved, I think there is still a long way to go, but they are improving and I am learning from other practitioners within the team and I am learning from the CAMHS service." (FG)

Further analysis of the focus group transcript revealed that the community psychiatric nurses, within Interagency Southern Service, were the only group of

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practitioners who did not identify an enhancement of their skills as a result of working within the interagency services. This issue was cross referenced with their individual semi-structured interviews, and again it was apparent that an enhancement of their skills was not identified. However, these practitioners were very positive about the skills of their colleagues from social care and were positive about the benefits to children and families about interagency teams.

It could be concluded that the community psychiatric nurses' occupied profession based roles within the interagency teams and this strongly influenced their reflections and analysis of the impact of interagency working upon their skill development. It was their role to offer advice and guidance to other practitioners within their team, thus maintaining a role based upon specialist knowledge. As a consequence, they experienced few opportunities to engage with colleagues in a two way dialogue that enabled them to learn from others and to apply different models of working that might heave extended their skills in the way that other practitioners reported.

The practitioners' positive views about the benefits of inter-professional team working are in concurrence with the findings of a case study conducted by Liedtka and Whitten (1998) of inter-professional team working across health and social care. They concluded that inter-professional team working may result in improved job satisfaction.

7.1.4   An improved service for children and families.

The practitioners believed that the services delivered by their teams to support children and families had improved. They reported approaching their work in a more 'holistic way'. Several practitioners used the word 'holistic' to describe the benefits of having other professionals within the team and one practitioner described, in the individual interview, what s/he meant by the word 'holistic':

> **Interagency Northern, Social Care Practitioner 5**: "We are looking at children with difficulties and it would be easy for one professional to focus on whatever their profession is, so if it was a professional from a health background they would not necessarily have done a focus on the social side of things. So when the team was set up the idea is that you will get a holistic view of the child and what is happening in the family and eventually what did happen, or has happened, is that all of us are quite competent at looking at all aspects of a child's background, whether it be health, social, whatever or education. So the interagency part of it has worked within the team and you are learning all the time basically. Yes I have gained a lot of knowledge about children's mental health; I think I can give a lot to clients because of that knowledge." (II)

They considered that the health and social care needs of children and families could be more comprehensively and more effectively addressed by one inter-professional team, rather than referring them on to other teams or services where there would invariably experience waiting lists. Children and families were therefore receiving earlier support, less repeat assessments and interventions, and a reduced number of different practitioners intervening in their lives in an un-

coordinated and confusing way. This point was strongly emphasised by practitioners from both the Interagency Northern and Interagency Southern teams:

> **Interagency Southern, Health Practitioner 1:** "Rather than sending in lots of people, one person can go in, unless there are specific difficulties and then two people can work in partnership with the family. Referrals to other agencies might take time, it might get lost in a hole somewhere and the family need people working together rather than this is happening now and something else in six months down the line and not coordinated." (II)

> **Interagency Northern, Social Care Practitioner 3:** "For the clients, we have one point that they are referred to, whereas before they might have been directed to all sorts of different places and I think the benefits are they are not on waiting lists forever, they might have been on the wrong waiting list for a long time. We do the assessment and hopefully that is used by other professionals we need to inform and likewise, we can use other people's assessments. At the end of the day they will get a service that is appropriate for them." (FG)

Evident throughout each of the focus groups interviews was the belief that the cumulative benefits of interagency working resulted in improved services for children and families:

> **Interagency Northern, Social Care Practitioner 4:** "I feel I know a lot about health, so it must be better for the clients because they are getting a holistic assessment and we are able to do that." (FG)

> **Interagency Northern, Health Practitioner 1:** "Through co-working you can resolve it at source, keep it close to the family and young person as possible." (FG)

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The contribution of inter-professional work to increased flexibility when working with children and families is supported by Day (2006), who emphasises that professional roles are not fixed and inter-professional often equates to more flexible roles.

Participants in both focus groups were observed to place less emphasis upon the benefits of interagency working than they did when participating in the individual semi-structured interviews. This was particularly noticeable within the health practitioners' focus group, which focused mainly upon the difficulties of inter agency working. It appeared to be the case that the focus group format generated a group dynamic that emphasised the less positive aspects of interagency working than the individual interviews.

7.2   The difficulties of interagency working.

In addition to the benefits of interagency working, the practitioners also identified a number of difficulties associated with interagency and inter-professional team working. There was general consistency, across the services and different practitioner groups, regarding the difficulties identified. However, some practitioners felt the issues more acutely than others, and their professional background and their place within the organisational structure of the interagency team appeared to be factors contributing to their perceived experiences. Practitioners' identification with their profession and with their 'parent' agency/organisation emerged as key factors in this respect.

7.2.1   High expectations and demands placed upon the services.

Practitioners from all the interagency teams reported feeling the pressures of high
workload demands and high expectations from people and agencies external to the
service or team. Their views applied equally to people working in services within
their internal 'host' organisation, their 'parent' or seconding organisation, and to
those working in other external agencies. A number of participants reported
feeling 'dumped on' by practitioners in wider children's services.

They considered that practitioners working outside their teams did not really
understand the range of work they were undertaking. Practitioners explained that
children and families were frequently referred to the interagency teams with
inadequate levels of assessment of their support needs prior to referral. In
addition, requests were made of them to undertake work that should have been
progressed by the referring practitioner/agency:

> **Interagency Northern, Health Practitioner 7:** "I think people outside
> the team don't actually realise the amount of work the team actually does.
> I think they don't appreciate the range of activities that includes training
> and consultation as well as the individual work." (FG)

> **Interagency Southern, Health Practitioner 4**: "They (local authority
> child care teams) kept trying to pass things on to me thinking that she will
> never know, she's from health. We sometimes feel as though we are
> getting dumped on." (FG)

Practitioners within Interagency Southern teams had, on several occasions, experienced the removal of practitioners from their teams by their 'parent' / seconding agency. This was reported to have usually occurred due to staffing shortages within the parent agency that was struggling to deliver what could be termed as their statutory or 'core' services. The health, social care, and welfare benefits services had all resorted to this course of action on occasions. As a result, the Interagency Southern teams had often been depleted of staff. Practitioners expressed their frustrations:

Interagency Southern Social Care Practitioner 5: "I've had to complete a number of child protection investigations because they (the local authority child care teams) have been short staffed. There was a shortage of social workers so they pulled the social workers (from Interagency Southern) into childcare teams." (II)

Interagency Southern, Health Practitioner 1: "Health pulled out their CAMHS post and they pulled out an admin assistant because the Primary Care Trust was in the red – quite disturbing at two weeks notice." (II)

The practitioners from Interagency Northern and Interagency Southern teams expressed a view that the teams had been under-resourced to meet the expectations placed upon them. One of the social care practitioners complained that some health visitors viewed their team as being 'the panacea for all', and as a consequence referred "anything and everything" to them:

Interagency Northern, Health Practitioner 8: "It is almost like everyone

wants a slice of you, and they wanted it yesterday and it is really hard; the

volume of work. If you raise standards you raise people's expectations.

It's pressure and expectations of others and referrers. That is the main

issue, and a lack of understanding of who we are and what our limitations

are." (II)

Practitioners from both Interagency Northern and Interagency Southern Services

discussed how staffing shortages within the local authority child protection teams

resulted in them experiencing difficulties in appropriately transferring children

and families to such services when more concerning child protection concerns

emerged. As a consequence, the practitioners reported being expected to continue

to offer a 'child protection' service to the child and family, thus jeopardizing their

capacity to deliver the services they were established for. As one practitioner

stated:

> **Interagency Southern, Social Care Practitioner 2:** "The (Interagency
> Southern) teams have been set up and people have high expectations of
> what they will do. When people see Interagency Southern are involved
> they think that is enough, but there is a point when it goes beyond what we
> can do and it has to be referred to the childcare team." (II)

The focus groups also identified these high workload demands and practitioners

expressed a feeling that mainstream children's services had high expectations of

what they could provide. This point is illustrated by the following discussion

within the social care focus group interview:

Interviewer: "Do you mind at Interagency Southern teams that referrals are made to you when they (the referrer) could do the work?"

Interagency Southern, Social Care Practitioner 5: "Occasionally yes."

Interagency Southern, Social Care Practitioner 2: "Mmm, yes."

Interagency Southern, Social Care Practitioner 8: "Yes."

Interagency Southern, **Social Care Practitioner 2:** "I will try to talk to them when making an enquiry if they could have done anything else. I think sometimes people have high expectations of what we are able to achieve."

Interviewer: "Is that something the Interagency Northern Service experience?"

Interagency Northern, Social Care Practitioner 5: "Yes, I think it is usually the social workers who are bogged down by everything else, they try and pass them on don't they."

Interagency Southern, Social Care Practitioner 2: "That's a good point. It is other people's workload, if they think they can pass it on (pause). That's work they could do." (FG)

The pressures resulting from high workload demands were associated with practitioners' views that managers (not their direct line managers) should do more to support them to contain the volume of referrals to the services. There was a perceived lack of support from (senior) managers in this respect.

7.2.2 A lack of support from senior health and social care managers.

The practitioners were frustrated at what they saw as a lack of support from managers more senior to their line managers. They reported a failure from the managers within their 'host' and 'parent' agencies to address the workload issues, and that their work was not afforded the same value as other 'core' or mainstream children's health and social care services:

> **Interagency Southern, Health Practitioner 1:** "I think sometimes they (other agencies) don't necessarily understand, or that they see they have kindly donated a member of staff to this service. It's not their core business but they have donated that member of staff. Therefore they can take back that member of staff as and when they need it. Doesn't help with relationships at all." (II)

The focus groups identified the withdrawal of staff from the Interagency Southern Service as a factor that had exacerbated their feelings of not being adequately supported by senior managers and causing ill-feeling as a result of increased workload pressures for the team:

> **Interagency Southern, Social Care Practitioner 9**: "We are saying for goodness sake we need a CAMHS worker in our team, but our CAMHS worker was taken out (by senior managers)." (FG)

The withdrawal of practitioners from Interagency Southern teams also reinforced a sense of isolation; practitioners described separateness from mainstream

children's services and not being treated with equal respect and value by their senior managers.

Although practitioners in the Interagency Northern service had not experienced the withdrawal of staff, they expressed similar sentiments in relation to the workload expectations placed upon them by colleagues in mainstream children's services. They also did not feel adequately supported by their senior health and social care managers. A social care practitioner from Interagency Northern Service commented:

> **Interagency Northern, Social Care Practitioner 5:** "They (senior managers) don't realise the work we're doing. We're **all** here to provide them (children and families) a service to meet their needs, so that's been an issue of conflict for the last three years. My key message would be to own and support an interagency service." (FG)

Practitioners' comments indicated that they considered themselves to be on the periphery of service provision; they saw themselves to be perceived as "a luxury", and felt they did not receive the amount of support they needed and deserved. The majority of practitioners did not feel listened to by senior managers responsible for the continued development of the interagency services, and this seemed to feed into the general perception of not being valued:

> **Interagency Southern, Social Care Practitioner 5:** "I think they need to listen to the workers at ground level. The changes need to be thought through carefully, because any re-organisation is stressful. They need to consult over decisions perhaps more than they do." (II)

Interagency Northern, Health Practitioner 8: "There is so much they (senior managers) should learn (from the practitioners). There is a need for a strategic vision and I don't have a feel for a vision." (II)

The health practitioners' focus group discussion continued to emphasise the need for increased support from senior managers. In particular, they identified a need for the senior managers to 'back them up' when re-directing referrals for input from other agencies:

Interagency Southern, Health Practitioner 5: "Certainly there was an expectation that we would be all and do all and that you wouldn't have the backing from your (senior) management structure to be able to say that perhaps you would like to re-direct that to the education psychologist. There would be the expectation that you would take every referral through." (FG)

The following dialogue, from the health practitioners' focus group, illustrates the theme further by identifying the absence of support in the context of interagency politics:

Interagency Southern, Health Practitioner 7: "But how much of the change in expectations or change in goals is because of your stakeholders' demands upon that service change."

Interagency Northern, Health Practitioner 2: "Yes, we have been drawn into the politics."

Interagency Northern Health Practitioner 8: "For the first three years there was a proactive interagency steering group. For the last eighteen months it hasn't been functioning and that is where the tensions and

problems have crept in. because everybody has said 'well we have this priority, we want that'." (FG)

Practitioners across both interagency services generally conceptualised the solution to their difficulties in terms of the investment of more resources to deliver the expected level of services, with the solution outside of their control. They did not offer any suggestions around their internal processes and how they could implement any solutions that were within their control and not dependent upon the injection of additional resources. Perhaps their feelings of being on the periphery of mainstream services had contributed towards a degree of disempowerment.

7.2.3   The challenges to professional roles, responsibilities and identity.

Although the practitioners considered their increased understanding of different roles had been a valuable aspect of interagency working, paradoxically they also discussed the tensions arising as a result of 'travelling this particular learning curve' and in particular the changes that were demanded to the ways they traditionally worked. The participants openly discussed their perceptions of their roles within the teams and the contributions they felt that they made to the work of the teams. The majority of the practitioners within the Interagency Northern Service described their roles as becoming more 'generic' and less 'specialist' in nature:

> **Interagency Northern, Health Practitioner 1:** "The different practitioners in the team, as I see it, have, I'll call it, a generic role. It is

those tasks undertaken by practitioners, and it doesn't matter about their background, that can range from offering duty cover through to carrying out assessments. Those tasks in offering support to primary care are generic. Alongside that there are some specific things that practitioners can bring to the team that are specific to their background and training. For example an RMN can have a lead, although not exclusive, in looking at self-harm. A social worker can take a lead when we receive referrals were there are issues in child protection. There are some specific tasks and some generic tasks." (II)

They reported undertaking many more tasks with children and families than they would traditionally have done, and as a consequence the differences between the various roles and responsibilities had diminished. It was seen as a positive feature in so far as the participants believed their knowledge and skills had widened and improved, thus offering a better service to people. However, Interagency Northern Service practitioners also identified concerns about becoming too generic:

Interagency Northern, Health Practitioner 2: "This is something that I struggle with tremendously because I think roles changed and you get quite clouded what your specific role is and what qualities you are bringing from your past experience, so this is something I constantly struggle with." (II)

Interagency Northern, Health Practitioner 8: "We are so ruddy generic; we are all things, consultation, triage, liaison, assessment, direct intervention and more and more mental health prevention. Our role has evolved to be more generic than people possibly envisaged." (II)

Hall's (2005) review of the literature in relation to inter-professional team working concluded that inter-professional team members have areas of

overlapping competencies and must share varying degrees of responsibility. This often leads to 'role blurring' due to confusion as to where one's practice boundaries begin and end. Role blurring can result in some team members feeling underutilised (having their role usurped), or in some members feeling they are doing everything (needing to usurp), a process referred to by Hall (2005) as ''role expansion.''

Practitioners expressed a belief that it was important to maintain their professional identity and a specific role through which their professional skills could be recognised. There was an articulated fear of everyone being 'the same' – 'a generic blob'.

> **Interagency Northern, Health Practitioner 1:** "I believe that practitioners do need some profession specific tasks to maintain their professional identity." (II)

The tensions surrounding roles and professional identity were felt more acutely within the three Interagency Southern teams. The service had been established with practitioners occupying much more clearly defined and profession based roles. Social care staff working within Interagency Southern teams would undertake the majority of core team tasks, including receiving referrals, offering telephone advice (office cover), initial assessments of the needs of children and families, and assuming responsibilities for ongoing support to children and families as their key worker.

The qualified social workers tended to work with young people and their families

when child protection issues had been more clearly identified. The community psychiatric nurses did not usually undertake general 'office cover' or initial client assessments; their role was more specific in relation to working with young people and families where mental health difficulties had been identified. They also worked in a more formal consultative capacity with the rest of the team. They would offer longer term support to children and families, but they were not responsible, as key workers, for the coordination of a range of services the child or family might require. A social care practitioner commented:

> **Interagency Southern, Social Care Practitioner 8:** "They (community psychiatric nurses) have their remit and that's what they stick to. The social workers, or social care workers, we pick up all the rest. So they have a very tight circle of what they will and won't go beyond, even if it's the case that we have no one to do duty." (FG)

The health visitors within Interagency Southern Service also occupied roles based more clearly upon their professional background, however, they were not as clearly defined as the community psychiatric nurses and there was more blurring of the role with the social care staff. Variation was found between the roles undertaken by the health visitors located within the different teams in the Interagency Southern Service. The health visitors varied in the extent to which they were integrated into the 'core business' of the teams, such as initial assessments of children and families, holding key worker responsibilities for the ongoing support of children and families and undertaking office cover arrangements. Difficulties were also expressed by other team members around the roles and contributions of the health visitors within Interagency Southern Service.

Interagency Southern, Health Practitioner 4: "I know the health visitor role wasn't what was anticipated." (II)

The reported experiences of health and social care practitioners within Interagency Southern Service mirrored those of the Interagency Northern Service in many respects. There was a perceived blurring of roles by Interagency Northern Service practitioners', but also a recognised need for some profession specific roles.

Interagency Northern, Social Care Practitioner 5: "In our team we are all doing the same, but as a social worker in the team my role is to maintain links with the social services and advise on child protection and likewise although we are still doing the same, I am there if people want to access me. I think it is the same for psychiatric nurses if we have got issues with risk or depression, we will be able to access them for advice. Although we don't keep to specific roles, we all try and do the same." (II)

Interagency Southern, Social Care Practitioner 2: "I think some of the roles overlap because of the nature of the work, but yes I do think the roles differ." (FG)

They expressed a general belief that it was important for them to have defined roles; but they also needed to be flexible. They reported an overlap of health and social care needs within families and argued that they should have the skills to meet as many of those needs as possible.

A Health practitioner from the Interagency Southern Service believed that

practitioners did need some profession specific tasks to maintain their professional identity, but identified value in the expansion of their role:

> **Interagency Southern, Health Practitioner 3:** "I was clear that I did not want to lose my identity as a health visitor, I wanted to focus on the health side of things, but have done a bit of everything really which is no bad thing really because I found that I had a lot of transferable skills." (II)

The Health practitioners within Interagency Southern Service generally felt that their roles and contributions to the interagency services had not been clearly defined from the outset. However, they believed that it had been made clear to them by their (health) manager(s) what tasks they were not expected to undertake. One of the practitioners stated that:

> **Interagency Southern, Health Practitioner 7**: "Not being a key worker, that caused difficulties in establishing a role because they (colleagues) had clear expectations of what they considered my role to be, and we were told by managers this is what you will be offering as a CAMHS worker. So it was quite difficult really and made you feel as if you were not particularly a team player." (II)

The majority of the health practitioners within the Interagency Southern Service expressed the view that they should have been allowed, by their senior managers, to undertake more generic team tasks:

> **Interagency Southern, Health Practitioner 7:** "We wanted to be key workers and carry cases."

Interagency Southern, Health Practitioner 6: "Yes."

Interagency Southern, Health Practitioner 7: "I felt quite bad that they were on half of what I was getting paid but were carrying cases that were really complex and that is why it would cause such ill feeling. We would have happily done what everybody else is doing." (FG)

There was a distinct view expressed by the social care practitioners within Interagency Southern Service that the health practitioners should undertake wider roles and tasks:

Interagency Southern, Social Care Practitioner 9: "I think there were some problems about roles and responsibilities of the way CAMHS work. There seemed to be a lack of flexibility working with families." (II)

The focus group discussion with the health practitioners also confirmed the view that there was a lack of clarity about the roles and contributions of community psychiatric nurses to the Interagency Southern Service. The following quotation illustrates the confusion they experienced:

Interagency Southern, Health Practitioner 7: "The role that we came in from CAMHS was never very clear. It was about see if you can develop a role and we were never given the chance to develop the role or given the time out or support, or even what people were looking for and ideas of what they wanted." (FG)

The issues and tensions surrounding roles and responsibilities were clearly felt more acutely by practitioners within the Interagency Southern teams than the Interagency Northern teams. This could be explained as a consequence of the

more marked differences in roles occupied by the health and social care practitioners within their respective teams and the different degrees to which the teams were integrated in relation to undertaking core team tasks.

For example, within the Interagency Southern teams, attempts to be clear about what the community psychiatric nurses did not do had, paradoxically, created role confusion about what they would do. The community psychiatric nurses occupied a more specific role that could be described as 'specialist' in nature, offering advice and consultation to the rest of the staff group. They did not usually undertake the tasks associated with the team's daily 'core' business. As a consequence, the health and social care practitioners identified team tensions associated with lack of clarity of role, and a sense of unfairness or inequity about their different contributions, as well as feeling the community psychiatric nurses were on the 'outside' of core team business.

The community psychiatric nurses within Interagency Northern teams were more fully integrated into the daily 'core' business of the service. They would undertake many similar tasks to those performed by the rest of the practitioners. The health and social care practitioners did not express the same tensions as their colleagues within Interagency Southern Service around the role and contributions of the community psychiatric nurses. They discussed tensions in relation to the need to strike a balance between developing their skills through expanding their role, while maintaining a profession specific role that would validate and reinforce their professional skills within the service.

Despite the tensions around professional identity and role, the issue did not feel insurmountable for practitioners within both interagency services. They reported that they would be happy and willing to take on wider roles and more general team tasks, providing they could also maintain their professional identity through having a more specialist role for specific pieces of work. Certainly, within the Interagency Northern Service, all health and social care staff would undertake more generic roles and share the core team tasks with their colleagues. As a consequence, they appeared to experience and report fewer tensions around the issues of team roles and function. In fact the health and social care practitioners within Interagency Northern Service shared a common concern that focused upon their desire to maintain a level of profession specific tasks and skills.

A health practitioner within an Interagency Southern team believed that issues around roles and contributions were constantly evolving and, over time, were being addressed by the service:

> **Interagency Southern, Health Practitioner 1**: "I think there is bound to be difficulties in making a different team. It takes time to iron things out and seek a way forward and get all the sort of boundaries in. I think that has been a major issue really." (II)

Practitioners within the Interagency Northern Service also reflected upon the benefits of the length of time the service had been operational and the opportunities this afforded the service to work through many of the challenges. At the time of undertaking the research interviews and focus group discussions, they

reported that the issues surrounding roles and contributions had largely been resolved:

> **Interagency Northern, Social Care Practitioner 6:** "There are frustrations with sorting it all out, you know with the health and social services things. I can't think of any examples but issues have been ironed out over the last couple of years." (II)

The need for time to plan roles and work out internal tensions was reinforced by health and social care practitioners within Interagency Southern Service. They reported that they did not feel they had been afforded the necessary time to plan, promote and develop their service in the way that they would have wished to. There was a feeling that the service had been set up 'in a rush'. They believed that it would have been useful if they had been allowed more time to agree roles and working patterns before becoming operational:

> **Interagency Southern, Health Practitioner 4:** "It was set up in a rushed way and there was a lack of clarity and assumptions about different roles. Trying to get a team of different people from different backgrounds into one team. You have to give yourself, your team, time to adjust to that." (FG)

The opportunity for social care practitioners to discuss their experiences within the focus group arena facilitated an emerging sub-theme around a perceived lack of professional flexibility by health care practitioners. It was the social care practitioners within Interagency Southern Service who articulated this view most strongly.

Interviewer: "Why do you feel some people have defined roles?"

Interagency Southern, Social Care Practitioner 8: "Well they are employed by another agency and they will have their defined roles and that will be within their contract or written agreements that this is what they will do, that is what they will undertake within our team."

Interviewer: "So do you feel it comes externally on them from their organisation that is what their criteria is? Or do you think it is what the practitioners set when they are in the team?"

Interagency Southern, Social Care Practitioner 5: "Both. They come in with their own expectations, their own job descriptions. If the work that we are asking them to undertake is not within that, then it's jobs worth really." (FG)

However, the practitioners also believed that the personality of individual health practitioners could influence the way in which they could overcome some of the structural barriers to working within an interagency team. A social care practitioner made the following comment within the focus group discussion:

Interagency Southern, Social Care Practitioner 9: "To me, being part of a team you have to muck in sometimes and they don't. But there are other professionals who will, you know if you are struggling, will bend over backwards to help, so sometimes I think it is down to personality as well, not just profession." (FG)

The health practitioners from Interagency Southern teams were observed to display high levels of animation in their focus group when discussing issues surrounding role and professional identity. There was a distinct increase in the volume of their voices when discussing the topic, and interjections were more

rapid and expressive. During the health practitioners' focus group, the differences between Interagency Northern and Interagency Southern Services rapidly became apparent, as did the differences between how the Interagency Southern teams operated. The following discussion in relation to team processes illustrates the issue:

Interagency Southern, Health Practitioner 7: "I guess if we started off with a telephone call it would have been the care officers or the social workers who would be on duty and take that call."

Interagency Northern, Health Practitioner 3: "Can I say that is quite different from our team because we would all take a turn at doing duty and still continue to do so. We are rota'd in to do duty. Every member of the team is rota'd in to do duty."

Interagency Southern, Health Practitioner 7: "I think that is how it should be. I think at the time we were very clearly told that is not our role."

Interviewer: For the purposes of the discussion we are talking about the contributions of different health professions here."

Interagency Southern, Health Practitioner 6: "The health visitor (in my team) did (do duty)."

Interagency Southern, Health Practitioner 7: "The health visitor didn't initially, certainly when I was there."

Interagency Southern, Health Practitioner 6: "I think it is all to do with the CAMHS role, it was never clearly defined. Then later on when we were pulled out to part-time then certainly the team I was in decided my time would be used more beneficially to do other things rather than duty."

Interagency Northern, Health Practitioner 1: "That would be slightly different within the Interagency Northern in that all the people who work within the team take part in duty. It doesn't matter what professional background you come from, that is taken on as a full-team responsibility." (FG)

The above dialogue clearly illustrates how the differences in roles and functions of practitioners were related to the professional background of the health practitioner within Interagency Southern Service; that is, health visitor or community psychiatric nurse. The differences also reflected which team, within the Interagency Southern Service, the practitioners were located in and finally if the health practitioner worked within Interagency Northern or Interagency Southern Service.

However, it is important to emphasise that the health and social care practitioners from Interagency Southern teams were at pains to point out that they valued working with their colleagues and they valued each others' skills. The issue of role definition was, on balance, considered to be a predominantly structural and organisational issue that required more effective management. As one social care practitioner from Interagency Southern Service commented:

Interagency Southern, Social Care Practitioner 2: "Can I just add the other people from the other agencies within our team do support us as workers. You know you were saying that you (Interagency Northern Service) do work together and they (health practitioners, Interagency Southern Service) do that. So when we did have a CAMHS worker and when we had a health visitor we could ask for advice and support so we

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did work together in that way, it's just that their roles, you know, what they do in the team was quite specific, about what they undertook." (FG)

A health practitioner from Interagency Southern Service, who was not a community psychiatric nurse, reported experiences of interagency working that had initially been similar to those of their community psychiatric nurse colleagues. However, over time, their role and contribution to the work had become clearer. It may be significant that this practitioner had generally undertaken more of the team's core tasks than the community psychiatric nurses, occupying less of a distinct and consultative role. In addition, the practitioner's manager was from the same professional background and therefore management and supervision of clinical practice had been contained within the practitioner's interagency team.

This approach of maintaining the full management and supervision of health practitioners within the teams/service was very similar to that adopted by health practitioners within the Interagency Northern Service, and reflected a more integrated model of interagency working. As the health practitioner stated:

> **Interagency Southern, Health Practitioner 3**: "I have been in the (Interagency Southern) team for well over three years and I started off thinking, you know, with no remit at all and we wrote our own job descriptions, and found our way along, and was thrown really by what was expected we might be able to do in the beginning, which seemed quite alien to me. But as time has gone on obviously I have had a lot of experience now so I don't feel there are particular issues for me now." (II)

All the health practitioners within the Interagency Northern Service had always undertaken more generic, core tasks within the team. It appeared that this had been a significant factor in contributing towards fewer internal team tensions in relation to the health and social care practitioners' roles and contributions.

The issues surrounding professional roles and responsibilities were the dominant themes of both focus group discussions, and were the themes that were observed to generate the most intense feelings, particularly within the Interagency Southern teams. The practitioners' strong feelings in relation to professional identity are supported by Adams et al (2006) who acknowledged the importance of professional identity upon practitioners' development. It may be concluded that, based upon the amount of time practitioners spent on discussing professional roles and responsibilities, this theme is a central theme for analysis when considering the benefits and challenges of establishing interagency services.

7.2.4   Physical, emotional and professional isolation:

Interviewees from all practitioner groups reflected upon a general sense of physical and emotional 'distance' from their profession and from their parent organisation. They felt that it was difficult to maintain contact with colleagues from the same professional background and to remain up to date with developments in their sphere of practice:

> **Interagency Southern, Health Practitioner 1:** "I do feel that working in a multi agency environment you need to keep the links about what it is that is going on in your organisation. For your own sanity you are still health

personnel and you need to hang on to that reality. I don't think it is necessary to keep it with you all the time because you are a team here even if you are from a different profession." (II)

Interagency Northern, Social Care Practitioner 3: "I feel the links are important, I have contact with a previous colleague on a regular basis. I also have supervision with a previous line manager. I read Community Care (magazine) and social services information to keep up with news within the department. I also go on social services training courses." (II)

Interagency Northern, Social Care Practitioner 5: "The key issue for me is keeping abreast of things, the changes. If people are turning to you to ask about the policies changing, then it is the case of keeping up with them because you are the one they (the interagency team) are going to turn to. I don't get chance to, although we have discussed how we can. You are not left on your own; you still have your supervisors and a manager with a social services background." (II)

The health and social care practitioners' feelings of isolation were exacerbated by a sense that they were not particularly valued by members of their own profession outside of their interagency team:

Interagency Northern, Social Care Practitioner 5 : "I think the social services don't value us enough, I don't know why that is, well I think I do know why that is. They have a very entrenched view about difficult cases and sometimes they get stuck and don't know what to do. They see the child with lots of problems and their reaction is to refer to CAMHS services and it is not always appropriate and we tell them that and they think we don't do anything basically." (II)

Interagency Northern, Health Practitioner 8: "I don't think I have been appreciated. I will say in terms of respect of health colleagues in the

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CAMHS team. I really did feel that for the first two years they didn't understand our role or function." (II)

Interagency Southern, Health Practitioner 3: "That depends upon the area. In one area they do and in the other I don't know, they (colleagues in health) are much more closed and set in their ways." (II)

However, it would appear to be the case that the length of time a service had been in existence had an impact upon this social care practitioner's reflections:

Interagency Southern, Social Care Practitioner 5 : "I think as social work colleagues outside of Interagency Southern Service begin to understand the role then yes I have started to feel valued by social service colleagues. Initially I didn't because I think they saw us as second class social workers." (II)

It would seem that practitioner views about how much they were valued by colleagues outside of the interagency teams were based upon their belief that others did not really understand their roles. However, it also appeared to be the case that perceptions changed over time as the services became more established and roles became more defined and comprehensible to those outside the teams.

Practitioners appeared to experience feelings of isolation at two levels. On one level they discussed feeling isolated from their 'parent' health or social care agency and at another level they felt isolated from their profession:

Interagency Southern, Health Practitioner 7: "The reason I felt so isolated was working in the social services structure." (II)

Interagency Southern, Health Practitioner 6: "I think some of the major things are lack of access to health information, yes, you are a lone worker really." (II)

There would also seem to be a connection between health and social care practitioners' reported feelings of isolation and the high demands placed upon them by colleagues external to the service. Feeling 'dumped on' by their professional colleagues and staff within mainstream children's health and social care services reinforced their separateness, difference and ultimately isolation.

The health practitioners' focus group, as a whole, identified professional identity and roles as a source of ongoing tensions. In particular, they emphasised the difficulties of maintaining their professional identity when they were located outside of their 'parent'agency; traditionally the 'home' of their profession. There was a general sense of isolation from their profession, as illustrated by the health practitioners' focus group discussion:

Interagency Southern, Health Practitioner 6: "We haven't got a bloody voice."

Interagency Southern, Health Practitioner 7: "I was joining social services for a year and certainly some of the ways that I would work completely conflicted with some of the ways that social services are working and there was no support."

Interagency Southern, Health Practitioner 6: "I felt very much that we were looked at to give more support to other members of staff from the CAMHS perspective and no support was coming to us apart from the three of us getting together". (FG)

The social care practitioners within Interagency Northern teams were also physically located outside their 'parent' agency and were working within the NHS Health Trust's CAMHS service. Their issues surrounding professional isolation were more concerned with the lack of perceived respect and value from mainstream children's social care services. Health and social care practitioners clearly felt the need for positive reinforcement of their professional identity, expressed through not only the need for clear profession based roles, but also reduced feelings of professional isolation. The positive affirmation of the value of their work from their parent agency would appear to contribute in some way to this.

The community psychiatric nurses within the Interagency Southern teams had very different views from the rest of the health and social care practitioners about how valued they considered themselves to be by colleagues, both within their own interagency teams and by health colleagues outside of their teams. They were generally uncertain as to how much they were valued by colleagues within the interagency teams, but were much clearer about feeling valued by their health colleagues within the child and adolescent mental health services.

The differences experienced by the community psychiatric nurses could be explained by the fact that they had retained a very distinct and profession based

role within the Interagency Southern teams, resulting in tensions within the interagency teams. Their role was clearly based upon their professional background and they retained very close supervisory links with same profession practitioners from their parent agency, thus reinforcing a strong professional identity. As a result, the community psychiatric nurses within the Interagency Southern teams saw themselves as less 'on the outside' of their profession and parent organisation, and more 'on the outside' of the interagency teams they were working within.

The experiences of the community psychiatric nurses within Interagency Southern Service contrasted sharply with those of all the other health and social care practitioners within Interagency Northern and Interagency Southern teams. The other health and social care practitioners had developed closer working relationships with colleagues within their teams and, conversely, were feeling less valued by their health or social colleagues working outside the interagency services.

It is evident that, to counteract feelings of isolation, the practitioners needed to 'belong' to something. They appeared to need to feel 'on the inside' of something, and that something could be their profession, their inter-professional team, or perhaps the parent agency from which they were seconded.

7.2.5   Addressing the influence of agency and professional culture.

Schein (2004) asserts that a culture consists of three levels; the most visible level

is behaviour and artefacts, such as behaviour patterns, architecture, dress code, and so on. The next level is values and norms, and these to a large extent determine behaviour. The third and most basic level of culture is denoted as underlying assumptions. These are often embedded in a given culture and are taken for granted by the people who share that culture.

Health and social care practitioners from both interagency services were clearly influenced by the culture of their profession and the culture of the parent agency from which they were seconded:

> **Interagency Southern, Health Practitioner 7:** "I had to go in and learn how to be part of social services. It was a nightmare because I constantly had a battle going on with the team around 'yes that might be how social services did it, but this is not a social services team, it is a separate and new team and needs to come up with a way of doing things differently'. Health and social services come from two completely different cultural backgrounds. Health is very bureaucratic and medical oriented, it's very linear, and you diagnose and prescribe. Social Services are a very different school of thought. Trying to bring the two together can cause a major clash. It makes you feel vulnerable if you are not working to the standards that are set down by your professional group." (II)

The health practitioner cited above clearly articulated, in vivid language, the difficulties experienced when seconded to work within a social care agency and all that entailed culturally. A health practitioner working within Interagency Northern Service also reflected upon some of the issues created by different professional cultures:

Interagency Northern, Health Practitioner 2: "I think initially the difference in professional perceptions could be a difficulty and sometimes that still raises its head, but probably less."

Interviewer: "Can you expand on what does that mean?"

Interagency Northern, Health Practitioner 2: "Well I think for instance you may bring a case to discuss and it might be that the social workers were coming from a child protection point of view and the community psychiatric nurses were coming from another angle and myself as a health visitor from a parenting family view. Sometimes that can lead to differences of opinion." (II)

There were also differences reported in beliefs about how proactive services should be to engage clients, with health practitioners leaning towards the responsibilities of individuals to engage with services and the social care practitioners leaning towards more pro-active methods of engaging resistant children and families. As one of the practitioners stated:

Interagency Northern, Health Practitioner 8: "We are divided in the team as two of us come from a very much motivation background. You (the child and family) have to demonstrate willingness. Other colleagues are more rescue, and I can't absolve the (social care) coordinator in that, who will say 'deliver (a service) to them'. That is a tension time and time again." (II)

The above quotations from the individual interviews illustrate how practitioners experienced tensions as a consequence of working more closely with different professional cultures and discussing different conceptual frameworks. The health and social care practitioners from Interagency Northern Service considered these

debates to be healthy and valuable, but Interagency Southern Service team practitioners were more likely to emphasise the tensions as barriers to developing harmonious interagency and inter-professional working relationships.

Professional and organisational cultures were discussed within the focus groups and were identified as a source of tension:

> **Interagency Southern, Health Practitioner 7:** "It felt very much like you were working for social services for a year and that was very difficult, certainly from my point of view that was extremely difficult. I imagined that I was going into a multi agency team with multi agency documentation, multi agency protocols, procedures and I wasn't." (FG)

The practitioners' findings are in support of numerous studies and literature reviews conducted by, for example, Molyneaux (2001), Blinkhorn (2004), Peck (2001, 2004)), Horwath and Morrison (2007) and the Children and Young People in Mind Report (DCSF, 2008e). The impact of different professional and agency cultures is considered, by such studies, to present barriers to more harmonious working relationships across health and social care. Various strategies, such as inter-professional education, are recommended by Evetts, (1999), Freth (2005), and Couturier (2008) as potential ways to overcome such cultural barriers.

7.2.6 The impact of structural and agency issues.

Those health and social care practitioners who were not 'hosted' by their parent agency were seconded to their respective interagency service. They had maintained their contracts of employment with their parent agency and this

resulted in practitioners, within the same teams, working to different 'terms and conditions'. There were differences in allowances for annual leave, salaries, practitioner grading structures and working hours. All of these created varying degrees of dissatisfaction for different practitioners within the interagency services.

All social care practitioners were generally concerned that the health practitioners received higher salaries. They considered this to be unfair, as they believed there to be few differences in tasks undertaken and levels of responsibility assumed within their teams. The issues were illustrated in the following individual interviews:

> **Interagency Northern, Social Care Practitioner 3:** "There is a problem in differences in salaries. There are differences with holidays, statutory days, which is sometimes difficult within the team to get cover on certain days, so it often falls on the health staff." (II)

> **Interagency Southern, Social Care Practitioner 9**: "I think there are some tensions in the team around different roles. Part of that boils down to terms and conditions that people have been employed on. Some staff are expected to work weekends, some staff are employed nine to five, some are on higher salaries for less responsibilities." (II)

The issues were also addressed in the social care practitioners' focus group:

> **Interagency Northern, Social Care Practitioner 4**: "I actually felt quite guilty because I had essential car users (allowance), whereas a lot of colleagues on the health weren't allowed it, but also their pay structure is different to ours. So I found out that they may be on a level, that I thought

was my level but they were actually getting a higher salary. So I suppose in some ways it does balance out."

Interagency Northern, Social Care Practitioner 5: "No, I know there is not equal pay in our team. It doesn't affect me that much but I do find it annoying that people who are doing the same jobs…. and er, it's not fair."

Interagency Southern, Social Care Practitioner 5: "Yes, I think it is an issue for everybody. There are also the contractual hours. For multi-agency services it is about flexibility when working with families and some of that could be out of hours and weekends and the other agencies don't want to buy into that." (FG)

Those social care practitioners who did not have a professional social work qualification felt this issue most strongly. They explained that they worked with extremely complex situations, holding key worker responsibilities, undertaking office/team duty tasks and working flexible hours, incorporating evenings and weekends. In contrast, the community psychiatric nurses within Interagency Southern Service received a higher salary, and as noted earlier, did not hold key worker responsibilities or undertake office cover. None of the health staff were expected to work the flexible hours worked by social care practitioners.

The social care practitioners also identified issues surrounding salaries as a source of tension:

Interagency Northern, Health Practitioner 6: "Pay, conditions and equality to my mind have not been addressed within Interagency Northern Service. Even now there is a major disparity between what team members are paid to do, which is fundamentally the same role." (II)

The different pay scales and employment terms and conditions were considered to be a source of irritation that required resolution rather than a reason not to progress interagency services. Their frustrations were directed towards their employers and senior managers rather than towards the individual practitioners whom they perceived to be in a more favourable contractual position. Practitioners suggested solution to this difficulty was to locate all practitioners under the same management umbrella. It was believed that matters such as annual leave entitlements and policies and procedures could then be consistent for all of the team members.

Further organisational issues that contributed towards the difficulties experienced by the interagency services related to what the social care practitioners' focus group observed as agencies' different priorities:

> **Interagency Southern, Social Care Practitioner 2:** "Because everybody has performance indicators and targets to meet, that's why services and managers are putting them in to allow them to meet that. But there is the work of the team and everybody achieving that in a multi-agency way." (FG)

The social care practitioners within Interagency Northern Service expressed the view that their social services department's agenda for placing them within an interagency CAMHS service was predominantly driven by a perceived need to improve the availability of child and adolescent mental health services to children and young people who were 'looked after' by the local authority.

Social care practitioners from Interagency Southern Service expressed their belief that community psychiatric nurses had been located within Interagency Southern teams to address the difficulties posed by lengthy waiting lists in the NHS for local child and adolescent mental health services.

The health and social care practitioners discussed how they were placed under pressure to meet the priorities of their parent agencies within the interagency services. They considered that any perceived failure by their interagency service to make a positive impact upon the priorities of their parent agency would have a negative impact upon how their senior managers viewed the value of the interagency service.

The reported concerns that surround the structural and organisational issues appeared to reinforce the practitioners' feelings of being on the outside of mainstream service provision. Several practitioners discussed a general lack of ownership and commitment by senior managers to tackle the challenges and tensions created by different health and social care structures and agencies working practices.

7.2.7   Children and families' antagonism towards social workers.

Health and social care practitioners described experiencing negative reactions from children and families accessing services to the presence of social workers in the inter- professional teams. They noted a general resistance from people in receipt of services to working with social workers:

Interagency Northern, Social Care Practitioner 4: "When they find out I am a social worker, often clients don't like it. Sometimes they don't want social services involvement and it makes it difficult sometimes." (II)

Practitioners reported that the presence of health staff within their teams helped to dilute this perception and it promoted the engagement of children and families in need of services with the teams:

Interagency Southern, Health Practitioner 3: "If it is seen as multi disciplinary it's seen as something different. The public and the users have a different view of it. I think people coming into a social services remit are always pretty anxious." (II)

Practitioners did not identify the integration of their services as a deliberate strategy for promoting a more acceptable 'face' for the work of social care practitioners. However, it appeared that a reduction in stigma could be an unintended consequence of the development of more integrated health and social care teams. This finding is supported by research conducted by Moran et al (2007) and Tunstill and Allnock (2007) into the delivery of early intervention family support services by inter-professional and co-located teams. They reported that offering services in community based settings other that traditional social services establishments had the effect of reducing any stigma associated with receiving such services.

The number of themes identified around the difficulties of interagency team working clearly outnumbered the benefits identified. However, the health and social care practitioners were consistent in stating, throughout the research

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interviews, that the benefits of interagency team working outweighed the difficulties.

It is also clear from a review of the findings that both health and social care practitioners shared very similar views of the difficulties and benefits of interagency team working. However, the degree to which they perceived the impact of the themes varied according to issues, such as differences between the nature of the roles and tasks they were undertaking, and if the day to day management of the interagency team was maintained within their parent/profession based agency or if they were seconded to a host agency that was not usually the employing host agency for their profession.

Finally, the interagency service within which the practitioners' were based was a key variable that impacted upon the practitioners reported experiences. To illustrate the differences between the interagency teams, Chapter Five described the structures and organisation of the two interagency teams and classified them according to their assessed degree of integration utilising Ovretveit's (1997) framework for analysis. This difference between the two interagency services has emerged as a fundamental factor from an analysis of the research interviews.

7.3   Inter-organisational network analysis as a framework to summarise the findings of the practitioners' research interviews.

Chapter Five described the structure and organisation of the interagency services participating in this study. The researcher assessed Interagency Northern and

Interagency Southern Services in relation to their levels or degree of integration according to a framework developed by Ovretveit (1997). Interagency Southern Service was classified as consisting of coordinated teams and Interagency Northern Service was classified as consisting of integrated core and extended teams.

The previous chapter described how the questions contained within the individual and focus groups were informed by a review of the literature and Benson's (1975, 1983) four domains for analysing the 'health' of interagency networks: ideological consensus, domain consensus, positive evaluation, and work coordination. After each of the four key questions used to structure the focus groups (refer to Appendix E), interviewees were individually requested to place a rating on a Likert scale to indicate their level of agreement with a statement that captured the essence of the question they had been asked to explore and that corresponded directly to one of the four domains.

The adapted Likert scale ratings were compared to the text of the health and social care practitioner focus groups and, for the purposes of trustworthiness and credibility, contrasted to statements made within the individual interviews. Benson's (1975, 1983) four domains are adopted as a framework to support an initial analysis of the themes identified and the key variables utilised were health or social care practitioner, and Interagency Northern or Interagency Southern Service.

7.3.1 Work coordination (the way the work is organised).

This domain captured the extent to which practitioners were operating within aligned working patterns, processes and structures. All the social care practitioners rated their alignment between working patterns and culture between four and five on the scale. These scores appeared to reflect the research interview discussions that identified positive working relationships between practitioners within the interagency teams and a general agreement over their attitudes and approach to organising their work within their teams. The high scores did not reflect their comments in relation to the tensions generated by different terms and conditions of employment or a perceived lack of flexibility from their health practitioner colleagues.

The social care practitioners within Interagency Northern Service were located within an NHS Health Trust, but this did not appear to impact in a negative way upon their evaluation of the extent to which the agencies and practitioners were prepared to work together. The tensions created by different employment terms and conditions did not appear to have impacted significantly upon the social care practitioners' ratings. The scores do appear to reflect their overall satisfaction and enthusiasm for interagency team working, and their view that many of the reported difficulties were perceived as surmountable on the road to more integrated team working.

In contrast, the health practitioners rated the alignment between working patterns and culture between two and five, representing a much broader spread of opinion

than the social care practitioners. The lower ratings were provided by the health practitioners from Interagency Southern Service and would seem to be a reflection of the tensions surrounding confusion in relation to employment terms and conditions. For the health practitioners this was exacerbated by their secondment to a social care led interagency team. Health practitioners within Interagency Southern Service identified tensions associated with working in an 'alien' culture and environment and feeling their 'voices were not being heard'. However, it is important to recognise that five out of the seven health practitioners did provide ratings between three and five for this domain.

7.3.2   Domain consensus (what are the tasks to be achieved?)

This domain captured evaluation of the extent to which there was agreement regarding the role and scope of each profession's/practitioner's contribution to the tasks of the team, that is, how the different practitioners would work together to achieve the necessary and agreed tasks. All the social care practitioners provided a rating of five in relation to the level of agreement over the role and contributions of the different health and social care practitioners to the work of the team. In reviewing the text of the transcript, it was found that Interagency Northern Service practitioners were clear that, irrespective of practitioner background, they would generally undertake the same tasks within the teams. However, they also identified some profession specific contributions that they were able to make that would distinguish them from colleagues from a different professional background. Interagency Southern Service practitioners were clear that health practitioners were more prescribed and limited in their role and contributions to the work of the

team.

The health practitioners provided ratings that covered the entire scale of zero to five, with lower ratings supplied by practitioners from Interagency Southern Service. There were particularly low ratings from all health practitioners in relation to the perceived roles and contributions of sessional practitioners to the work of the teams; for example the education psychologist, clinical psychologist, and education welfare officers.

The focus group discussions in relation to roles and contributions to the interagency teams were almost entirely dominated by the health practitioners from the Interagency Southern Service, indicating that feelings had been running high over this issue:

> **Interagency Southern, Health Practitioner 6:** "What needed to be done was clear, not how it would be done." (FG)

> **Interagency Southern, Health Practitioner 7:** "I think there was a disparity, certainly as CAMHS workers going in to Interagency Southern Service, what we considered to be our role to be and what the rest of them (Interagency Southern practitioners) considered our role to be and that never truly matched up." (FG)

In contrast, the health practitioners from Interagency Northern teams appeared to be much clearer about their roles and contributions to the work of the team, including those of the CAMHS community psychiatric nurses. They all provided scores that were towards the higher end of the Likert scale, illustrating clear and

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marked differences between the interagency services in relation to this domain.

7.3.3 Ideological consensus (how will the tasks be achieved?)

This domain captured the perceived amount of agreement over what tasks are to be achieved. All the social care practitioners provided a rating between three and four in relation to the amount of agreement over the tasks that their team would undertake and how they were achieved. The lower scores were provided by the social care practitioners from Interagency Southern Service, and the lower ratings were supported by analysis of comments made during their individual interviews.

The practitioners had expressed frustration at a perceived lack of flexibility from their health practitioner colleagues. Close scrutiny of the text from the focus group and individual interviews was undertaken, but it was difficult to ascertain why the Likert ratings were slightly lower for this domain than for work coordination. A possible interpretation is that the tension surrounding role definition may have contributed in some way to the lower overall ratings.

In contrast to the social care practitioners, the health practitioners provided a spread of ratings across the whole scale of zero to five, again with five out of the seven practitioners providing ratings between three and five. Health practitioners from the Interagency Southern teams appeared to be frustrated about how work was allocated and also the lack of clarity about how allocated tasks were then undertaken, thus contributing to overall lower ratings for this domain.

7.3.4   Positive evaluation (how we feel about each other).

This domain captured the extent to which practitioners had a positive view of the contributions of practitioners from different professions to the work of the teams. The social care practitioners wished to distinguish between their evaluations of the contributions of professional groups to the work of their teams and their evaluations of the contributions of the different agencies.

For example, social care practitioners from Interagency Southern teams gave ratings of one and two in relation to the contributions of the Health and Education Services to the work of their teams. These scores were probably a consequence of the withdrawal of health and education practitioners from the Interagency Southern teams. However, the practitioners provided ratings of between four and five in relation to their evaluation of the contributions of the different professional groups to the work of their teams. These ratings would seem to be consistent with the positive comments expressed by the social care practitioners throughout the research interviews and focus groups and their obvious respect for their colleagues from different professions.

All the health practitioners gave a high rating (between four and five) to the contributions of different practitioner groups to the work of their teams. They wanted to differentiate between the work of the 'core' team members and their evaluation of the work of the sessional practitioners, for whom they provided ratings between zero and three. The high ratings for professional colleagues

within the interagency teams were a consistent feature of the research interviews and focus groups for both health and social care practitioners.

The findings of the practitioners' research interviews can be usefully summarised by the following tables which categorise the levels or degree of consensus across Benson's (1975, 1983) four domains as low, medium or high. These are not quantitatively based research categories, but are the qualitative judgments made by the researcher as a result of reflections upon the outcomes of the practitioners' individual and focus group interviews, including the Likert ratings exercise. To give some indication of the alignment of the qualitative judgement to the Likert rating scale, an average Likert rating of zero to one would be considered as low, two to three as medium and four to five as high.

Table 8

An evaluation of the levels of consensus expressed by health and social care practitioners within Interagency Northern Service.

Domain consensus	Ideological consensus
HIGH	MEDIUM
Positive evaluation	**Work coordination**
HIGH	HIGH

Table 9

An evaluation of the levels of consensus expressed by health and social care practitioners within Interagency Southern Service.

Domain consensus	Ideological consensus
LOW	MEDIUM
Degree of positive evaluation	**Degree of work coordination**
HIGH	MEDIUM

7.4   Summary.

An appraisal of the findings of both the individual interviews and focus groups would indicate that Interagency Southern Service, classified in this thesis as coordinated teams, had achieved lower levels of equilibrium across Benson's (1975, 1983) four domains than Interagency Northern Service, classified as core extended teams. It would appear to be significant that the greatest difference between the interagency services concerned domain consensus, expressed through tensions surrounding the role and contribution of each professional group to the work of the teams.

When considering the practical application of Benson's (1975, 1983) framework to addressing the issues raised by the health and social care practitioners, at a very simplistic level, it would indicate that Interagency Southern Service had achieved a level of disequilibrium. The goal for Interagency Southern Service would be to achieve higher levels of equilibrium across all four domains by taking practical steps to resolve issues contributing to the lower levels of consensus within each

domain. For example, the lowest level of consensus was achieved within domain consensus. This would indicate that the service would need to address issues surrounding agreement in relation to what the tasks of the interagency team should be, and what the roles and contributions of different professional groups should be to support and address the identified tasks. This analysis is reflected in the research findings where practitioners repeatedly expressed tensions arising from confusion over what their role was in the interagency service.

The different research methods applied in this study did not generate different themes and the issues raised in both the individual interviews and focus group discussions were remarkably similar. However, the focus groups proved to be a valuable research tool as the discussions added more qualitative depth to the information produced, enabling a different emphasis to be shed upon the existing themes. For example, in contrast to the findings of the individual interviews with the health and social care practitioners, there was less discussion within the focus group interviews about the benefits of working within the interagency teams.

The focus group format appeared to support a group dynamic that concentrated upon the problems or difficulties of working within interagency teams. This dynamic was particularly powerful within the health practitioners' focus group, where the researcher found it challenging to move the conversation from focussing upon the difficulties, such as professional roles, to the remainder of Benson's (1975, 1983) four domains; as covered by the remaining three questions.

However, as previously discussed in Chapter Four, this project is essentially

qualitative in nature and does not seek to uncover absolute truths. Therefore, it is not the researchers' intention to establish which research interview method was most successful in eliciting the 'true' attitudes and experiences of the practitioners. It is, however, the role of the researcher to openly and transparently observe the differences and place them within a framework of analysis that seeks to make connections and increase understanding of reported experiences by triangulating the emerging data.

The utilisation of inter-organisational network analysis and Benson's (1975, 1983) four domains as a tool for both structuring and analysing the research interviews allowed consideration of the themes identified by the health and social care practitioners in relation to levels of equilibrium being achieved within the interagency services. It would seem to be the case that practitioners from Interagency Southern (coordinated) teams expressed their dissatisfaction with the organisation of their teams more strongly than practitioners from Interagency Northern (core extended) teams. This analysis was particularly evident from the health practitioners' working within Interagency Southern Service.

Health and social care practitioners from Interagency Northern teams were positive, across Benson's (1975, 1983) four domains, about their experiences of interagency team working. Their participation in core team tasks was identified as extending their skills, and their concerns, in relation to the need for a profession based contribution to the work of the teams, were being addressed over time. It is concluded that high levels of equilibrium were a consequence of the way in which the teams were organised and the degree of team integration.

In contrast, health practitioners from Interagency Southern teams, specifically the community psychiatric nurses, were less integrated into the core activities of the teams and felt very strongly that the lack of clarity in relation to their roles had contributed towards many of their dissatisfactions with interagency team working.

The extent to which practitioners were integrated into the 'core' work of the team was clearly a significant factor influencing their experiences of interagency team working. Paradoxically, the more specialist and professionally prescribed the practitioner's role, the greater the level of confusion surrounding their contributions to the work of the interagency teams. The more generic the role occupied by a practitioner, the fewer the tensions surrounding their roles within the teams.

Underpinning all the identified benefits and difficulties of interagency and inter-professional team working, identity remained a key factor for all health and social care practitioners as they struggled to ensure that they maintained a profession based identity within the interagency teams. The practitioners' need for an identity was an overarching theme of the research interviews as they expressed a need to 'belong' to something.

In addition to their identified need to have a professional identity, practitioners reported that, over time, they were working through the tensions surrounding role and professional identity and as a consequence increased satisfaction emerged with interagency team working. With the exception of the community psychiatric

nurses within Interagency Southern Service, the health and social care

practitioners had developed a stronger identity with their interagency teams.

Despite the challenges and frustrations identified by health and social care

practitioners, they were all positive about interagency and inter-professional

working, believing that the experience had improved their skills. They were also

clear that increased integration of health and social care children's services was

the way forward to organise and deliver services to children and families.

8. The managers' views and experiences.

The previous chapter discussed the perceptions of the health and social care practitioners. This chapter focuses upon the findings from the individual interviews and focus group discussion with six health and social care managers. Three of the managers were from a health agency background and three were from a social care agency background. All six of the managers had participated in the planning of the services and none of the managers had any immediate operational management responsibility for the services. However, the managers continued to have direct managerial responsibilities for the team leaders within Interagency Northern or Interagency Southern Services and also the deployment of resources to them.

Chapter Five discussed and compared the assessed levels of integration of the teams that comprise Interagency Northern and Interagency Southern Services. This chapter explores the levels of integrated working which the managers experienced in relation to working with their health or social care colleagues. The differences between the practitioners' and managers' perceived levels of integration provide a valuable opportunity to analyse the impact of different levels of integrated working upon practitioners' and managers' experiences of interagency working.

The findings of the managers' individual interviews and focus group were analysed in the same way as the practitioners' interviews and focus groups. It was recognised that the managers occupied different roles in relation to their

contributions and involvement in the development and operations of the interagency services, and therefore they were expected to report different experiences to the practitioners.

The data from the individual interviews and the focus group discussion revealed no fundamental differences in findings between the two methods. The findings are therefore presented together to illustrate the common themes, irrespective of the research method used.

Due to the limited number of managers participating in the research, it was not practical to convene a focus group for health managers and a focus group for social care managers. Therefore the managers participated in a single focus group interview. It is acknowledged that this difference in the structuring of the focus group interview may well have had an impact upon the dynamics of group discussions, thus influencing the managers' expressed views and opinions. For example, the health or social care managers might not have felt able to be as open about their experiences of interagency working in the presence of colleagues from different agencies. However, group discussions do facilitate a dialogue and offer an arena within which the managers could further explore and discuss their views and opinions.

The limited number of participating managers could result in the possibility of matching a quotation to a particular manager. To ensure that confidentiality was maintained, the managers' number code is not revealed and the quotations cited do not identify the service for which the manager has responsibilities. However,

the method from which the data arose is identified as either individual interview (II) or focus group (FG).

The inclusion of managers in the research allowed for the identification of new or different themes and categories to those of the practitioners, and analysis of the data was sensitive to the possibility that managers might place a different emphasis upon the relative importance of some of the themes discussed by practitioners. This was found to be the case and the findings are presented under similar, but different, category headings to those of the practitioners. The key categories were classified as either benefits or difficulties and are identified as follows:

The benefits of interagency working:
- Promoting ease of communication.
- Enhancing practitioners' knowledge and skills.
- An improved service for children and families.

The difficulties of interagency working:
- Addressing the influence of professional and agency cultures
- The impact of structural and agency issues
- Children's and families' antagonism towards social care practitioners.
- The role of central government.
- The lack of trust
- The availability of resources.

This chapter presents an analysis of the findings of the managers' responses and considers the impact of variables such as their role as a health or social care

manager, which interagency service they had managerial responsibilities for and an assessment of how they organised their collaborations in terms of level of integrated working.

To maintain a consistent research methodology, the schedules for the managers' semi-structured interviews (refer to Appendix D) and focus group (refer to Appendix F) were developed to a similar format to that of the practitioners. They were also designed to elicit responses that facilitated exploration of consensus surrounding Benson's (1975, 1983) four domains. However, it was necessary to adapt the questions to be more relevant to the managers' circumstances and work experiences.

For example, the practitioners were asked to discuss any benefits to working within their interagency team, followed by a question that asked them to discuss any difficulties of working within their team or service. In contrast, the managers did not work within an integrated team setting, but were located within a single health or social care agency. Therefore the questions were adapted to their circumstances and in this instance they were asked what they considered to be the benefits and difficulties of an interagency approach for the client group.

The application of Ovretveit's (1997) typology for describing inter-professional teams (as discussed in Chapter Five) allows for consideration of where, upon the continuum of cooperation through to integration, the managers might be located:

- Degree of integration – the managers were not located together and their priorities were determined by their agency.

- Memberships of a group –the individual managers did not share a common single agency or single professional group membership.
- Process (client/patient pathway) – the managers shared a common interest in relation to the organisation and provision of services to children and families, and a common overarching strategic framework for children's services in their locality. However, they worked predominantly to their own agency's protocols, processes and priorities.
- Management arrangements – the managers did not work within a common, single or coordinated management structure.

It can be concluded that the managers working arrangements can be described as a coordinated network association, that is, not a formal team. Such an analysis offers the opportunity to study any differences between the practitioners' and managers' experiences of interagency working and the potential impact of different levels of integrated working as an important variable.

8.1   The benefits of interagency working.

Consistent with the views expressed by the practitioners, the individual interviews with the managers also revealed a strong belief in the value of interagency working:

> **Health Care Manager**: "My vision is a wholly integrated children and young people's service. Moving to a Children's Trust and building more disciplines into it. I don't see any barriers between the agencies, I know there are, but I don't think there need to be." (II)

A social care manager expressed their vision for children's services as:

> **Social Care Manager**: "Probably a more integrated service delivered by a range of professionals on the basis of shared professional knowledge and understanding and probably transferable skills." (II)

However, compared to the views expressed within their individual interviews, the managers' support for interagency working was expressed more cautiously in the focus group:

> **Social Care Manager**: "I think that whilst the idea was good there were some structural problems that militated against, but that doesn't mean that it wasn't a good one." (FG)

The managers justified their overall optimism for interagency working by identifying the benefits discussed below:

8.1.1 Promoting ease of communication.

The managers described how coming together to plan the development of Interagency Northern and Interagency Southern Services had opened up discussions about children's services and improved their communication with the resulting benefit of reducing the number of disputes between them over issues such as criteria for access to the wider mainstream children's services. They reported that improved communication had contributed towards the breaking down of barriers between them as health and social care managers:

> **Health Care Manager**: "A lot of time was (previously) spent on battles about whose criteria fitted what and the frustrations about not working

together. Joint and interagency models give real scope for the breaking down of the old barriers and the perceptions that some people do this and others don't do that." (II)

However, the reported improvements between them appeared to be short lived and confined to the planning stages of interagency working, when they were having frequent meetings and contacts. A social care manager commented:

> **Social Care Manager:** "From my point of view we had a very positive and successful planning stage. We spent a lot of time talking about underpinning values and approach. Don't just sit there and be a social work manager and health professional, just think about what might be the shared ethos and values that underpinned the service." (II)

8.1.2   Enhancing practitioners' skills and knowledge.

There was a belief that practitioners' skills and knowledge had been enhanced through working within more integrated interagency teams. They reported that practitioners were learning from each other and they believed that the level of understanding between practitioners was resulting in an improved quality of service. A health care manager quoted a health visitor informing them that working for the Interagency Southern Service was:

> **Health Care Manager**: "Absolutely brilliant, it has helped my professional development and I feel I am doing a better service." (II)

A social care manager stated:

> **Social Care Manager:** "It means that there was a more coherent understanding of what children's needs are; better assessments. It breaks down some of those professional constraints, enhances the skill base of individual workers." (II)

The managers considered practitioners to be more flexible in how they worked and, as a consequence, joint training plans had been developed across the health and social care agencies.

> **Social Care Manager:** "It makes the workforce more flexible at a time when we are struggling to recruit to our respective professions or disciplines." (II)

The managers made no reference to any positive benefits that interagency working might have had upon their own knowledge and skills.

8.1.3 An improved service for children and families.

The managers discussed the view that access to CAMHS and family support services had improved and families were not experiencing multiple referrals to multiple services before receiving the support they required. They believed that resources were being used more effectively as families received a more coordinated response to meet their needs. Therefore, families experienced less duplication of assessment activity and reduced contacts from numerous practitioners and agencies:

> **Health Care Manager:** "From a user perspective it enables them to be pointed into the service that is most appropriate instead of waiting several months only to be re-directed. When you tracked it back you could identify that you could have done things earlier in a coordinated way that would have a better outcome for the family, and, for our organisation, would have been a cheaper option. It is the way to get preventative support to families." (II)

Within the focus group discussion, a social care manager expressed the view that children and families preferred more integrated services:

> **Social Care Manager**: "It's what children and families' say they want when asked their views about services." (FG)

However, despite the managers' belief that the interagency teams had improved services for children and families, there was no discussion in relation to the team's ability to evidence improved outcomes in children's mental health and well-being. This is unsurprising as a study of managers' views on the early impact of implementing more integrated children's services (Kinder et al 2008) reported that managers were more aware of the impact of integrating services upon changes to inputs, processes and structures at team level, but were less able to evidence or describe improved outcomes for children and families.

8.2   The difficulties of interagency working.

Despite their stated beliefs that interagency and more integrated working across health and social care was the future for public service delivery to children and families, the managers also identified difficulties in achieving such a vision. It is

important to acknowledge that the managers' focus group and individual interviews contained less data in relation to the benefits of interagency working than the practitioners' interviews and focus groups. The difficulties are themed into headings and discussed below:

8.2.1 Addressing the influence of professional and agency cultures.

Overall, the managers' focus group and individual interviews devoted more time to discussing the difficulties of interagency working than the practitioners. They described how their everyday use of language differed across health and social care agencies. Although they reported the benefits of improved communication, they also discussed misunderstandings over what they believed had been agreed when discussing the planning of the interagency services at the outset:

> **Social Care Manager:** "So you get people using the same language but meaning something completely different. The classic one would be in a child protection arena where people came together for a conference but walk away thinking completely different things were happening. I think some assumptions were made and were not thought through in terms of what that would actually mean in practice. People need to be clear about what it means; it is not just a banner." (FG)

The misunderstandings created by the health and social care managers' use and understanding of language was identified as a difficulty of interagency working. A social care manager commented how, at the service planning stages, they believed there was overall agreement about the tasks that the interagency service would achieve. Several months after the service had become operational, it was stated

that they realised they did not have a shared understanding with their health colleagues over the language used and how this translated into the tasks they thought the interagency service was designed to achieve. The following focus group dialogue illustrates the point:

> **Health Care Manager:** "We can use the same words, but what I mean is completely different to you."
>
> **Social Care Manager:** "Absolutely."
>
> **Health Care Manager:** "It's quite a lesson to be learned because as you say, you think you have agreed something, but it turns about to be something different." (FG)

The perceived practice autonomy of health practitioners was discussed by health and social care managers as presenting potential barriers to making decisions. The social care managers commented upon their frustrations when health practitioners within the child and adolescent mental services, would make decisions regarding the 'treatment' or assessment of young people that they considered to be inflexible. It was stated that the health practitioners would 'hide behind codes of practice'. A social care manager highlighted the issues in relation to health practitioners clinical/practice autonomy during their individual interview:

> **Social Care Manager:** "We are asking clinicians who have clearly been educated and worked within a particular theoretical framework and have a fair degree of professional autonomy, to behave in ways that compromises their professional integrity. There is still a lack of understanding, or people haven't sufficiently been able to get out of the box, if you like, and think

about what it really means to work not just jointly but in a completely integrated way – beyond partnership if you like." (II)

This theme also emerged within the focus group discussion:

Social Care Manager: "The bit I personally struggle with is the expert thing, the clinical position where people are able to say 'because it's not in my area of clinical expertise' or whatever, I can't do anything. I find it usual to hide behind a code of ethics or professional code of conduct." (FG)

The manager's use of 'hide behind' indicates a level of mistrust in relation to how health practitioners in CAMHS make decisions about how they practice. The clinical autonomy of health practitioners was considered by the social care manager to mean that resource decisions were made by practitioners, for example, whether to offer a service or not. However, within social care, resource decisions were more likely to be made by team managers than practitioners. Professional and agency/organisational culture is thus seen to impact upon the ways in which different agencies were structured and would undertake their daily business.

8.2.3   The impact of structural and agency issues

In this context agency structure refers to the role a person occupies within an agency and encapsulates the manager's accountability and authority. It also refers to the agreed policies and procedures adopted by the health and social care agencies and the interagency teams. The managers identified several different issues from those reported by the health and social care practitioners within this

theme. The differences reflected the different roles that the managers occupied in relation to these interagency services.

Once the services became operational, both the health and social care managers stated that communication between them deteriorated. They became less clear who to speak to about interagency service issues. They were unclear which 'level' of manager or practitioner they were supposed to communicate with in their partner agency, resulting in difficulties in getting decisions from 'the right person':

> **Social Care Manager:** "One of the real difficulties for me has been trying to liaise to the right bit of management that has the power to do something about it. Nobody down the lower (NHS) Trust hierarchy would communicate up the difficulties and then it would be too late." (II)

The health care managers generally had more discretion than their social care colleagues over decision making, particularly around the commitment of resources. They found it frustrating that their counterparts in social care often had to defer decisions to more senior managers, thus holding up the planning and decision making processes.

All the managers discussed how agencies were driven by different national and local priorities, creating tensions. A health manager stated:

> **Health Care Manager**: "Because people have different performance measures and targets then I don't think we had enough planning and running time to sort those things out." (II)

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A health care manager reported that they had located community psychiatric nurses within the Interagency Southern Service in response to their priority to reduce the waiting times for young people and families to access child and adolescent mental health services.

However, following several months of the service being operational, the manager stated that it was clear this strategy did not have the desired effect. They reported that social care priorities related primarily to the provision of family support and placed inappropriate demands upon the community psychiatric nurses to respond to general family support issues. As a consequence, the community psychiatric nurses within the service did not have the capacity to respond to children requiring their specific skills. Therefore, waiting times for a specialist CAMHS service did not reduce as children and families were not being diverted by the interagency service.

A social care manager reported similar difficulties. They had committed social care staff to the Interagency Northern Service in an attempt to obtain more rapid access for children and families to child and adolescent mental health services. It was their belief that this had not been achieved and that access to CAMHS was as difficult as ever:

> **Social Care Manager**: "There is still a strong sense for us that actual access to specialist provision and the manner in which specialist CAMHS is deployed is increasingly inconsistent with where we are trying to move strategically. It (the interagency service) became increasingly health dominated." (II)

Clearly the different agencies' priorities were having an impact upon their satisfaction with interagency working. It appeared that the social care hosted Interagency Southern Service was perceived by health managers to be social care dominated. Conversely, the health hosted Interagency Northern Service was perceived by social care managers to be health dominated.

The differences in the employment terms and conditions of health and social care employees were discussed as presenting the managers (and practitioners) with challenges. They commented upon the need to have the time to sort out personnel issues and the paperwork/ bureaucracy surrounding the secondment of practitioners to different agencies.

8.2.4 Children and families' antagonism towards local authority social care practitioners.

The managers, akin to the practitioners, commented upon children's and families' negative perceptions of children's social care services. A social care manager believed that social care practitioners liked working within the interagency teams because there was 'not the stigma of child protection'. A health care manager commented:

> **Health Care Manager**: "Social work does get a negative press around child protection. It is about ensuring that families saw (the interagency service) as support." (II)

The managers did not identify the issue of stigma as a driver for developing the interagency services, however, they acknowledged concern that public perceptions of social work might be a barrier to accessing integrated services. As noted in the previous chapter Moran et al's (2007) research concluded reduced stigma might be an unintended consequence of delivering family support through integrated teams.

8.2.5   The role of central government.

National policy developments were considered to both facilitate and present barriers to interagency working. The managers believed that they received conflicting messages from Government that hindered the development of inter agency relationships:

> **Social Care Manager**: "There are mixed messages from central Government about what our priorities should be in different agencies. We then try to match our conflicting priorities and carve out common areas of interest and it's just so un-joined up. I think that we are going to spend a lot of energy working out what the Government wants and how to do it." (FG)

The focus group initially discussed their concerns that interagency working was not joined up at a national level and this created the tensions at a local level:

> **Social Care Manager**: "I think that probably for me the thing is the Government talks a good tune about things being integrated but I think the experience of most of us round here is we feel that the Government is not

joined up in its own mind in terms of some of the key aspects of the

agenda." (FG)

However, they also considered that the New Labour Government had played a

crucial role in moving towards creating the right environment for more productive

interagency working relationships. Legislative developments such as the

flexibilities contained within the Health Act (1999) were thought to be beneficial.

Government was considered to have introduced increased accountability into

partnership arrangements between health and social care and to have helped to

prevent agencies from reneging upon joint agreements. The provision of national

grants and additional funding to 'pump prime' developments were seen to be

important Government strategies for encouraging interagency working, as the

following dialogue illustrates:

> **Social Care Manager:** "You need the national context really to give it the
>
> profile it needs. It attracts additional resources from the Government such
>
> as Children's Trusts. The benefit of Sec 31 (Health Act 1999) is it
>
> underpins this approach and makes it more difficult to draw back
>
> resources."

> **Health Care Manager:** "If we never had the CAMHS grant I am not sure
>
> that we would have ever had the ability to put that extra bit in you know
>
> for the health or CAMHS bit." (FG)

The managers' findings reveal a concentration upon structural, legislative and

financial levers to encourage interagency working, as discussed in Chapters Two

and Three. However, it is the case that their support of such levers would appear to be driven by a fundamental mistrust of each other, a need to seek recourse to frameworks that enforce collaboration. The managers' focus upon the role of central government as an accelerator to, or barrier for, interagency working can be compared to the practitioners' theme of a perceived lack of support from senior health or social care managers. Both practitioner and manager groups looked 'upwards' in a hierarchy of influence or perceived power to support their efforts to develop interagency and more integrated children's services.

8.2.6 A lack of trust.

Some of the challenges of developing interagency services were clustered under a theme entitled 'lack of trust'. Managers reported a lack of confidence in the abilities of managers in partner health or social care agencies to develop services that would meet their agendas and priorities. Both the health and social care managers discussed a general perception around 'hidden' agendas and a lack of transparency in their working relationships. For example, within their individual interviews, the following managers commented:

> **Health Care Manager:** "All we get is excuses of what it (the interagency service) is not doing. I am not sure what it is not doing as I cannot get a straight answer." (II)

> **Social Care Manager:** "There has not been a great deal of empathy between social service and health, in particular CAMHS. There has not been a great deal of trust there. A sense that both people are not doing their

bit. A lot of suspicion. Giving health our resources, who will then go off and do their own thing basically." (II)

Social Care Manager: "I have not seen any evidence that health would actually be very good at running a service that involved other agencies and wasn't a primary health focused service. I find it difficult to imagine." (II)

The managers discussed problems in obtaining an adequate level of commitment and ownership, from their health or social care manager colleagues, to the interagency services. Interestingly, both the health and social care managers highlighted this issue in relation to each other. It appeared that the comments were made within the context of believing that their partner agency had not demonstrated adequate levels of commitment or engagement in the successful operational running of the teams. Essentially, the health and social care managers reported a lack of commitment from each other. The focus group discussion illustrates this point:

Social Care Manager: "We must not underestimate the level of commitment needed at middle and senior management level and the fact that it needs to be managed properly by people who understand multi-agency working is difficult."

Health Care Manager: "If there is commitment, true commitment, I am not sure there are any problems. A lack of commitment undermines progress. Changing group membership affects level of commitment. Accountability to ensure commitment maintained. My opinion is that it does not really matter what the national and regional agendas are, it's what the commitment of the people are locally to this way of thinking." (FG)

It is recognised that 'commitment' is a value based judgement that is difficult to quantify. However, several of the managers used the word to describe their concerns regarding their colleagues' willingness to support interagency services. One practical example that managers gave to illustrate a measure of commitment was a perceived resistance from their health or social care colleagues to transfer resources between agencies.

Managers also discussed concerns that one agency could dominate the operation of the interagency service to the detriment of the partner agency's performance agenda. The following comments were made within the context of the managers individual interviews:

> **Health Care Manager**: "It turned into a social services beast, not an integrated health, social services, and education team. It was a family support model which was local authority led and I guess the priorities became local authority. People were working to their own objectives and were not collective." (II)

> **Social Care Manager:** "I think it feels like it got more health dominated and more remote." (II)

The focus group discussion emphasised the need for good interpersonal relationships and trust between the health and social care managers in the different agencies:

> **Social Care Manager**: "I think good relationships go a really long way. Most of us rely on good relationships most of the time and certainly at local level, and on the operations side it is enormously helpful and by far

the most useful thing. That is what happens to inform strategic decisions about what might work and what happens is that you end up relying on relationships and perhaps personalities being around in a particular post and not in being embedded in structures and processes which will see that through regardless of who might be in a particular post at a particular time." (FG)

At this point in the focus group discussion, it was noted that the managers were becoming more animated in the conversation, rapidly making comments and the volume of the conversation increased. However, they also noted that good relationships between them could also lead to a false sense of security. For example, a social care manager described how s/he had a good working relationship with their health manager colleague and they were both engaged in the planning of the service. However, several months after becoming operational it had become apparent that what was being delivered was not what had been expected:

> **Social Care Manager**: "You can have the illusion of sharing the vision, or perhaps you do share the vision, but actually find yourselves when it comes to being operational that, to degrees, you may have been at cross purposes for months. Whilst the end goal might be one that everyone shares, the desired outcome, but the ways and means that you do it are sometimes poles apart. So I think that good relationships can lead to a sense of false security about what is actually do-able on the ground and that can be a bit of a surprise." (FG)

The absence of trust between managers featured strongly in their views that their colleagues in the other agencies could not meet their respective priorities and targets and therefore there was a reluctance to transfer resources. However, the

managers did not articulate this feeling as directly within the focus group as they did in the individual interviews. The lack of trust in each other was expressed more subtly in the focus group by one of the managers:

> **Social Care Manager**: "The more difficulties there were the more people revert back to the orthodox and get back in the box and say" 'well that's health being typical, it was always like this, we are being hoodwinked and they have got their hands on our money and what are they doing with it"? (FG)

The critical importance of good inter personal relationships between the managers was discussed, but it was recognised that this alone could not provide the foundations of strong interagency working. The managers considered that what was needed were systems and structures that would survive the constant changes of personnel and therefore changes in relationships. A health care manager reflected that it felt like 'tribalism and territoriality' and that there was a need to increase the levels of trust.

The general absence of trust, a fear of being dominated by health or social care, and criticisms in relation to a perceived lack of commitment from each other is in stark contrast to the practitioners' expression of improved understanding of professional roles and perspectives, and in particular positive regard for each other as practitioners. The managers' expressed views point to the protection of the agency and its resources and can be analysed in relation to social theories, such as, cooperation and social exchange theories as discussed in Chapter Four, which stress exchange and mutual gain as a facilitating factors for collaboration.

8.2.7   The availability of resources.

The managers discussed the impact of limited resources on their ability to engage with the development of interagency services. The need for additional 'pump priming' funding was discussed and the managers reported that they were struggling to deliver existing services within the resources available to them. This was considered to be a huge drain upon the time that they had available to develop new and interagency services. The following focus group dialogue illustrates some of the challenges for managers arising from limited resources:

> **Social Care Manager**: "It is about having the courage and the backing from senior management to take some quite scary operational risks along the way and that is what we don't always have in any service. There is going to be a period when we move from here to here when something might fall off, especially if we haven't got any transitional funding to do things different and that's the point where people start getting cold feet and pulling out, don't they?"

> **Health Care Manager**: "I think you are right. Unless you have some pump priming money on top to maybe have that space. I think that was what we agreed to use the CAMHS grant money for wasn't it?" (FG)

This view is supported by the findings of the *Children and young people in mind: CAMHS review* (DCSF, 2008e*)* where it was stated:

> .   "While there is an increasing amount of research to show multi-agency arrangements working well, we think it is important to sound a note of caution. We have seen examples where multi-agency working is vital, but

we have also seen that some arrangements can be time-consuming and expensive". (DCSF 2008e:61)

This emphasis on the restrictions imposed by limited resources was reflected by the practitioners who identified the high expectations and resource pressures placed upon them by the same managers.

One of the fundamental principles of interagency working has been to pool health and social care resources with the expectation that there would be a reduction in the duplication of work between agencies – thus releasing resources. There was little discussion by the managers of how existing resources might be deployed differently to release resources. It was the managers' impression that duplication of effort had been reduced by the interagency services. However, at the time of undertaking this research, this had not translated into the realisation of increased productivity and the release of additional resources.

These findings are supported by research conducted by Kvarnstrom (2008) into inter-professional team working in healthcare. His study concludes that management at the level above the team had some weaknesses in allocating optimal resources to allow inter-professional teams to effectively perform their tasks.

The managers stated that they were all measured on the performance of 'core' children's services, and therefore they were all likely to withdraw resources from interagency services that did not significantly impact, in a positive way, upon their agency's performance indicators. Although the managers acknowledged the

shared outcomes identified within Government's *Every Child Matter: Change for Childen* Programme (DfES, 2004), this did not translate into a discussion about interagency services achieving such outcomes through shared performance indicators for the interagency services.

8.3 Inter-organisational network analysis as a framework to summarise an analysis of the managers' research interview findings.

To ensure a consistent and comparable methodological approach with the practitioners', during the managers focus group discussions they were also requested to individually place a rating on an adapted version of a Likert scale to indicate their level of agreement with a statement that captured the essence of the question they had been asked. (refer to Appendix F)

For the purposes of trustworthiness and credibility, the ratings provided by the managers were contrasted to statements made within the focus group and the managers' individual interviews. Benson's (1975, 1983) four domains were adopted as a framework to support an initial analysis of the themes identified and key variables of concern for this chapter, that is, health or social care manager, and manager of Interagency Northern or Interagency Southern Service.

8.3.1 Work coordination (the way the work is organised).

This domain captures the levels of alignment between the managers in relation to

working patterns and cultures. The managers provided ratings for this domain between two and three on a scale of one to five. These ratings would seem to be a reflection of the broad agreement between the managers about the need for interagency working in relation to family support and the mental health and well being of children of families. However, higher ratings may have been tempered by social care managers' concerns in relation to health practitioners' perceived autonomy to make practice and resource decisions, thus potentially undermining collaborative decision making processes across health and social care. In addition, the health managers' perception that social care managers were constantly deferring to even more senior managers for a decision was a constant source of frustration.

The managers also discussed the perceived failure of Government to coordinate health and social care agendas, potentially manifesting itself locally as a difficulty for managers in aligning their working patterns, cultures and resources. A social care manager illustrated this challenge when considering investing in interagency services:

> **Social Care Manager:** "Nobody dare quite abandon their core priorities, so the Government needs to do something to unblock that sort of dam that keeps everyone keeping their core funding to themselves and not to have the confidence to invest core services money into interagency services." (FG)

It can be concluded that competing priorities and competing for resources would appear to inhibit improved collaboration between managers within agencies .

8.3.2   Domain consensus (the tasks to be achieved)

This domain captures evaluation of the extent to which there is agreement regarding the tasks to be achieved and the contributions of the different agencies to achieve the tasks. All managers provided a rating of zero or one. The health and social care managers considered that, initially, there had been agreement over the role and scope of the interagency teams and what the respective contributions of the agencies would be to achieve the task of establishing the teams. However, they unanimously observed that the levels of agreement over the operation of the teams had significantly reduced over time.

The health and social care managers discussed, in both their focus group and individual research interviews, how misunderstandings, created by their different use of language, had created tensions for them. In retrospect they did not think that they had been clear about what the services would do and had not been very clear about how they would operate in practice.

It was observed by a social care manager that Interagency Northern Service, hosted by the NHS Health Trust, had not developed in the way that they had expected. Similarly, a health manager observed that Interagency Southern Service, hosted by social care, had not developed the way they had anticipated. It can therefore be concluded that the service hosting arrangements had an impact upon the degree of managers' satisfaction with the interagency services. As discussed in the previous chapter, this factor also had a significant impact upon the practitioners' reported experiences of interagency working.

8.3.3 Ideological consensus (how tasks will be achieved).

This domain captures the perceived amount of agreement over how tasks would be achieved. The managers provided ratings between one and two. They considered that initially there had been broad agreement over what the services needed to achieve. A social care manager commented in their individual interview:

> **Social Care Manager:** "With structural and cultural differences aside, there was (in the beginning) a genuine sense of wanting to work in partnership and recognition of the difficulties that were there." (II)

However, once the services became operational, there was little agreement over not only what tasks were to be achieved, but also how they were to be achieved. They were generally pessimistic that the differences between the agencies were currently surmountable. As one health care manager openly stated in the focus group:

> **Health Care Manager**: "We need common agendas to integrate services. Changing membership (to the managers planning group), new people come in to post with different levels of experience and understanding of the political agendas have been brought onto the scene. If we are not delivering what we are expected to deliver; if people share and give us the information then we will do something about it, but that never happens." (FG)

The health care manager's statement was not met with any dissent from social

care managers and the fact that it ended with 'but that never happens' illustrates the levels of frustration and pessimism for the future.

8.3.4   Positive evaluation (how we feel about each other).

This domain captured evaluation of the extent to which managers had a positive view of the contributions of their colleagues in health or social care to the development of partnerships and interagency services. The evaluation of their colleagues from partner agencies was rated at either two or three. This rating was in stark contrast to the practitioners' extremely positive evaluations of the contributions of the different practitioner groups to the work of their teams. The rating reflects many of the statements that emerged from the research interviews and was categorised as a lack of trust.

The findings of the managers' research interviews and focus group discussion can also be usefully summarized by the following table which rates the levels of consensus across Benson's (1975, 1983) four domains as low, medium or high.

Table 10

An evaluation of the levels of consensus expressed by health and social care managers.

Domain consensus	Ideological consensus
LOW	LOW
Positive evaluation	Work coordination
MEDIUM	MEDIUM

It can be concluded that an appraisal of the findings of the research interviews and focus group with the managers would indicate a high level of disequilibrium across the four domains. This disequilibrium is reflected in the general dissatisfactions the managers expressed regarding their working relationships with their health or social care colleagues. These findings are in stark contrast to the findings from of the experiences of the health and social care practitioners, but perhaps more closely resemble the experiences of the health practitioners within Interagency Southern Service.

Utilising Benson's (1975, 1983) framework as a practical tool to examine interagency working relationships, these findings indicate a need for managers to achieve improved equilibrium across the four domains. The following chapter considers how the managers might usefully benefit from adopting some of the strategies and lessons learned from the practitioners' experiences of collaborating and interagency working in order to achieve improved equilibrium.
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8.4   Summary.

This chapter identified a fundamental difference between the working relationships of the health and social care managers and the working relationships between the practitioners. Utilising Ovretveit's (1997) framework for analyzing levels of integration, the managers' working relationships have been described as resembling a coordinated network association; a less integrated way of organising collaboration when compared to those of the health and social care practitioners within the different inter-professional and interagency teams.

Comparing the views of health and social care practitioners' and managers' revealed some differences between them in relation to the perceived benefits and difficulties of interagency working. However, despite the differences, many comparable themes emerged that were reduced to categories that are comparable to those of the practitioners. For example, the research findings revealed that both practitioners and managers offered unanimous belief and support for interagency and inter-professional teams in recognition of the potential benefits for children and families, for practitioners' skills, and for health and social care agencies; such as the reduced duplication of resources.

Both managers and practitioners devoted more discussion time to the difficulties of interagency working rather than the benefits. It was the practitioners from Interagency Northern Service who achieved more of a balance when comparing the volume of transcribed text in relation to the difficulties and benefits of interagency working. Despite the amount of discussion time devoted to the difficulties of interagency and inter-professional teams, the practitioners' and managers' considered the benefits to outweigh them.

The managers' focus group format was different to that of the practitioners in so far as it consisted of both health and social care managers in a single focus group. The themes identified within the focus group discussion reinforced those of the individual interviews, with some differences in relation to how issues were emphasised. For example, the managers were more cautious in expressing their reservations about interagency working in the focus group setting than within the individual interviews.

In contrast, the single agency practitioner focus groups proved to be a more critical environment than the individual interviews. Perhaps the mixed group of health and social care managers had a moderating effect upon how they expressed their views in front of their colleagues from another agency.

This chapter also discussed the utilisation of Benson's (1975, 1983) four domains as a tool for both structuring and analysing the managers' research interviews and focus group discussion. This approach enabled the researcher to review the managers' themes and assign an essentially qualitative judgment in relation to levels of equilibrium being achieved. The managers' general levels of equilibrium across the four domains were found to be lower than those of the health and social care practitioners.

It can be concluded that, overall, the managers found interagency working to be particularly challenging, with less direct benefits or rewards to them as a group. At no point did any of the managers identify their experiences of collaboration as building their skills or enhancing their relationships with their colleagues. When compared to the findings of the interviews with practitioners, the managers' experiences more closely resembled the findings from the interviews with the community psychiatric nurses from Interagency Southern Service.

These findings would then support a direct link between the experiences of practitioners and managers and the organisational structures that reflect collaboration in terms of the level of integrated working. For example, the teams within the Interagency Northern Service, classified as core extended teams,

evidenced higher levels of equilibrium across Benson's (1975, 1983) four domains and were generally more positive about integrated team working. The teams within Interagency Southern Service, classified as coordinated teams, evidenced slightly lower levels of equilibrium across Benson's domains. Finally, the managers, judged to be working within the least integrated structures and classified as a coordinated association network, clearly evidenced lower levels of equilibrium and higher levels of dissatisfaction with collaboration.

The managers' findings indicate that their allegiances are firmly rooted within the agency for which they were working and the managers' sense of belonging was clearly located within their parent (health or social care) agency. Their emphasis was upon achieving agency priorities and protecting agency resources. This would suggest that that managers' identity was firmly entwined in their role as a manager within their employing agency.

Strauss and Corbin (1998:143) advise that it is important to remember that themes identified within research are abstractions, representing not one individual's story but rather the stories of many persons and/or groups reduced into, and represented by, several highly conceptual terms. When analysing research findings, the researcher to questions their data further to determine 'what is really going on'. It is not until the major themes are finally integrated to form a larger theoretical scheme that research findings take the form of theory building and of adding to the field of knowledge.

 It is therefore necessary for the researcher to further reflect upon the findings of

the practitioners and managers research interviews, the contradictions, emerging themes and subsequent categories, and attempt to explain 'what is going on'. The following chapter aims to achieve this by reviewing the research findings in relation to relevant theory.

9.   Belonging as a key element of integration: developing the analysis in relation to wider theory

The strategy for data analysis has three key stages: the first stage involves the indexing and coding of data, the second stage involves grouping the coded data into themes and categories, and the final stage demands the interpretation of data. Findings should therefore be presented as a set of inter-related concepts, not just a listing of themes and categories.

Strauss and Corbin (1998:146) state that an essential element of theory building is that themes and categories are inter-related into a larger theoretical scheme. Other researchers should then be able to follow the analyst's path of logic and agree that it is one plausible explanation of what is going on. It is the task of the researcher to develop relational statements that can be used to answer the questions "What is going on here?" "What is the main issue?" Once the researcher has grasped the essence of the research, then a name can be given to that central idea or concept

The first step then is to identify a uniting concept that explains the research findings. It is expected that other themes and categories will logically fit within the uniting concept to explain the data. This approach helps the researcher to locate their findings in the larger body of professional knowledge and to contribute to further development and refinement of existing concepts in the field. This chapter concludes an analysis of the experiences of health and social care practitioners and managers working within child and adolescent mental health and family support services by attempting to identify and explain a central and uniting

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concept arising from the data. This concept can then be utilised inform the policy and practice of collaboration at a micro, meso, and meta level of implementation.

It has been argued in this thesis that, historically, studies of interagency collaboration and service integration have tended to focus upon structural constraints to the development and effectiveness of integrated services. Table 1 in Chapter Two illustrated how successive governments have demonstrated a tendency to concentrate upon structural solutions to address the many difficulties identified. Examples include the introduction of financial incentives and the continued development of legal frameworks to act as levers to secure more integrated children's health and social care services.

These research findings support the assertion that collaboration is essentially an interpersonal process that requires the presence of a series of elements influencing the relationships between practitioners team and managers. These elements include, for example, a willingness to collaborate, trust in each other, mutual respect and effective communication. Yet, even though the above conditions are necessary, it is argued they are not sufficient, because in complex health and social care systems, agency determinants such as resource management, organisational priorities, and professional power all have a crucial impact upon behaviours.

Willumson (2008:356) states that although most researchers primarily take an interpersonal or inter-organisational stance, they still have to deal with both elements as the stances appear to be interrelated in terms of both theoretical and

empirical implications. This study supports the notion that the dynamics and the nature of relationships require just as much attention as the organisational and structural factors influencing interagency collaborations. Such an approach enables the researcher to illuminate the inherent tensions and conflicts for practitioners and agencies attempting to forge new ways of working that are designed to more comprehensively meet the needs of people requiring services.

Robinson et al (2008) suggest that a recurring feature of different models of collaboration and interagency working is that integration is multi-layered: there is a meta level of integration, taking account of national policy drivers and Government Departmental remits; there is a meso level of integration, taking into account locality and regional structures and processes that aim to improve integration; finally, there is a micro level of integration which concentrates upon interagency teams and services.

The findings discussed in this chapter are presented in two ways. Firstly they are presented at three different levels of analysis: the micro, meso and meta. A micro level of analysis has direct relevance for practitioners working within teams. A meso level of analysis has implications for managers tasked with planning interagency services and a meta level of analysis has the potential to inform the wider health and social care policy agenda for collaboration. Such an approach to analysis will enable the differentiation of strategies required for the different groups of practitioners, managers and policy makers when considering how they might seek to achieve equilibrium across Benson's (1975, 1983) four domains of

inter-organisational network analysis and, as a consequence, improve the outcomes of interagency working for children and families.

Secondly, having considered the findings of this research and applied a central and uniting concept for understanding, this chapter then moves beyond a simple description of the findings, as outlined in the previous two chapters, towards an explanation that is grounded in the application of theoretical constructs. Social theories such as social identity theory and systems theories emerge as useful tools in support of achieving an explanatory understanding of the dynamics of interagency collaboration. Organisational theories also emerge as valuable constructs in support of the further analysis of the issues and, in particular, informing the deployment of practical strategies that aim to ensure more effective interagency collaborative arrangements.

It is anticipated that an improved theoretical understanding of the dynamics of collaboration, and relating them to the organisational and structural issues of integrating services, will contribute to a more theoretically informed debate in relation to the choice of practical strategies that will contribute towards achieving this particular policy ambition. Presenting the findings in this way offers a framework for understanding the explanatory power of the research findings and their relationship with the wider research literature. It will indicate how a theoretically informed analysis of collaboration and integration suggests practical strategies in support of collaboration across different levels of operations, for example from integrated team working through to policy networks and policy making.

9.1   The micro level: an analysis of the experiences of practitioners.

Ovretveit (1993) maintains that people working in groups need suitable organisation if their constructive and creative potential is to be allowed expression. An evaluation of practitioners' and managers' perspectives on interagency collaboration would suggest that the dominant themes, categorised in the previous two chapters (classified as either benefits or difficulties), can be connected to an overarching concept that offers a framework for explanation. Such a framework for explanation would then provide the necessary direction to create 'suitable organisation'.

A review of the findings and the identified themes and categories for practitioners and managers indicates that they have a fundamental need to belong to something: a profession, a team, a service and/or an agency. Having a sense of belonging provides practitioners with feelings of security from which they could assert their identity and assume a role and function that held meaning and value for them. Having established their identity and where they belong, in turn, appeared to improve their reported levels of satisfaction with their interagency working arrangements. Therefore, the overarching and uniting concept, identified from this research is a 'need to belong'.

This research does not assume there is a best model of organisation, but rather seeks to develop a theoretical and explanatory understanding of the practical strategies and processes, which will allow practitioners and managers to build local arrangements necessary for agencies to construct services and teams that

cultivate a sense of identity and a place to belong. It is maintained that such an approach will contribute to the achievement of success in facilitating the organisation and delivery of services that are responsive to the needs of local people.

This analysis utilises the idea of having a 'home' as a metaphor to reflect the experiences of practitioners and managers in their search for a place to belong and to assert their identity. For example, social care practitioners within Interagency Northern Service moved from a social services agency 'home' to a 'new agency home' within an NHS Health Trust. Similarly, health practitioners from Interagency Southern Service were seconded from an NHS Health Trust agency 'home' to a social services department. All practitioners retained a 'link' to their agency home as their employment terms and conditions remained with their 'parent' agency and not with the new 'host' agency. Such complex arrangements resulted in a level of confusion amongst the practitioners as they strived to find somewhere to belong, and from where they could assert a positive social identity within the workplace.

The interviews and focus group with the social care practitioners from Interagency Northern Service revealed dissatisfaction with their 'parent' agency, (the social services agency they had left) and a feeling of being on the outside of mainstream social care services. They reported unrealistic expectations from social care colleagues and not being valued as much as they thought they should be. They had moved from feeling as though they were on the inside of social care

and its organisation to becoming outsiders. This was clearly uncomfortable for them and they appeared to be striving to find a new 'home', somewhere to belong.

At the time of this research, the teams had been established for a period of two to three years. This research found that practitioner loyalties and allegiances had been slowly moving from their parent agency across to their new service and in particular to their inter-professional team. Increased trust and respect for the different practitioner groups emerged, perhaps indicating they had found a new 'family' and a new 'home' from which to assert their identity.

It was evident from the research findings that many of the practitioners who had moved from their agency home appeared to locate their identity in the new team rather than the new agency host to which they had moved. It is interesting to speculate if, after more time, they would begin to locate their identity and allegiance in their new agency host, and if this would be facilitated by their employment contract terms and conditions being located within it.

Factors that facilitated a shift of belonging to the interagency team included being based in the same office where the ability to communicate, talk to each other and seek mutual advice was enhanced. Practitioners reported increased understanding of the different perspectives of others and understanding the constraints that might have been placed upon their colleagues.

Further factors included having shared team tasks, which promoted feelings of achieving common goals; they were 'all in it together'. Allegiance to team and a

balance between sameness and uniqueness appeared to be the core 'life-giving' factors to the successful operation of the teams. The organisation and structure of Interagency Northern Service was more closely aligned to this approach and, as a consequence, it can be concluded that this ensured the practitioners achieved higher levels of equilibrium across Benson's (1975, 1983) four domains.

The part-time or associate members of Interagency Northern Service, such as the psychologist, expressed positive views in relation to the interagency skills and contributions of all practitioners to the work of the teams. However, they were less clear in relation to their own role and input into the team. It could be concluded that one difference for the associate members of the service was they had not left their agency home. They belonged to another team, another service from within which they located their primary identity. They contributed specific profession based functions only to the work of the inter-professional team and did not generally undertake core team tasks. Therefore, it is suggested they had not so acutely experienced the need to assert their profession specific skills to achieve an identity or sense of value within the inter-professional team.

It is paradoxical that the practitioners offering more specific and profession based functions and skills to the interagency services, generally remained unclear how, when and where to deploy those skills – leading to feelings of role uncertainty and a level of confusion over their contribution and value.

In addition to agency and team identity, the practitioners also located their identity within their profession, for example, within social work, nursing, or education

services. In the field of child and adolescent mental health and family support services, there is a significant amount of overlap in the skills and knowledge base of, for example, health visitors, social workers and community psychiatric nurses. However, practitioners reported value in being clear about issues such as profession based roles and tasks when designing more collaborative and integrated health and social care teams.

Practitioners expressed a need to spend time clarifying their own and others' roles, including core tasks that were common to all, as well as practitioner specific roles that were based upon professional training and skill acquisition. Teams then needed to work out who did what on a day to day basis, and to be flexible to respond to as wide a range of children and families' needs as possible. Much confusion and conflict did arise within the teams where roles had not been clearly defined. It is concluded that a full understanding of the different levels of team integration, as outlined in Chapter Five, would seem to be an important consideration when designing and determining the roles and functions that are required for practitioners to deliver more collaborative working practices within interagency and inter-professional teams.

Practitioners articulated a need to recognise professional differences in levels of skills and experience in order to address the more complex needs of children and families. They argued that ignoring differences in practitioner skills and professional background can result in people who access the services missing out on opportunities to receive more competent and profession based interventions.

Practitioners reported feeling de-skilled through the complexity of attempting multiple tasks, many of which they did not feel competent to carry out. They also considered that they did not have opportunities to effectively utilise their professional skills and described being swamped with the demand to undertake more generic team tasks.

A general absence of opportunities to practice more specialised skills resulted in practitioners feeling undervalued, particularly in the early stages of service and team development. The task would therefore seem to be a careful balancing act between improving and developing core or common skills that the majority of practitioners are competent to undertake within a team, while allowing scope for profession based specialisation. These findings are supported by Hugman (2003) who found that:

> "What is happening in Australia is that the reality of the 'generic worker' has been seen as de-professionalising rather than inter-professionalising (Hugman, 2003:117)

Hugman (2003:64) comments that the move to greater flexibility, or to reduce boundaries, has been met with a reassertion of the distinctive natures of each of the separate professions as the basis for collaboration.

It is helpful to contrast the experiences of practitioners within the Interagency Northern Service, with their assessed higher levels of equilibrium across Benson's (1975, 1983) four domains, to those of practitioners within Interagency Southern Service. The health and social care practitioners within Interagency Southern

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Service occupied more profession specific and less generic roles than their colleagues within Interagency Northern Service. However, it has been reported that they experienced more tensions than their Interagency Northern colleagues. This has been explained as a result of an absence of shared tasks and a lack of perceived clarity surrounding the contributions of their profession specific skills.

The health visitors within Interagency Southern Service were observed to be more fully integrated into their teams than the community psychiatric nurses. They contributed to some core team tasks as well as more specialised functions associated with their professional background. They reported fewer tensions than the community psychiatric nurses and considered that clarity of role and function was being achieved over time. The health visitors' sense of belonging was observed to be moving towards their new team, but they reported that their health visitor professional identity/uniqueness of contribution remained of importance to their sense of worth within their inter-professional team.

The health and social care practitioners within the Interagency Northern Service had expressed concern in relation to losing their professional identity and becoming too generic. However, over time, the service had recognised this dilemma, ensured uniqueness of professional contribution was acknowledged, and as a consequence were attempting to balance professional uniqueness and core activities, and as a consequence experiencing reduced tensions surrounding professional identity. This approach is suggested by Oshry (1995):

"Wherever there is differentiation – the elaboration of our differences –

special attention needs to be given to dedifferentiation: developing and maintaining our commonality." (Oshry, 1995:149)

The practitioners in this study supplied numerous positive examples of how the sharing of information, tasks, and skills were all essential components of successful collaborative practice. However, for some of the practitioners within Interagency Southern Service, their structures and processes required them to undertake more profession specific and more specialised tasks, thus limiting the degree of task sharing. Consequently, these practitioners reported some dissatisfaction with their role and function. Indeed, one of the practitioners expressed a desire to be engaged in more of the team's core tasks as a mechanism to improve relationships and understanding of roles and responsibilities.

It is useful to consider the reflections of Rees (2004) who, from a review of research literature into interagency working in CAMHS, concluded that:

> "It is vital for the healthy functioning of multidisciplinary teams and the individuals within those teams that they develop a core language for the service being delivered by their team, examine the values on which the service is built and the purpose of the team and the individual professions represented within it – a point that is frequently missed when new services are developed. Professional identity gives an individual a sense of worth, provides an external universal descriptor and implies a valuable set of knowledge and skills" (Rees, 2004:36)

Rees (2004) argues that it is only through building an understanding of core activities which can be undertaken by any team member and appreciating the difference between team members in terms of professional qualification, and

experience, that we can adequately address the composition of teams and their potential to impact on positive outcomes for families. Achieving such clarity will enhance the sense of professional identity and value of each team member.

Rees (2004) recommends supporting professional identity in the following ways to ensure successful multidisciplinary working:

- Valuing individual staff experience and skills.
- Supporting professional identity through continuing professional development and identifiable career pathway.
- Challenging and rewarding supervision.
- Clear pay scales.
- Agree shared values and language.
- Robust management of conflict.

(Rees, 2004:37)

The above recommendations were recurring themes identified by practitioners in Chapter Seven. Greig and Gregory (2003:28) suggest that professional identity can be explored with practitioners by asking them the following three questions: 1. How embedded was their notion of themselves in their old role before moving on to their new one? 2. How valued were the skills they brought into the new service? 3. Was there an opportunity to use those skills and make a qualitative difference within the service?

It is difficult to measure the degree to which practitioners' identities were embedded in their old roles and agencies. However, it could be hypothesised that practitioners' desire to maintain their identities was an indication of how

important their notion of themselves within their parent agency and profession was and that this mitigated against the easy transfer of skills and functions to new organisational forms, services and teams.

All but two of the practitioners participating in this research joined the interagency and inter-professional teams upon their inception. As time elapsed, it was apparent from the comments of several practitioners that their loyalties, trust and sense of belonging started to shift towards the team, irrespective of professional or agency background. Practitioners' need to belong to something was being transferred to their new team while simultaneously their need to have a positive professional identity was being strongly asserted.

The practitioners brought to their new inter-professional team a culture that was grounded in how health, education and social care practitioners 'do things'. It is argued that this provides a very different and challenging experience for practitioners who are used to working within an agency and a team that usually consists of people working within the same/similar professional background with the same/similar professional and agency culture. The findings of this research illustrate how more integrated working can promote an understanding of different cultures and behaviours of professions and agencies, and can therefore assist in developing strategies that enhance the opportunities to effectively manage collaborative relationships, thus creating an optimum environment within which collaborative approaches and integrated working can flourish.

D'Amour et al (2005b) conclude that different professional and agency cultures

influence the approaches of practitioners to collaboration activities. These issues clearly surfaced in this research as the social care and health practitioners referred to tensions arising from the different approaches to the work of the teams. However, for the majority of practitioners, these different approaches were considered to generate energy as they enhanced their knowledge base and skills through the cross-fertilisation of ideas and approaches.

Trust and sharing emerged as core values that practitioners in this study considered as necessary components of collaborative practice. Trust implies confidence in others and being able to rely upon their competence. This was most plainly illustrated by the high levels of trust and confidence reported by practitioners working within the more integrated structures of the Interagency Northern Service.

The practitioners participating in this study were experiencing the effects of working within an environment that challenged them to re-consider their identities and where they belonged. They had the opportunity to explore their different values and cultures and therefore forge new relationships and new ways of working and new cultures. Recognising the impact of professional role and culture is an important consideration for integrating inter-professional teams in the future as more integrated services develop. Individual practitioners may join them during different stages of team development – all with support and development needs surrounding their professional identity, their role and where they belong.

## 9.2	The meso level: an analysis of the experiences of managers.

The managers participating in this study were working within less integrated structures and processes than the practitioners. In stark contrast to the reported experiences of practitioners, analysis through Benson's (1975, 1983) framework observed lower levels of equilibrium achieved across all four domains.

The views of health and social care managers from Interagency Northern and Southern Services were remarkably similar – irrespective of their agency or professional background. In support of Benson's approach to inter-organisational network analysis, the higher level of disequilibrium was reflected in the managers' levels of dissatisfaction with the interagency services.

Interviews held with both health and social care managers in this study revealed that they did not trust their counterparts' motives for collaborating, did not feel they could relinquish control of 'their' resources and expressed doubts in relation to perceived competencies. It would seem that the managers were struggling to create the necessary structures and processes to disarm the negative consequences of a lack of trust.

The interviews with the managers revealed that when difficulties were encountered with the operation and achievements of Interagency Northern and Southern Services, tensions between the managers increased. The managers did not consider the priorities and objectives of their agencies were being adequately met by the interagency services. As a consequence, levels of trust between the

managers were generally observed to be low, with an associated mistrust of their colleagues' motives.

The managers discussed how they collaboratively conceived and developed plans for both of the interagency services. They successfully established interagency steering groups that constituted the reporting arrangements for service activity and performance. However, the managers were not part of an integrated management team, did not belong to the same agency, did not have a shared identity and did not have the opportunity to share the same working space (co-located) to promote communication and understanding of role, function, language, culture and agency constraints.

The findings from the focus group and individual interviews with the service managers supports a belief that the achievement of equilibrium across Benson's (1975, 1983) framework, is constrained by the managers working to achieve the imperatives of their agency. Lupton (2001) argues that these imperatives relate centrally to the need to ensure a secure supply of resources (money and authority), to defend specific organisational (and professional) paradigms, to maintain public support and legitimisation and to pursue distinct service objectives. In turn, Lupton (2001) argues that these factors are underpinned by the power relations that characterise the wider policy sector and society more generally.

Managers cited differences in language and agency culture as barriers to developing more successful working relationships. The importance of personalities and positive inter-personal relationships were agreed by the

managers. However, they reported misunderstandings and in some instances feelings of being mislead, resulting in reported feelings of mistrust.

Managers considered that the different organisational priorities and targets sometimes got in the way of collaborative working. They reflected upon the different cultures of the agencies and cited examples, such as health practitioners' clinical autonomy to make casework and resource decisions, contrasted with the higher levels of managerial control within social care settings which results in less devolved decision making responsibilities.

The findings of this research therefore support the need for individual managers to develop a more cross-organisational context that promotes collaboration for mutual (as opposed to individual agency) gain. Despite this Government's determination to introduce shared outcomes for all children's services as outlined in the Every Child Matters report (DoH, 2003) , the experiences of the managers reflected continued competition for resources and a need to achieve agency targets in an attempt to defend agency interests.

Odegard (2007:54) suggests that differences of opinion and competing interests need not necessarily act as negative forces upon collaborative relationships. Differences should be understood as a positive signal, since dialogues, discussions and even conflicts may produce new ways of understanding and also new solutions, to the present problem. This view was supported by the reported experiences of practitioners working within more closely integrated structures and processes. They clearly experienced opportunities to work within an environment

that encouraged working through tensions and identifying mutually acceptable
solutions.

The findings of this research supports the argument that when practitioners' and
managers identities are located within different agency and professional cultures,
structures and processes that promote opportunities to build positive working
relationships and shared identities are essential. Such an approach, applied to the
circumstances of the managers, would have the effect of enabling them to mirror
the experiences of practitioners through the development of cultural norms that
promote collaborative and interagency managerial practices.

For the managers participating in this study, the necessary disarming structures
and processes to promote collaborative practice were not as effective as they
could be. It is concluded that the managers' sense of belonging was clearly
located within their agency 'home', more firmly so than in a profession or an
inter-professional team. Loyalty was very definitely rooted within the agency, its
objectives and priorities. Their sense of identity appeared to be as a 'manager'
tasked with the delivery of agency priorities. Their mode of operation was
influenced by the cultural and managerial norms of the parent agency, its
structures and processes.

It is suggested in this thesis that the problem with much central policy has been
the assumption by Government that agencies with very different priorities and
cultures are somehow naturally inclined to cooperate for the benefit of people who
receive their services. This ignores the impact of what Benson (1975, 1983) terms
'sub-structural factors' on the dynamics of collaboration. These sub-structural

factors include not only cultural norms and ways of doing things, but also the need for resources to ensure the survival of the agency, the delivery of service objectives, and the need to have public support and legitimacy as part of reinforcing value.

Hudson (2006a) concluded from his research into interagency team working in adult health and social care services that there was something of a cleavage between two levels of Benson's (1975, 1983) inter-organisational network analysis. At the level of the team's operational activity, there seemed to be relatively high early achievements and aspirations, whereas at the level of substructure/environmental context, there were wider factors at work that hindered the accomplishment of the partnerships aims and objectives.

Hudson's (2006b) findings are mirrored in this research as the practitioners within the interagency teams strived to establish a 'new home', a new identity and develop more harmonious and effective working relationships. However, the managers had no need to search for a new identity and their affiliation remained within their 'agency home', responding to the demands of wider sub-structural imperatives.

At both strategic and operational levels, this research concludes that effective collaborative working arrangements and more integrated service provision is affected by additional imperatives acting on agency/professional behaviour. These imperatives are directly related to individual practitioner's and manager's need to feel as though they belong to something, to have a social identity in the workplace

that can be positively enhanced through 'parental' approval. That parental approval can be provided through, for example, fulfilling a professional role, or being a valuable member of a team, and/or an agency.

9.3   The meta level: considering implications for the wider policy environment

This research has focussed upon the experiences of practitioners and managers operating at the level of individual, team and service delivery. The experiences of policy makers operating within the wider children's policy environment is beyond the scope of this study. However, this research has discussed theoretical frameworks for collaboration and it is therefore argued that the research findings, analysed at a micro and meso level, have relevance to the application of a common set of theoretical and explanatory principles at a meta level of examination.

This thesis has noted that previous research tended to focus upon reporting the difficulties of interagency and inter-professional team working. The difficulties are often explained in terms of personalities, agency and Government structures and processes, rather than understanding the critical nature of interactions and interdependencies across social, economic and political environments.

For example, as reported in Chapter Two, the New Labour Government introduced New Public Management methods which separated responsibilities for the development of policies from their implementation. *The Every Child Matters:*

Change for Children programme (DfES, 2004) is a clear example of this approach. Chapter Three highlighted how Government had set the framework of expectations and outcomes for children's services while remaining divorced from the details of how to deliver the necessary outcomes. Similarly, Government recommended the establishment of Children's Trusts, enhanced by statutory guidance, but remaining divorced from the detail of the specific service models.

At a meta level of analysis, the Government introduced mechanisms designed to create the conditions for improved collaborative enterprise. Examples include the appointment of a single Director of Children's Services, the introduction of Local Area Agreements as the common strategic planning process for children's services and the introduction of a single inspection and regulatory framework for children's services. However, when considering the wider political economy, there are examples of how Government policy ambitions could negatively impact upon agencies' collaborative endeavour.

For example, primarily within adult health and social care services, policy guidance has been implemented to empower people in need of services through an approach that has been called the 'personalisation of care'. (DoH, 2007). Under such an approach a person will receive an assessment of their care needs and then be allocated an amount of money that they are encouraged to spend and purchase services capable of meeting those needs. The allocation of monies in the form of Individual Budgets to people in need of services has been identified as a vehicle through which this policy goal could be achieved.

In support of this policy ambition, pluralisation has become the means by which Government attempts to encourage the development of a 'market place' of an increasing number of service providers who will compete for the 'business' of people in need of services. As a result there may be tensions between the expectation that services will collaborate in their delivery of integrated services and the competitive ethos of a service provider intent on securing the market for their business.

This policy ambition could also result in public sector fragmentation, through increasing the number and types of agencies involved in service delivery. Therefore, the potential for agency and practitioner dissonance in working together could be increased as practitioners and managers attempt to forge their identity within a profession and a service, as well as protecting their agencies' competitive market advantage.

Hudson (2007) cautions there is a danger that Government policy and practice is prioritising choice and competition over collaboration. As a consequence, the policy ambition of increasing effective collaborative models of service delivery is jeopardised as agencies retreat to more self-protective modes of operation. Hudson's (2007) note of caution is supported by the managers' responses within this research, as allegiance to, and protection of, the agency was their mode of operation.The implications from this research would suggest that policy development at the meta level must also consider strategies that focus upon the dynamics and inter-dependencies of policy development and implementation. It is

argued that only in this way will the challenges posed by the collaboration 'policy implementation gap' be adequately addressed.

Certainly at a meta level of analysis, social theories and organisational theories, as discussed in Chapter Four, would seem to offer a framework for analysis and intervention in relation to the existence and operation of inter-organisational and policy networks. A key factor in the successful operation of such complex networks is the need to recognise interdependence and to 'manage' such interdependencies based upon insights provided by theories, such as systems and complexity theories, network management and policy network analysis.

9.4   Theoretical frameworks as tools for analysis and explanation.

To make sense of this fundamental need to 'belong' to something from where they can assert a positive identity in the workplace, collaboration must be understood in terms of a set of inter-related concepts. The most complete frameworks for analysing and understanding interagency team working would seem to be those that seek to explain the influences on key components of interagency collaboration. A strong theoretical foundation must therefore take into account organisational/structural factors alongside the social and process dimensions of collaboration and how they influence each other. This chapter now considers the relevance of social and organisational theories for this task.

9.5   Using social theories to develop the research findings.

Social identity theory emerges as a core explanatory theory relevant to the analysis of the findings of this research. It provides a theoretical framework through which the central themes and categories of this research can be understood. Social identity theory asserts that an individual's group membership is the focus of concern, offering an integrated theoretical perspective on the relationship between self-concept and the behaviour of individuals in groups.

Social identity is the identification of 'self' in terms of one's own social group, belonging to an 'in-group', rather than another group; an 'out- group'. During an interaction between groups, individuals compare their own group with the others in order to establish positive distinctiveness in relation to the out group (Ellevers et al 1999). Jenkins (2002) believes that the relationship between an individual's unique identity and their collective or shared social identity is relatively unexplored. He argues that they are both intrinsically social. Jenkins states:

> "Perhaps the most significant difference between individual and collective identities is that the former emphasises difference, the latter similarity." (Jenkins 2002:20).

The relevance of this statement to the findings of the study is apparent. Practitioners' need to belong to an agency, a team or profession can be observed in their need to establish a collective identity, a group of people to which they belong and to which they attach some emotional value and significance. Over time, the majority of practitioners within Interagency Northern and Southern

Services achieved a collective identity that was located primarily in their interagency team.

Practitioners' need to assert an individual identity can be observed in this research through their search for a professional identity. They sought opportunities to have a clearly defined role that secured an advantageous position within both a collective function (common or core tasks) and with a more specialised function (profession specific tasks).

Webb (2006) distinguishes between identity and self; where self is a person's unique sense of 'being' and identity is more fluid, being socially constructed and changing in response to our social circumstances. Such a framework allows consideration of how practitioners' identities can evolve in response to changing environments, specifically environments that demand integrated and inter-professional team working practices and the potential for re-constituted identities. The changing identities of practitioners has been discussed in this research and compared to the relative absence of changes in the managers' identities.

At a micro level of analysis, we can apply this theoretical framework to improve understanding of internal team relationships. This in turn will enhance our knowledge of which strategies will successfully improve the experiences of practitioners within integrated teams.

Hogg and Terry (2001) report that social identity and inter-group behaviour is guided by the pursuit of evaluative positive social identity through positive inter-

group distinctiveness, which in turn is motivated by the need for positive self-esteem. It is argued that people then seek to maintain their self esteem by working to build and enhance the reputation of the group. Jenkins (2002) goes on to suggest that the less people have in common with each other, the more problematic social cohesion becomes. It could be argued that the experiences of community psychiatric nurses within Interagency Southern Service, and managers across both services, offer evidence to support this assertion. Their relative lack of shared roles, functions and common form of organisation, all served to reinforce difference.

The practitioners' and managers' cooperative behaviour can best be understood as an effort to create and maintain a favourable view of the self. Jenkins (2002) asserts that people's views of their identity are rooted in being a member of a high status agency, and they seek to maintain their high status by working to build and enhance that of the agency. Through working on behalf of their agency, people become respected members of their group, further enhancing their feelings of self worth.

Frost and Robinson (2007) also report identity as a key issue for practitioners when they are expected to learn new team-specific generic skills. However, despite their concerns about loss of specialist status, they reported many positive aspects of re-shaping a professional identity:

> "Individuals within teams spoke of the creative energy released by forging enhanced identities within multi-agency teams. Misgivings could be overcome where the culture and management of the team valued

everyone's professional expertise regardless of their structural position/label within team activities. It appeared easier for permanent staff and those whose career prospects were felt to be enhanced, to embrace changes in their professional identities". (Frost and Robinson, 2007:196)

This research discusses the managers' motivations for engaging in the respective interagency service developments as being, at least in part, underpinned by the acquisition of resources (the teams) to achieve agency objectives, targets and goals, so enhancing their agency's and ultimately their own, performance. Therefore a model of collaboration across agencies must pay attention to both identity and resource based motivations for joining and remaining with groups.

It is acknowledged that the above account of social identity theory is simplistic and the theory is not without its critics. Reicher (2004), Jost, Banaji, and Nosek (2004) discuss the strengths and weaknesses of social identity theory, claiming that it overemphasises in-group bias and therefore inadequately explains out-group favouritism. Sidanius et al (2004) note that the evidence for social identity theory's self-esteem hypothesis is equivocal. However, Rubin and Hewstone (2004) and Huddy (2001), consider that the weakness of social identity theory relates more to deficiencies in social identity research than to deficiencies in the theory itself.

In addition to social identity theory, further social theories for understanding human behaviours (as discussed in Chapter Four) at the micro/team level can be applied to analyse and explain the findings of this research. Systems Theory is relevant because it offers an understanding of complex systems which are both

interdependent and whole in themselves. For example, a social services department or a mental health trust are 'whole' systems, yet they are also interdependent with each other and need to relate closely with one another to survive. They need to collaborate to plan interagency services to meet the Government's policy agenda for children's services and in an attempt to improve performance when meeting their agency's objectives. The behaviours of the people working within the agencies will have an impact upon the actions and behaviours of each other.

The behaviours of practitioners and managers appear to be grounded in systems, structures and processes that highlight the interplay between professional, agency and team identity and culture. The impact of all these different components is played out in the nature of relationships between individuals operating within such complex systems. Any changes introduced, such as co-location of practitioners, or new agency targets, would seem to affect the operation of the 'system' with resulting changes in the nature of relationships, behaviours and identities.

For example, one of the social care managers considered there to be high levels of interagency collaboration and positive working relationships when the services were being planned. However, from the perspective of that particular manager, several months later the service was not delivering the expected outcomes, relationships had become strained and levels of trust had declined. As a result the continued operation of the interagency service was jeopardised.

Systems theory facilitates an understanding of the constraints, challenges and strategies of interagency collaboration within a framework of analysis that explores the interaction and interdependence of practitioners or managers within, and external to, the services concerned. Such an approach allows consideration of issues such as people's identity and their need to belong in terms of strategies and interventions that will positively impact upon the patterns of relationships that develop. It is expected that this, in turn, will produce behaviours that affect the way 'the system' operates and in a manner that is more conducive to collaborative working.

Relationships are central to understanding the operation of a social system. Health and social care systems are complex and, moving from a micro, to meso and meta level of analysis, those systems become more diverse and more complex. The actions of the managers in particular can be observed and understood to be a consequence of the behaviour of a complex system that emerges from interactions among different people. The managers were not just responsible for Interagency Northern or Southern Services; they were operating in an environment that required them to respond to multiple demands from multiple agencies, all functioning within different organisational, professional, cultural and policy environments. The impact of these sub-structural factors had a negative impact upon their ability to collaborate and strive for collaborative rather than competitive gain.

Complexity theory involves studying how patterns emerge from randomness to form complex dynamic systems (Chapman, 2004). This research found that

moving health and social care practitioners away from their usual profession based agency home, to a home in a different part of the 'system' had a negative impact upon the nature of their relationships with practitioners who had previously been their colleagues. However, in contrast, their relationships with practitioners from different agency and professional backgrounds improved.

This lends support to the assertion by Shutz (1967) and Cohen (1986) who suggest that the more people have to do with each other in everyday life, the more likely they will be to identify each other as fellow individuals rather than primarily by reference to collective identifications such as health or social care professional. The implications for managers are clear, reinforcing the need for strategies that support opportunities for them to identify primarily with each other as individuals rather than associate each other with their role in an agency.

Complexity theory maintains that complex systems constantly change and evolve over time in unpredictable ways as a result of their non-linearity, and that it is necessary to explore how order emerges from chaos (Plsek, 2003). Byrne (1998) maintains that when attempting to understand collaborative working, the significance of the complexity approach is the recognition that while there is no inevitable outcome or single answer for success, it is nonetheless possible to analyse actions in order to see what the possible set of outcomes might be, what the possible answers are, and then to intervene to achieve those we want to see happen.

These research findings contribute to just one area of study in relation to the

complex field of collaboration, but they offer the opportunity to explain behaviours that can then be tested through the implementation of strategies. The outcomes of such strategies can then be analysed in relation to the impact of a wide range of other strategies designed to improve collaboration, for example structural and process changes.

Gitlin et al (1994) states that Social Exchange Theory's two fundamental concepts are exchange and negotiation. They expand Social Exchange Theory into a four parameter model: exchange, negotiation, trust, and role differentiation. The overlap with social identity theory and the experiences of practitioners' and managers in this research can be observed. For example, issues surrounding trust and role differentiation were critical factors for practitioners building new identities. In terms of exchange, practitioners were unequivocal about the benefits of collaborative working, including extending their knowledge and skills and reporting improvements in outcomes for the service user.

The managers reported that the planning of interagency services was characterised by positive working relationships and identifying mutual benefits from their development. When those benefits were not realised as expected, relationships between the managers deteriorated. Clearly the idea of mutual exchange and benefit plays an important role in nurturing positive collaborative relationships.

Cooperation theory argues that, in conditions of change and uncertainty, conditional co-operation is an effective strategy for promoting increased trust, ensuring overall mutual benefit, achieving organisational priorities and ultimately

ensuring organisational survival (Axelrod, 1997). Cooperation theories emphasise the role of power and its impact upon collaboration. The agency that 'hosted' the interagency service was perceived by the managers to be the one with most power, and was felt to be disproportionately influencing the operations of the interagency service to achieve their priorities.

Despite these tensions, it is interesting to observe that neither party chose to 'cut and run' by completely withdrawing from the interagency service. A cooperative framework of enquiry facilitates examination of events through understanding power relationships and the conditions of cooperation and predicting in what circumstances conditional cooperation could be placed at risk.

It was highlighted earlier in this thesis that collaboration has been a significant policy goal for several decades. Government incentives and legislation to collaborate were highlighted. It has been suggested that such a strategy, on its own has not been enough. However, incentivising strategies continue to be introduced by Government, and could form increasingly significant 'conditions' of cooperation, influencing agencies to review the balance of costs and benefits of collaboration and any decisions to 'cut and run' from a partnership.

In terms of outcomes, the findings of this research are very much aligned to those of many previous studies. For example, the researcher could have predicted possible outcomes such as tensions between managers in relation to trust and practitioners' struggles with professional identity. However, the different observed experiences of practitioners and managers within Interagency Northern

and Interagency Southern Services illustrate the impact of different structures and processes upon the individual and collective construction of self and identity. It would seem that the null hypothesis, as described in Chapter Six, does not apply, and the degree or level of team integration, as manifested through team structures, processes and organisation, does have an impact upon practitioners and managers experiences of collaboration.

The relevance of social theories to understanding the findings of this research have been discussed with social identity theory as a uniting concept. However, reference has also been made to the application of organisational theories. Such theories have relevance to not only understanding issues such as relationships and interdependence, but also to contributing practical tools that have real world applicability to enhance the outcomes of interagency collaboration.

9.6 Using organisational theories to develop the research findings.

Organisational theories, as discussed in Chapter Four, can be utilised in conjunction with social theories to enhance our understanding of these research findings. Chapter Four discussed the principles of policy networks, network management, inter-organisational network analysis and their fundamental focus upon social interaction and interdependence. A policy network approach considers that the achievement of central policy ambitions will depend on the relationships between those responsible for policy implementation at regional and local level.

A policy network approach attempts to explain behaviours by describing the structure of relationships between individuals, groups, and agencies, focussing on the relationships between them and identifying what ties them together (Hatch and Cunliffe 2006). Network management suggests practical strategies, for example the governance requirements of networks, that can usefully be deployed to create an environment in which networks achieve their objectives.

These research findings emphasise that what ties practitioners and managers together is the need to belong to something and a need to own a positive social identity. The key conditions that promoted practitioners mutual ties and positive identity have been identified as sharing common tasks and goals while retaining a unique and profession based role. The implications of these findings are discussed in relation to policy networks and network management and inter-organisational network analysis..

Policy networks and network management approaches offers, primarily at a meso and meta level of analysis, an understanding of interagency collaboration that moves beyond inter-professional and interagency teams. Such an approach explores how interagency networks are established around policy problems and can inform strategies for collaboration across health and social care. How policy networks operate and are governed underlines the highly interactive nature of policy processes, while at the same time highlighting the institutional contexts in which these processes take place. Inter-organisational network analysis focuses upon how policy networks operate in the wider policy environment, how they influence and are influenced by the actions of each other.

Applying the principles of policy networks, network management and inter-organisational network analysis would mean influencing the processes of interaction by recognising the interdependencies between practitioners, managers, policy networks, their relationships, and the rules that guide their interactions. Kickert et al (1999:46) advocate that, in addition to strategies aimed at influencing the interaction processes directly, network management should also focus upon the institutional context, the structure and culture of the networks, in order to improve the conditions for collaboration indirectly. Thus, two forms of network management may be identified: managing interactions within networks and building or changing the institutional arrangements that make up the network, referred to as network structuring.

Kickert et al (1999) report that a characteristic of network management is a strong orientation towards facilitating interaction processes; mediating between different actors with an orientation to goal searching rather goal setting. Goodwin et al (2006) state that the development of mandated and formally encouraged policy networks as a way of planning and delivering interagency and integrated services is gathering speed. Managers and practitioners face several challenges in making policy networks effective, and as yet there is little evidence on the best way to do this. Howarth (2004) argues:

> "An effectively crafted network can provide the basis on which to achieve successful partnership working between organisations. Such crafting requires significant network management skills in articulating strategies and ties between organisations that are robust enough to endure, legitimate enough to become accepted, yet flexible enough to tackle the inherent

weakness to which all inter-organisational arrangements are subject."
(Howarth, 2004:13)

By framing agencies as complex adaptive systems operating in non-linear ways, we can utilise knowledge from the field of social organisational theory to design more fluid and adaptive organisational forms, and practices that are more capable of achieving effective collaboration. To understand the importance of social theories and systems thinking for organisational theory, it is argued that it is necessary to grasp the concept of a system, its characteristics, and within the context of this research, the strategies required to impact upon managers' and practitioners' need to belong and to have an identity.

Integrated health and social care teams are not always the solution to collaboration. It is not possible for all practitioners, managers and policy makers to work within a single integrated team, service or organisational structure. However, policy networks, network management and inter-organisational network analysis provides a framework for public sector agencies to work together (and with the private and voluntary sector) to support the delivery of shared outcomes, reinforcing the role of partnerships and policy networks at local, regional and national levels.

With complex network arrangements as standard features of contemporary interagency and integrated working policy, then new perspectives and strategies are required to address the problems of such complex arrangements for the planning and delivery of services. However, Sullivan and Skelcher (2002) found, through a review of the literature, that empirical studies of policy networks and

network management and its effects are scarce. This research has identified, at the level of the team (micro), strategies that promote 'belonging' and identity. It is maintained that the operation of policy networks and network management would benefit from an understanding of where the participants of networks locate their sense of belonging from which they assert their identity. Therefore, it is suggested that learning from the practitioners' experiences of collaboration within this research is extended to the operation of policy networks and how they manage the business of collaboration both internally and across networks..

Such an approach promotes strategies in support of collaboration that are underpinned by theory, such as social identity theory. A theoretically informed framework provides logic that explains the choice of practical strategies that would then form part of an over-arching and multi-pronged strategy in support of moving away from agencies, managers and practitioners deploying competitively based behaviours to more effective interagency collaboration. The application of theoretical frameworks such as policy networks, network management and inter-organisational network analysis would clearly offer the opportunity to learn from organisational theories, to implement practical strategies and to monitor/evaluate their impact at the micro, meso and meta levels of analysis.

Further research into the operations of policy networks and their interaction with, for example, social identity theory could enable exploration of the necessary conditions that will enhance and promote interdependence and a sense of belonging that roots practitioners, mangers and policy makers firmly within an interagency and collaboratively minded network. Such a network would then be

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expected to encourage shared tasks, unique contributions and provide positive affirmation to its members through their interagency focus.

The findings of this research would support a view that analysis of activities, strategies and outcomes is complex. There is no single solution, no single explanatory theory and no inevitable outcome to the strategies employed. However, this research adds value to the current body of knowledge in this field through exploring the implications of different models of team organisation upon people's social identity in the workplace. This knowledge provides an explanatory framework to direct the application of practical strategies that increases the likelihood of a positive social identity in the workplace, and therefore ensuring more harmonious interagency and inter-professional team working.

The significance of social identity theory is asserted in this research, alongside further social and organisational theories. These theories have the potential to provide insight into ways of designing and managing organisations in complex and dynamic environments by paying close attention to practical strategies that encourage interdependence and shared identities as well as uniqueness of role and contribution to interagency services. It is recommended that further research is then required to study the impact of the strategies upon the construction of identity and the outcomes of interagency collaboration.

9.7   Practical strategies for improving collaboration and service integration.

It would seem common sense to assume that there will always be boundaries and

therefore group alliances and allegiances. Chapter Three, Table Two, identified the factors that contributed towards building emotional well being and resilience in children and families. Addressing the full range of factors would require contributions from several different agencies and professional groups. It simply would not be possible, practical or necessarily desirable for a single interagency team to meet all the varied and complex needs of all children and families.

There will always be different services, comprised of different practitioners, faced with different tasks, roles and functions when working with children and families. However, there will also always be opportunities to consider how different practitioners and managers from different agencies may come together within integrated teams, or interagency and inter-professional networks, to share their knowledge and skills for the benefit of children and families.

Partnerships and collaboration continue to be a priority policy agenda for public services and Chapter Three highlighted the Government's vision for integrated children's services. The relevance of this research is evident as The *Children and Young people in Mind* (DCSF, 2008e) report highlighted the proliferation and range of interagency team working arrangements:

> There are number of multi-agency teams around the country dedicated to addressing the needs of vulnerable groups such as children in care, children with learning difficulties and disabilities, and young people in contact with the youth justice system. (DCSF, 2008e:60)

Networks tasked within the local implementation of public policy are also a

feature of the future policy landscape, as evidenced through a key

recommendation of the *Children and Young People in Mind* report:

> **"Key recommendation:** The legislation on Children's Trusts should be
> strengthened so that each Trust is required to set out in its Children and
> Young People's Plan how it will ensure the delivery of the full range of
> children's services for mental health and psychological well-being across
> the full spectrum of need in its area. We would recommend that areas
> setup local multiagency boards for children's mental health and
> psychological well being, or other appropriate local arrangements to
> facilitate this." (DCSF, 2008e:30)

How might we then understand the implementation of practical strategies for

collaboration at a micro, meso and meta level of analysis? Benson's (1975, 1983)

approach to inter-organisational network analysis has been utilised by this

research to enable the application of a theoretical and diagnostic framework at the

micro level of interagency team relationships. It allows consideration of the

dynamics of collaboration, where there is and is not equilibrium, and how

multiple strategies can be deployed with the aim of securing a 'place to belong'

from which a positive self-identity is asserted.

It is argued that such a systematic and diagnostic approach to analysing

relationships will have the effect of positively influencing the choice and

application of organisational, structural and process strategies that will recognise

social identity and belonging as core components of plans to improve

practitioners' and managers' collaborative relationships. The utilisation of a

diagnostic tool also enables continued tracking, over time, of the implications for

practitioners and managers of changes in levels of equilibrium that may have been affected by the implementation of strategies and changes in the wider policy environment.

A key task for agencies must be to adopt and research strategies from group/ organisational behaviours that will ameliorate the effects of competitive group behaviours and minimise the number of boundaries by promoting interdependence, through focussing upon similarities and core sameness. Such an approach will be counter to the rather traditional approaches of professions and agencies that, particularly during times of resource shortages, tend to assume specialist skills that define difference and attempt to rationalise those specialist skills by creating differences and boundaries to roles and responsibilities.

The global economic downturn in 2009 and, as a consequence, the expected reduction in public expenditure would indicate the need for public services to ensure strategies are in place to promote collaborative working practices, rather then revert to more traditional strategies designed to protect resources and reinforce boundaries and separateness.

9.8   Defining identity and finding somewhere for practitioners to belong in a world of collaborative endeavour.

At the level of individual practitioners, how, when and where can their skills be deployed most effectively? Strategies must consider what groupings of practitioners will deliver optimum outcomes for children and families, for

practitioners and for agencies. Whatever the level of team integration, strategies are necessary to enable practitioners to collaborate and organise their work in a positive manner. Practitioners' need to know what knowledge and skills they and other team members can offer to the team. They need to spend time clarifying their own and others' roles. Teams then need to work out who does what on a day to day basis, and to be flexible to respond to as wide a range of service user needs as possible. Much confusion and conflict can arise when roles are not defined, or are incompatible.

The findings of this research suggest that teams also need to recognise differences in levels of skills and experience in order to address the more complex needs of children and families. Ignoring differences in practitioner skills and professional background can result in children and families missing out on opportunities to receive more competent interventions. It may also result in practitioners feeling overwhelmed with the complexity of task and, as a consequence, de-skilled. They might also feel undervalued.

Examples of practical strategies that have emerged from these findings as supportive of interagency and inter-professional team working include the following:

- The co-location of staff, within the same building, within the same office, or within the same team. This approach promotes communication and a breaking down of stereotypes, understanding of language, culture and practice; therefore promoting mutual respect and trust.

- Agree shared core tasks that will be undertaken across team members to promote sameness, equity of contribution, a sense of fairness and improved understanding of team or service tasks, therefore promoting a sense of shared purpose and belonging.

- Ensure the need for practitioners to make a unique contribution to the service is addressed.

- The importance of belonging to a profession in which to locate identity, role and contribution.

- This research identified a shift of identity to the interagency team as well as profession. Therefore a transitional strategy should be deployed to enhance uniqueness as well as ensure sameness; it is not interagency team or professional identity, one or the other; it is both.

- Identify shared goals, leading to a belief that outcomes for service users have improved, and a belief that practitioner skills and knowledge have improved – thus enabling practitioners to work with children and families more effectively. Such an approach is enhanced through working with a shared client group, as experienced by both services participating in this research.

- Single management arrangements to promote a sense of belonging to a single team and service. This approach had the effect of reducing opportunities for conflicting loyalties and conflicting expectations from managers or parent agencies.

- Single employment terms and conditions to promote equity and fairness across professional/practitioner groups.

- Ensure opportunities for joint training and service development are maximised.

It is suggested that single strategies alone are unlikely to fully address many of the challenges of interagency working, such as power differentials between practitioners and agencies. However, the implementation of multiple strategies, as indicated above, is supported by the evidence from Hudson's (2007) Sedgefield study. He concludes that:

> "Given the right degree of inter-organisational commitment, preparation, planning and sustained fashioning, it is feasible to transcend traditional professional boundaries, at least across the ''semi-professions'. In the Sedgefield study there is good evidence that a well-prepared, co-located team can use commonality of cases to establish a culture within which team learning can flourish and accountability is to service users rather than to professional domains." (Hudson, 2007:14)

This conclusion ties in closely with the notion of ''communities of practice'' (Lave & Wenger, 1991) in which knowledge is produced in the context of practice. Wenger (1998) argues that a community of practice involves three key elements – mutual engagement (the sustenance of dense relations organised around what people do), joint enterprise (in which professionals form their own practice and create meaning in everyday settings) and a shared repertoire of tools, discourses, styles and actions, that sustain and reflect a history of mutual engagement. These three elements neatly encapsulate the experiences of Interagency Northern and Interagency Southern Services, and their effects can be reduced or amplified depending upon the structures and processes designed to promote more integrated working practices.

Wenger (1998) writes of the importance of professionals' constructions of their

identities in shared practices and learning within work settings. For Wenger, identity is a way of talking about how learning changes who we are in the context of communities. In Wenger's model, professionals in interagency teams confront challenges to their professional identity and as they move between communities in the work place, professional identity is re-negotiated, integrating forms of individuality and competence through participation in work activities (Wenger, 1998:158–159).

This research has shown that it is necessary, particularly while integrated services are in their embryonic stages, to ensure that the practitioners do have a role that enables them to connect physically and emotionally with their professional identity. This would seem to be particularly important for those practitioners who move away from their usual profession based agency 'home'. The implications are for more joined up and shared training over core skills, but the need for specialisation remains, that is more developed skills in specific and profession based areas.

The above findings are supported by research into inter-professional team-working conducted by Molyneux, (2001), who concluded that a secure professional identity increases practitioners' ability to engage in collaboration. Keeping's (2006) study of social workers working within the Avon and Wiltshire Mental Health Partnership Trust reported that social workers maintained a strong attachment to their professional identity and a social model was the defining feature of their professional identity. Keeping (2006) identifies strategies for sustaining professional identity:

- Staying integrated in professional community.
- Staying connected with practice and a sense of purpose.
- Clarity of role, with room for flexibility.
- Enlist support of managers.
- Enhance skills in negotiating the case for the approach.

The difficult question remains, what are the tasks, how much can be shared as core business and how much can be undertaken through separate roles? Perhaps this can be more appropriately determined at local service level (micro) and is dependent upon the nature of the services to be delivered, the degree of integration and the potential to incorporate core and more specialised practitioner skills to meet the needs of people who require support. Biggs (1997) summarises the dilemma:

> "In summary, success will depend upon the correct balance being achieved between the maintenance of separate identities, merging to fulfil a shared objective and the resolution of possibly conflicting loyalties". (Biggs, 1997:189)

Benson's (1975, 1983) goal of achieving equilibrium across four domains would indicate the need for multiple strategies to create an environment that promotes opportunities for maintaining and developing practitioners' and managers' identities while minimising the impact of external influences upon emerging and re-constituted identities. The uniting and explanatory concept of 'belonging', it is argued, is a constant across the four domains which practical strategies must be designed to enhance.

9.9   Defining identity and finding somewhere for managers to belong in a world of collaborative endeavour.

Chapter Three reflected upon the historical development of child and adolescent mental health services and the continuing search for the holy grail of organisational structure for health and social care services. However, the findings of this research stress the need to consider organisational structures and processes in the context of interdependence, of promoting trust, positive working relationships, clarity of role and contributions while simultaneously promoting secure identities for all.

The findings of this research support the idea that people need to feel as though they belong to something they value. Strategies, at the meso level, must encourage managers to engage in collaborative practice and foster this need to belong through recognising the central importance of identity, culture and relationships. We can apply the learning from this research to ensure a theoretically informed understanding of what strategies are required to influence the interaction processes between service managers

Social theories can once again be utilised to assist managers' efforts to recognise where there is mutual advantage in collaboration and integration, to share tasks, to understand the pressures and interests of others and jointly assume some responsibility for addressing them. The relevance of systems theory is apparent when considering strategies for managers to improve their experiences of collaborative and integrated working practices. It is maintained that we cannot

understand the behaviour of managers without an understanding of the wider social, political and economic context within which they are operating. Oshry (1995) reinforces the value of 'seeing' the whole system and states:

> "Once you see systems as wholes, you also begin to see power differently. From a systems perspective, power has little to do with strength or command or toughness or the position you hold or even the size and quality of the resources you control. System power is the ability to influence system processes – to act in ways that enhance capacity of the system to survive and develop in its environment, to cope with the dangers facing it and prospect among the opportunities." (Oshry, 1995:175)

The managers' forays into collaboration can be seen as guided by cooperation and social exchange theories. Their behaviours appeared to be shaped by the need to match national policy objectives with local implementation plans to achieve agency objectives. Guiding such social transactions was a focussed analysis of the cost-benefit exchanges that might occur.

For example, the social care managers in the study belonged to two different social care agencies. Their investments in Interagency Northern and Interagency Southern Services were independently reported as a means to achieve improved access to child and adolescent mental health services for children, young people and families. The health care managers reported investment in the interagency services as a means to reduce the volume of referrals to their services, shifting some of the burden to social care agencies and as a consequence reducing waiting times for their own services. For both groups, agency priorities took precedence, and as a consequence tensions in their working relationships developed.

As discussed in Chapter Three, the creation of interagency and inter-professional Children's Trusts and Children's Centres has been promoted by Government as a vehicle through which more integrated working arrangements will be achieved. There is a clear expectation from Government that child and adolescent mental health services will be one of the constituent components of Children's Trusts.

However, it remains uncertain as to how the new organisational arrangements will facilitate managers to recognise and focus upon commonality rather than difference. What then are the strategies to be deployed to support the attempts of managers to move to what Hudson (2007) described as an optimistic model of collaboration?

The extents to which Children's Trusts are pro-actively addressing issues around the practitioners' and managers' need to belong somewhere and to have a positive identity is unclear. This research supports the application of strategies that ensure their employees find a 'home' within a new team, a new agency or even, perhaps, new hybrid health and social care professions. However, there is a risk that, through the creation of Children's Trusts, Government is recommending structural solutions to collaboration and creating another agency through which rivalry and competition are re-enacted across practitioner and manager groups.

Managers could adapt the very practical strategies for nurturing interdependence and positive interactions utilised by practitioners working within more integrated structures. The managers in this study did initially create a fertile planning environment for developing and establishing Interagency Northern and

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Interagency Southern Services. The subsequent deterioration in relationships might well have been prevented if principles around identity and belonging had been applied to the managers' circumstances.

Underpinning all of the practical strategies is the suggestion that managers' identification with a single agency should be minimised while simultaneously enhancing their identity as an effective manager to a group of peers who assert the positive values of collaboration and to which they feel they belong. For example, practical strategies could include the following:

- The creation of more horizontal management structures, for example, providing opportunities for the co-location of managers to promote improved communication. Other strategies designed to improve communication and mutual understanding could include opportunities to routinely 'shadow' each other in the workplace, and the allocation of managers as mentors across agency boundaries.

- More single management structures for interagency teams, undertaking a wider range of more varied roles, functions and tasks.

- Defining shared service outcomes in terms that define them as benefits for children and young people that can only be achieved collaboratively.

- Governance arrangements for children's services that ensure that all managers are jointly responsible and accountable for the delivery of all identified service outcomes, irrespective of agency priorities – thus promoting shared core tasks.

- Defining managers' contributions to the success of the services in terms of managers' unique contributions as well as shared core tasks.

- Maximising opportunities for managers to undertake joint training and service development.

It is suggested that, through adopting such strategies, a manager's need to belong would not be solely located within a single agency. They would also develop a sense of belonging to a peer group of managers, irrespective of agency. That peer group would share common tasks that require them to deliver a range of services and their interdependence and need to interact would be unequivocal. However, they would also have more specialised management functions that provided them with specific (perhaps agency) responsibilities. This uniqueness would allow managers to perceive value to their contributions to the overall objectives of service delivery and would confer an identity upon them that is located within a profession, an agency or a service.

Network management has been discussed in this research as an explicit strategy that could be adopted by managers. The aim would be to both influence the nature of their collaborative interactions and the governance of the institutional arrangements that make up the network, such as integrated budgets and performance frameworks. It is suggested that the practical strategies listed above would all contribute to a network management approach.

9.10   Closing the policy implementation gap in the wider policy environment of collaborative endeavour.

A meta level analysis of interagency collaboration is outside the scope of this

small scale research project focussing upon interagency collaboration, inter-professional team working and the experiences of practitioners and managers. However, the learning from this research, the research literature and from social and organisational theories can be considered in relation to practical strategies that may support participants in the wider policy environment with the challenges of collaboration.

It has been argued that the dynamics of collaboration as well as its organisation, structures and processes must be the subject of more sophisticated research. Traditional solutions adopted by successive governments, such as re-structuring Government departments, revising legislation, introducing population based shared outcomes, shared budgets, and joint education and training are all useful levers for improved collaborative enterprise – but as a history of experience reveals, they are not the only conditions required to deliver the aspirations of collaboration and inter-professional team working across health and social care.

Practical strategies that Government Departments and leading professional bodies may wish to develop are informed by research conducted by Barr et al (2005). His research reports that educational systems are of significance in preparing professionals for practice. It is argued that through the socialisation process of becoming a professional, perceptions of collaboration as a working method are formed.

For example, Barr et al (2005) and Barr (1994) suggest that it is reasonable to suppose that practitioners engaged in shared learning during their education and

training, develop a perceptual awareness of the importance of collaboration processes. Over time this perceptual awareness may develop into attitudes that have impact on professional behaviour, for example with regard to how motivated professionals are to engage in collaboration activities.

Pollard and Miers' (2008) study of inter-professional education supports the value of inter-professional education, stating that it enhances attitudes that are essential for inter-professional working. Webb (2006) asserts that a professional identity can be achieved through engaging in social relationships in the workplace and through education. Professional education can therefore provide a route to a new professional identity.

Schein (2004) argues that from a cultural perspective, the socialisation process induces the individual to assimilate norms and values of the profession and agency they belong to. In this regard, individual perception must also be understood as being interwoven with shared beliefs of collaboration. This gives reason for Schein (2004) to believe that inter-professional training programmes could enhance teamwork and, indirectly, the quality of service delivery through focusing on the development of shared meaning through shared learning processes. (Pearson and Pandya, 2006; Larivaara and Taanila, 2004),

During 2005, the Government consulted on its proposed children's workforce strategy. Proposals to reform qualifications to support improved career pathways and opportunities within the children's workforce were welcomed. Responses called for an integrated qualifications framework built around a common core of

skills and knowledge. The 2020 Children and Young People's Workforce Strategy (DCSF, 2008f) identifies the following priorities:

> "Strengthen leadership and management across the workforce to ensure that everyone understands when and how they should be working together, and to strengthen the core skills and knowledge that everyone who works with children and families should have" (DCSF, 2008f:20).

Workforce reforms, and potential opportunities for a more integrated training and development framework for staff at all levels, illustrate how policies and strategies developed at the meta level may be positively informed by theories of interaction and interdependence. It is expected that the effects of implementing policies that promote relationships, interaction and interdependence will permeate staff attitudes, culture and behaviours across the meta, meso and micro levels of analysis.

Barr and Ross (2006) caution against diluting the professional basis to practitioners' education and training. They consider that the development of interagency teams in children's services appears to be placing the practitioners' needs as secondary to those of children and families and refer to a 'veiled threat to the integrity' of the professions. They argue that to successfully deliver more integrated services, practitioners need to feel their professional knowledge and commitment is respected.

Such caution is supported by the findings of the research interviews with the practitioners from the Interagency Northern Service. They positively embraced

their 'home' with the interagency team and recognised the value of extending their skills through the sharing of core tasks. However, the possession of a unique and profession based identity only served to enhance their sense of value and worth in their 'new home'.

This approach reinforces the contribution of social identity theory to the dynamics of professional relationships. It provides a very practical strategy that encourages practitioners to enhance their professional and group self worth through adopting collaborative practice, which is integral to forming a positive identity shared by professions. However, identity can be consolidated through contributing more specialised skills and knowledge to the work of teams and SCIE (2009) recommend that profession based skills, over and above core skills, must continue to remain a part of the education and training agenda within children's services.

Chapter Four discussed the existence of social policy networks and the utilisation of network management strategies to promote opportunities to see 'the whole system' in operation. This approach reinforces how strategies designed to promote understanding of the culture and behaviours of agencies can provide opportunities to reinforce interdependence and organise effective collaborative relationships across the whole system, at the micro, meso and meta levels of analysis.

A collaborative strategy that utilises network management may facilitate processes and structures that encourage interaction between diverse participants in the immediate and wider policy environment. It is suggested that creating fully integrated policy networks at the meta, meso and micro levels of diverse agencies

means agreeing structures for their governance, sharing challenges, agreeing priorities and mutual goals, and sharing common tasks whilst allowing for specialised areas of service delivery.

Such an approach will have the effect of promoting interdependence, a sense of shared ownership, shared resources and a sense of shared belonging; leading to increased understanding of roles, functions and constraints. This strategy reflects the experiences of practitioners working within Interagency Northern and Southern Services, but is far removed from current practices that focus upon the needs of the agency.

Network management encourages diversity and uniqueness, but is set within governance arrangements that promote responsibility and accountability for the whole as well as individual parts. This approach is very different to the narrow and task focussed approaches that have traditionally been utilised by health and social care agencies. It is anticipated that, for example, at the meta level of interagency working, managers' and policy makers' sense of identity will experience a subtle shift from the employing agency to an increased emphasis upon an organisational form where service delivery is located within the wider 'whole' system' of children's services. Roles and respective functions will be clearly located within the priorities of 'whole system' attempts to achieve outcomes that improve the quality of service delivery for children and families.

This approach to collaboration supports managers and policy makers to assume an identity of a collaboratively trained professional/manager, operating from a

collaboratively minded organisation, with collaborative governance structures that are located within interagency networks and designed to prioritise the delivery of outcomes for the benefit of children and families.

Understanding social and organisational theories of interaction and organisation, and the potential to utilise tools such as inter-organisational network analysis and principles of network management, remains relevant to closing the 'policy implementation gap' for collaboration, service integration and inter-professional team working. This research supports the notion that strategies designed to develop interdependence and mutual understanding, and promote positive working relationships and identities, continue to be central to achieving the collaborative policy ambition.

9.11   Summary.

Previous chapters have highlighted how, for several decades, interagency collaboration has been recommended as a framework for managing and organising resources and for delivering services. It is suggested that, to move forward, collaboration needs not just empirical study, but a theoretical appraisal.

It is argued that social and organisational theories have received inadequate attention when attempting to develop a theoretically informed understanding of interagency collaboration. Addressing the collaboration and integration policy gap requires theoretical debate; only in this way can policy learn from the decades of experience of practitioners and managers tasked with bringing this policy

ambition to life. Hardiker (1981) argues that practitioners are often aware of the

agency only as a constraint and controller over people and resources:

> "But the greatest contribution of organisation theory is to develop a more
> sophisticated sociological awareness of agency functioning....an ability to
> draw upon and contribute to agency processes if client services are to be
> improved" (Hardiker, 1981: 126)

It has been the goal of this research to illustrate how social and organisational

theories can be utilised to organise the findings as a set of inter related and

explanatory concepts, not just a listing of themes. This approach enables

researchers to locate their findings in the larger body of professional knowledge

and to contribute to further development and refinement of existing concepts in

the field.

This chapter has reviewed the research findings and discussed a unifying concept

identified as 'a need to belong'. This need to belong can be explained in relation

to social theories surrounding social identity, interdependence and relationships

and organisational theories surrounding cooperation and social exchange. It is

then possible to advance knowledge in the field through the application of this

concept to, for example, how the degree of team integration can impact upon

people's need to belong and upon their development of a collaborative identity.

The need for practitioners and managers to have a secure sense of belonging and

identity was evident and achieved most successfully by those practitioners

working within a more integrated team environment, but with the opportunity to

assert unique value. The people who were least satisfied with interagency working were those whose sense of belonging was located within a traditional single agency setting, without the opportunity to experience higher levels of integrated working. This is not a criticism of the individuals concerned, but more a reflection on the applicability of social and organisational theories to understanding their circumstances and how, across the decades, the organisation and dynamics of interagency collaboration demand similar behavioural responses from those people involved.

This chapter concludes by emphasising the contribution of this research to knowledge in the field of collaboration. Social and organisational theories are related to the practical strategies that practitioners, managers and policy makers might harness to increase the chances of developing more successful interagency collaborations. It is anticipated that a focus upon interdependence and the dynamics of collaboration at a micro, meso and meta level of analysis will result in the implementation of strategies that will lead to improved equilibrium across Benson's (1975, 1983) four domains of inter-organisational network analysis. As a consequence, the anticipated benefits of interagency collaboration and integration will be more systematically researched and measured.

It is important to acknowledge the anticipated benefits of interagency collaboration, service integration and inter-professional team working. However, it has been recognised that there are continued challenges in realising those expected benefits. A note of caution is expressed to ensure that collaboration and

integration do not become 'ends' in themselves, and that the primary focus should be upon improved outcomes for children and families.

This thesis maintains that the research evidence base in relation to inter-professional team working and improved outcomes for children and families remains relatively weak. Hingley-Jones and Allain (2008) criticise the policy assumption that services will automatically improve outcomes for children and families if they become more integrated. However, it is expected that one consequence of improved understanding of the dynamics of interagency collaboration at micro, meso and meta levels of operation, will be an improved opportunity to research, more robustly, the anticipated outcomes of integration. This should then build on an emerging evidence base about the impact of interagency collaboration, service integration and inter-professional team working upon outcomes for children, young people and their families.

10. Conclusion

This research has aimed to add value to the existing body of knowledge by ensuring the findings are presented within a theoretically informed debate that aims to make more successful interagency collaboration a reality. This research has addressed how people from different professions and agencies work together to meet the health and social care needs of children and young people experiencing difficulties in their family, and with their mental health and emotional well being. It has explored how people can make the most of their skills to meet people's needs, and how they create satisfying and supportive interagency working arrangements to achieve such an aim.

The task has been approached by undertaking a small scale qualitative study of the experiences of children's health and social care practitioners and managers, when brought together to work collaboratively within integrated models of service delivery. This research is therefore about providing an informed future context for organising and delivering services that improve child and adolescent mental health and emotional well being, and family support to children, young people and their families.

This conclusion summarises the focus of this research and discusses how the methodological approach ensures that this study makes a unique contribution to the current research literature in relation to collaboration and integrated team working. The findings of this research are summarised in relation to an overarching theme that is understood through the application of theoretical

frameworks that explain the behaviours of practitioners and managers collaborating across health and social care. An increased theoretical understanding enables the prediction and application of practical strategies that can contribute towards the building of agency structures and interpersonal relationships that enhance the likelihood of improved experiences for practitioners and managers collaborating within interagency and inter-professional team environments.

Finally, the limitations of this research, and the need for further empirical study, are acknowledged, but it is argued that the findings remain relevant to contemporary public policy in children's services.

10.1   The focus of this research.

Chapters Two and Three identified the history of collaboration and the difficulties and successes of interagency working across health and social care. This thesis has identified that collaboration and integrated team working are complex and multi-faceted and as such there are no simple solutions to making it happen. D'Amour et al (2005a) identify the key components of any study concerned with interagency team-working, stating:

> "The two constant and key elements of collaboration are: (1) the construction of a collective action that addresses the complexity of client needs, and (2) the construction of a team life that integrates the perspectives of each professional and in which team members respect and trust each other. The two purposes appear to be inseparable, in as much as one cannot collaborate without having taken the time to develop a

collective life, and there is no use in developing a collective life without having first established the need to collaborate in responding to identifiable patient needs." (D'Amour, 2005:127)

This research addresses D'Amour's (2005) two key elements by:

- Reviewing the complex needs of children and families in need of support, and in particular the case for collaboration and interagency working within child and adolescent mental health and emotional well-being.

- Researching how two interagency teams have constructed a team life in which practitioners from different health and social care agencies can work together to deliver services.

To further inform current knowledge into collaboration across children's services, this thesis has combined a literature review of the policy, practice, and theory of collaboration with practical research into real world examples of interagency team working. This research has focussed upon the explanatory power of social and organisational theories in relation to the findings of this research and how the concept of a sense of belonging and social identity can inform practical strategies for collaboration. The remainder of this chapter considers how this thesis has successfully addressed the following key research question:

"Does the organisation and levels of integration of inter-professional and interagency teams have an impact upon the experiences of practitioners and managers working within them?"

When discussing a response to the above question, it is also necessary to review how this research approached the task and what might be the further implications of the research findings. This task is reviewed in relation to the sub-questions outlined in Chapter Six, p174:

- What are the benefits and challenges for practitioners and managers working within interagency and inter-professional teams?
- Are the benefits and challenges influenced by the different models of integration?
- How can theory be used to develop understanding of the underlying issues that prevent or promote the delivery of more integrated children's health and social care services?
- What are the practical strategies that will improve practitioners and managers experiences of collaborating, organising and delivering more integrated services for children and families?

This concluding chapter goes on to consider the contribution of this research to the questions and issues raised above.

10.2   Contributing further understandings to collaboration across health and social care.

Chapter Three discussed how the mental health, emotional well being and social care needs of children and families are inextricably intertwined. Since agencies, managers and practitioners will always need to collaborate across agency

boundaries to deliver services that will meet the complex and diverse support needs of children and families, collaboration and service integration must become more grounded in an evidence based approach to the effective delivery of public services.

The contribution of this research to the existing literature in this field is not just confined to validating the findings of previous research into interagency team working within family support and child and adolescent mental health services. This research contributes to the current body of knowledge through a unique opportunity to:

- apply a single qualitative research methodology to studying both practitioners' and managers' experiences of interagency team working within child and adolescent mental health and family support services.
- analyse and evaluate the impact upon practitioners and managers of working within different models and degrees of integration.
- apply social and organisational theoretical frameworks to analyse the research findings.

This research aims to be of value to the real world and therefore it is intended that the findings will contribute knowledge in support of the development of practical solutions and strategies, from which to construct improved models for collaboration and interagency team working. Loxley (1997) states:

"The processes of collaboration built on trust and sharing recognise the difficulties of integration, but anticipate them by creating structures and

processes which disarm and contain them, so reducing defensiveness, tolerating anxieties and preventing disabling responses such as projection and stereotyping which encourage wasteful enmities" (Loxley, 1997:93)

It is therefore necessary to ensure that practitioners, managers and policy makers possess sufficient knowledge, a repertoire of relevant skills, appropriate structures for the exchange of information and resources and processes which facilitate building productive and collaborative working relationships.

Building such a knowledge base was achieved by analysing the interagency teams participating in this research in relation to their level of integration using Ovretveit's (1997) typology for describing integrated teams. This approach has enabled the researcher to identify the impact of the level of integrated working as a key variable upon practitioners' and managers' experiences of collaboration and interagency team working.

10.3 The application of theoretical frameworks to explain the findings of this research.

Willumsen (2008) states that theoretical approaches that illuminate social theories in relation to interagency working provide valuable insights, but they mainly focus on different aspects associated with the interpersonal level. However, she also states that interagency also implies interactions between agencies on an inter-organisational level which requires theoretical consideration.

This thesis has discussed the relevance of social theories to enhancing our

understanding of the findings of this research. An understanding of systems theory, complexity theory, social exchange and cooperation theories has facilitated understanding of the behaviours of people working in teams and across services.

However, integrated teams are but one facet of collaboration. Therefore this thesis also explores how the learning from this research can be utilised to enhance an understanding of the contributions of organisational theories such as policy networks and network management to situations where integrated teams is not the only solution. It is maintained that such an approach has particular relevance for the managers within this research, who did not work within integrated teams/agency structures.

The findings of this research confirm much of the research literature, discussed in Chapter Four, regarding the benefits and challenges for practitioners and managers of collaborative and integrated working practices. For example, problematic issues surrounding differential power relationships between agencies and professional groups are discussed alongside the tensions underpinned by different patterns of accountability and governance within participating agencies and by the different physical structures and cultures of the agencies involved. The effects of sub-structural factors upon the behaviours of individuals are also highlighted, for example, managers' pursuit of their agency objectives, their defence of different agency paradigms and the need to secure sufficient resources.

The findings indicate that for practitioners entering a new interagency service,

their 'home' and identity were located primarily within a profession. They were keen to maintain their feelings of worth and value by ensuring the 'survival' of their professional skills within their interagency and inter-professional team. However, structural and process factors, such as degree of integration, role and function within the team, all had an impact upon where practitioners located the 'home' to which they belong and from where they were able to build a positive social identity in the workplace..

When practitioners remained within the interagency team and shared core tasks, their 'home' shifted from primarily a profession based home to the interagency team, and an interagency identity that was underpinned by professional knowledge and skills. The experiences of practitioners who were less integrated into the core tasks of the team resulted in feelings of dissatisfaction and frustration and, as a consequence, their sense of belonging to a 'home' remained within their profession.

This research identified that the managers were the least integrated group of people participating in this research and the group that found collaboration and interagency working the most difficult. The managers' primary home and identity were located within their agency and did not change over time. Unlike the practitioners, they were not structurally integrated and their behaviours indicated a need to ensure the 'survival' of their employing agency. A positive relationship emerged in this research between levels of higher degrees of integrated working and more positive experiences of collaboration.

Chapter Six outlined the research methodology adopted and maintained that theory building is about presenting and analysing a set of inter-related concepts and not just a list of themes. This research has identified an overarching explanatory concept that has been termed a 'need to belong'. Once practitioners and managers feel they belong to something, they can assert their identity and develop the productive working relationships required for successful collaborative endeavour.

This research concludes that the benefits and challenges of interagency and inter-professional team working are influenced by factors such as the degree of team integration. However, collaboration and integration are multi-faceted concepts and this research stresses the need to include a focus upon the interpersonal nature of relationships and reports the need for attention to people's social people's identities that are built upon people's feelings of value and worth. Social identity theory is identified as a key explanatory theory that assists understanding of the underlying issues that prevent or promote the delivery of more integrated children's health and social care services.

10.4   The practical implications of this research.

It is maintained that the dynamic established between people in the workplace is as important as the organisational and structural context of collaboration. The practical implications of the findings from this research indicate the need for collaboration and interagency working to utilise strategies that will enhance practitioners' and managers' need to belong to a shared 'home', with shared

responsibilities that reinforce positive social identities in the workplace. Practical strategies, as discussed in chapter nine, can include for example, co-location, shared tasks, single management and practice supervision structures, and shared training. All these strategies must emphasise a culture of interagency and collaboration as a positive practitioner attribute and as the overarching 'home' of positive outcomes for children and families. The differences between 'in-groups' and 'out groups', as highlighted by social identity theory, then becomes less clearly defined.

It is necessary, particularly while interagency services are in their embryonic stages, to ensure that practitioners have a role that enables them to connect physically and emotionally with their professional identity. The implications are for more joined up and shared training over core skills, but the need for specialisation remains, that is, more developed skills in specific and profession based areas.

In the field of child and adolescent mental health there is a significant amount of overlap in the skills and knowledge of, for example, health visitors, social workers and community psychiatric nurses. However, the overlap may not be so great in other service areas, hence the need to be clear about which services to integrate, what model of integration is used, and what the roles, tasks, rewards and relationships are that will support the delivery of services that work closely together in the best interests of the child, young person and family.

The overall task for practitioners and managers would be to maximise team

identity through shared or common tasks, maintain professional identity through specialisation and minimise the impact of agency identity. Therefore, a key requirement is for agencies to adopt and research strategies from social and organisational behaviours that will ameliorate the effects of competitive group behaviours and minimise the number of boundaries, by promoting similarities and core sameness rather than, at times of resource shortages, a tendency to define difference and rationalise specialist skills by creating boundaries to roles and responsibilities.

10.5   The limitations of this research.

This research is a small scale qualitative study utilising research interview methods within two interagency team settings and the limitations of the research methodology are discussed in Chapter Six. It is acknowledged that collaboration is multi-faceted, and this research covers one dimension only: the experiences of health and social care managers and practitioners collaborating to deliver service for children, young people and their families.

It is recognised that interagency and integrated teams are not a universal panacea to all the challenges of collaboration. A single practitioner cannot undertake all of the tasks required to meet all the needs of children and families. Similarly, all the practitioners required to meet the full and diverse range of children and families' needs cannot always be located within the same building, have a single line management structure and equal status.

Miller and McNicholl (2003) emphasise that there is no single way to go about integrating services for children and their families. Therefore the organisational form of collaboration must be determined by the needs of children and families, which in turn will determine the nature of collaborative endeavour, the tasks required from practitioners and managers, and the level of integration required.

This research supports a future of collaboration and integration that ensures organisational form is also built upon a policy and service delivery environment that moves beyond simple organisational and structural solutions. It reinforces the need for people engaged in collaboration to focus upon interdependence, relationships, trust, a sense of belonging and the need for people to have a positive workplace identity.

This thesis also highlights the need to test the assumption that, for example, greater collaboration results in improved quality of services. Chapter Four outlined the assumed benefits of collaboration as including cost effectiveness, quality improvement and more comprehensive and coordinated provision. Schmidt (2001) states the need for the following:

> "More multi-site studies, which provides the opportunity to study variability in inter-professional collaboration. As there are greater opportunities to study variation in collaboration, more conceptual work needs to be done. It is important in future assessments of collaborative models of care delivery to include elements of structure that are relevant to collaborative processes and outcomes." (Schmidt, 2001:60)

Strategies might well be implemented that improve practitioners' and managers' abilities to work together, but do the costs of implementation outweigh the benefits? What mix of collaborators? For whom does it make a difference? What are the outcomes and what are the costs? All of these questions indicate the need for continued and more rigorous empirical research that focuses upon the outcomes of collaboration.

10.6 The contribution of this research to contemporary public policy

The value of this research, and it's relevance to the world of child and adolescent mental health and family support services, can be seen in relation to recent Government policy ambitions. For example, *The 2020 Children and Young People's Workforce Strategy* (DCSF 2008) discusses what is meant by integrated working and how Government plans to support progress and develop a workforce with the knowledge, skills and leadership to make integrated front line working a reality across all children's services. *Children and Young People in Mind: The final report of the National CAMHS Review* (DCSF 2008e) places partnership, collaboration and service integration at the heart of its vision for the future provision of children's services.

Certainly in the field of young people's mental health and emotional well-being, new partnerships are being formed and are becoming more diverse. For example, the Targeted Mental Health in Schools Programme (TaMHS), sponsored by the Department for Children, Schools and Families, aims to provide a framework and practical proposals for the commissioning of targeted mental health services and other services that promote emotional health and psychological well being within

the school environment. The summary report of the learning from the

participating pilot sites states the following:

> "It is clear that the partnership arrangements used in TaMHS have helped
> strengthen – and in some areas re-establish – relationships between
> agencies, namely between health and education. TaMHS has also enabled
> a wider group of agencies to come together than in previous working
> arrangements between mental health support workers:
> They've brought new partners to the table." (DCSF, 2009: 8)

This learning from this research has direct relevance for the TaMHS Programme.

The analysis of the findings from the data suggest a theoretically informed

framework that will assist the wide and varied partners to implement strategies

that promote effective models of collaboration at a strategic (interagency

networks) and operational (inter-professional teams) levels, with social identity as

a core and unifying concept.

Chapter Three of this thesis discussed recent Government guidance on Children's

Trusts (DCSF, 2008a). The guidance highlights integrated front line delivery,

integrated processes, integrated strategy and interagency governance as essential

components of integrated working within Children's Trust arrangements (DCSF

2008a). If Children's Trusts are to be the key vehicles through which

collaboration and integrated models of service delivery are expressed, then there

must be improved understanding of different models of collaboration.

Interdependence must be an organising principle as well as the structures and

processes required to maximise the opportunities for practitioners and managers

from different agencies, and different professional backgrounds, to come together

to ensure improved outcomes for children and families.

This research has been undertaken at a time when integrated working continues to gather momentum. However, the following quote illustrates a continued frustration with collaboration, expressed as joint working, across health and social care:

> "This newsletter includes coverage of several government reports and consultations. A key theme in these documents is the importance of joint working. This is such a shame because all agencies should be working together anyway. It continues to be a point of dismay and frustration that vulnerable children and adults may be put at risk by the very people who are supposed to be helping them." (SSRG News, Aug 2009 editorial)

This research and the history of collaboration demonstrate that structural solutions on their own are not enough. Challenges to the implementation of collaboration and interagency working remain. Chapter Three raises the potential for new Government policies, such as personalisation and the allocation of individual budgets, to work against collaboration. Increasing the size of the 'market place' and the number of service providers in health and social care runs the risk of public sector fragmentation. Therefore, the potential for organisational and practitioner dissonance in working together is increased as tensions could be predicted to arise between the exhortations to collaborate and the competitive ethos of the market place. Where do they belong?

Ham et al (2008) suggest an alternative challenge, and state that the benefits of more integrated services might not be realised as health and social care agencies integrate to become unresponsive monopoly providers of support, with no challenge to their inefficiencies. It remains the case that Government policy ambitions outline a series of principles and aspirations that require interpreting and shaping into models of integrated service delivery at a range of different levels on the continuum of collaboration.

The nature of the gap between policy ambitions, policy implementation and policy outcomes illustrates the difficulties encountered between those making policy at national level and those involved with its implementation at local level. This research identifies some of the 'life giving' forces that can create an environment in which collaborative endeavour can flourish and how these forces may be applied to aid implementation, primarily at the micro and meso levels of analysis. However, the learning from this study, and the application of social and organisational theories, it is suggested, can also be extended to apply to a meta level of analysis.

Personalities and relationships are identified as important factors influencing experiences of collaboration, but the wider social, political, economic and organisational environments in which people operate can militate against the efforts of the most collaboratively minded individuals and agencies. This research supports the view that policy makers and people working in health and social care need to understand the complexity of interdependence and that integrated services do not necessarily respond to simple structural solutions with linear patterns of

cause and effect.

The findings of this research contain some significant messages for the future concerning the proliferation of models of interagency team working, their contextual variety, and the complexity of integration. However, the overarching theme of a need to belong suggests that, irrespective of the model or extent of integration, a working environment must be created that promotes secure identities that are supported by more collaborative and integrated working practices which are not dependent upon the best efforts of individuals.

Positive social identity, relationships, interdependence and trust must be the underpinning principles that guide any organisational form, from policy networks through to interagency and inter-professional teams. Such an approach, it is suggested, would ensure a more robust environment that survives inevitable organisational, policy and personnel changes. Such an environment can provide the necessary conditions for Children's Trusts and child and adolescent mental health and family support services to realise their true potential in supporting the realisation of positive outcomes for children, young people and their families.

This thesis ends with the following poem which uses dance as a metaphor to illuminate the challenges of collaboration and interagency working. It is suggested that the final five lines of the poem succinctly capture the current dilemma that must be addressed if health and social care are to change the history of collaboration for the better:

The Sound of the Old Dance Shaking

Systems are not simply collections of individuals,
they are patterns of relationship.
We exist only in relationship – sometimes on one side,
sometimes on the other.
We dance in the relationship,
and in the dance, we grow apart from one another –
becoming the Burdened
and the Oppressed
the Unsupported
and the Torn,
the Judged
and the Screwed
the Righteous
and the Wronged.
We dance without seeing the dance.
On the inside there is no dance, only our feelings, our beliefs –
so solid, so sure,
"Reality,"
the way things *really* are.
Can we change the dance?
Maybe, maybe not.
Maybe we will go on dancing to the end of our days-
not seeing one another, not loving one another,
misunderstanding, hurting and destroying one another.

Or maybe we will see the dance.
And maybe we will stop the dance.
And maybe we will create a new dance.
But first,
there will be the old dance shaking.
(Oshry, 1995:121)

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Appendix A.

PARTICIPANTS INFORMATION SHEET

Inter-Agency Working in Child and Adolescent Mental Health Services: A comparison of two different models of inter-professional team working.

Project reference number/identifier

Subject Information Sheet

I wish to invite you to take part in a research study. Before you decide whether to do so, please read the following information carefully and discuss it with friends, colleagues or a service manager if you wish. Please ask if there is anything that is not clear or if you would like more information. You will be given as much time as you need to make a decision.

What is the purpose of the study?

There is a substantial amount of literature that recognises the need for the greater co-ordination of appropriate services to meet the needs of children and adolescents with emotional, behavioural and mental health difficulties. The complex nature of child and adolescent mental health difficulties often requires the skills of practitioners from wide and varied professional backgrounds to address the problems. The emphasis is therefore upon the close co-operation of different practitioners within different agencies and organisations.

Locally there are two different models of integrating services and practitioners working with children and adolescents who present with emotional, behavioural and mental health difficulties. This research study is concerned with identifying and comparing the experiences of local practitioners and managers working within the two different models of inter-agency working i.e. the *Interagency Northern and the Interagency Southern Services.*

It is the objective of the research to identify, from practitioners, the factors which both facilitate and inhibit more integrated working practices. It is expected that the outcomes of the research will enable service planners to design collaborative working structures that will promote the optimum opportunities for practitioners to deliver more integrated client/patient care.

Why have I been invited?

You have been invited to take part in the research as you are a practitioner who is working (or has been within the last two years) with the *Interagency Northern or Interagency Southern Service.* It is planned to interview up to 32 practitioners with approximately equal representation from the two services.

What will happen if I decide to take part?

If you agree to take part then you will be asked to participate in an individual

interview with the researcher and a focus group discussion with other practitioners
The interview will aim to explore your experiences of inter-agency working within your service area. It is anticipated that the interview will last between 60 - 90 minutes. The focus group discussion will consist of a group of practitioners participating in a group discussion of their experiences and undertaking a case study exercise. It is anticipated that the focus group discussion will take approximately 60 - 90 minutes. The interview and focus group discussion will take place within weekly working hours and at a venue that is accessible (i.e. minimal travel time).
Feedback to all participating staff-groups will be provided by the researcher upon completion of the research. If any person is interested in the subject matter, the researcher is happy to discuss the study in more detail.

What do I have to do?

If you agree to participate in the research then you will be expected to be available and contribute to both parts of the study i.e. the interview and the focus group discussion.

Do I have to take part?

Only if you want to

Participating is voluntary, you may not wish to participate or you may wish to withdraw from the study at any time. However, please let the researcher know if you are unable to participate fully, as doing only parts of the study will affect the value of the research. You do not need to tell me why you do not want to take part. If you choose to withdraw or not to participate, your decision will in no way compromise your workplace situation.

Are there any risks involved?

There are no identifiable risks to your participation in the study.

Are there any costs involved?

The time taken to contribute towards the study will be included within the normal weekly working hours.

Confidentiality

The records, coded by the researcher, will identify you by number only, and your employer will not have access to the coding schedule. The information obtained from the individual interviews and from the focus group discussions will be tape-recorded and transcribed by the researcher. A copy of the informed consent form and of the transcribed interview will be given to you. The information provided will be treated in the strictest confidence, unless any information that you offer is considered to jeopardise the safety of others. You would be notified of any intention to breach your confidence.

The researcher may also be your line manager or you may have line management responsibilities towards the researcher. In this situation a distinction is required between the role of the researcher and their role in employment. As a researcher there is a commitment to maintain the integrity of the research process. Openness and honesty is valued and any information obtained as a result of the research process will not be transferred into the work arena and will not prejudice your position within the organisation.

The researcher only will retain the information from this study. Tapes will be stored in locked cabinet for a period of one year following completion of the research. After this time the tapes will be destroyed. The researcher will retain anonymised/coded transcripts of the data.

By signing the consent form you give permission for the above to occur

If you agree to participate in this study it is entirely voluntary and refusal will not prejudice your employment or situation in any way.

Who is organising the funding of the research?

The study has been sponsored by the xxxxx NHS Health Trust.

THANK YOU FOR YOUR TIME & CONSIDERATION

Researchers contact details

Appendix B

INFORMED CONSENT SHEET

Interagency working in Child & Adolescent Mental Health Service and family support:
A comparison between two different models of inter-professional team working.

Project Reference Number/Identifier:

Name of Local Lead Researcher: Steve Stericker,

Please initial box

1. I confirm that I have read and understand the information sheet dated …………………………………... for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I understand that any information that I provide will be anonymised by the researcher and then may be viewed by the researcher's supervisor as part of scrutinising the research process. I give my permission for access to the anonymised records.

4. I agree to take part in the above study.

Thank you for agreeing to take part in this study.

| Name of Participant | Date | Signature |

| Name of Person taking consent | Date | Signature |

Appendix C

PRACTITIONERS INTERVIEW SCHEDULE

Date of Interview:

Interviewer:

Place of Interview

Code

Explanation of participants' information sheet
Explanation of consent sheet and signature obtained

Participants Details

Before talking about your experiences of inter-agency working, I would like to ask a few questions about you and your professional background.

1. **Would you mind telling me which team or service that you work for?**

Interagency Northern Service

Interagency Southern Service

2. **Could you tell me about your professional background, and what you are currently employed as?**

HEALTH   Specify Designation

SOCIAL SERVICES   Specify Designation

EDUCATION   Specify Designation

OTHER   Specify Designation

SERVICE DESCRIPTION

3. **Can you describe the structure of the team that you work in?**

Prompts:
Professional composition   **WORK COORDINATION**
Employing agency
Secondment/full-time/part-time
Physical base
Participating agencies
Client group served

4. What was your motivation for joining the team?

5. Can you describe how your team works?

Philosophy   **IDEOLOGICAL CONSENSUS**
Aims and objectives

Referral pathways   **WORK COORDINATION**
Allocation of work
Tasks undertaken
Roles/Responsibilities

6. Can you describe your role within the team?

Give examples what you do   **DOMAIN CONSENSUS**
Unique-how is it different?
Generic
Links to professional body?

7. Can you describe the roles of the different professionals within the team?

Unique - how
Generic   **DOMAIN CONSENSUS**
Give examples

INTER-PROFESSIONAL TEAM WORKING

8. Are there any benefits to working in this team/service?

Compare to previous employment   **POSITIVE EVALUATION**
For self
For client group
Related to inter-agency nature?

9. Are there any difficulties to working in this team/ service?

Compare to previous employment   **POSITIVE EVALUATION**
For self
For client group
Related to inter-agency nature?
Tensions?

10. Do the benefits identified outweigh the difficulties or do the difficulties outweigh the benefits?

Explain

11. What are the key issues for you working within a multi professional team/service?

Barriers   **ALL DOMAINS**
Incentives
Training Needs?

12. What, in your opinion are the key issues for the other professionals working within the team/service?

By profession   **ALL DOMAINS**
Barriers
Incentives
Training needs?

13. What would be your key messages for promoting the emotional, behavioural and mental well-being of children and young people?

14. What would be your key messages for those planning inter-agency and inter-professional teams?

Appendix D

MANAGERS INTERVIEW SCHEDULE

Date of Interview:

Interviewer:

Place of Interview

Code

Explanation of participants information sheet
Explanation of consent sheet and signature obtained

Participants Details

Before talking about your experiences of inter-agency working, I would like to ask a few questions about you and your professional background.

1. **Would you mind telling me with which service were you are employed?**

   HEALTH   Specify Designation

   SOCIAL SERVICES   Specify Designation

   EDUCATION   Specify Designation

   OTHER   Specify Designation

2. **With which service were you involved/consulted with at the planning stages?**

   Interagency Northern

   Interagency Southern

3. **Has your involvement with the service continued during its operation?**

   YES

   NO

4. **What influenced you to develop an inter-agency and integrated team approach to promoting the emotional, behavioural and mental well-being of children and young people?**

   Shared values

Facilitation forces
Finances
Strategic planning processes   **IDEOLOGICAL CONSENSUS**
Agency relationships
Govt lead/local lead
Communication

5. What do you consider to be the benefits of an inter-agency approach for this client group?

Finances   **WORK COORDINATION**
Avoid Duplication
Improves Communication
Cross-cutting needs - identify service gaps
Promotes mutual understanding of services.

6. What are your views about the role of social care practitioners within the Team?

POSITIVE EVALUATION
DOMAIN CONSENSUS

7. What are your views about the roles of the health practitioners within the team?

DOMAIN CONSENSUS

8. What do you consider to be the difficulties of planning an interagency approach for this client group?

Barriers
Agency priorities   **DOMAIN CONSENSUS**
Cultures
Planning cycles   **WORK COORDINATION**
Competition for resources
Lack of Trust   **POSITIVE EVALUATION**
Lack of mutual understanding of agency demands and responsibilities

8. Can you describe any factors that influenced you to develop the particular model of inter-agency working ?

Was it the preferred model? If not why not?
Was it underpinned by evidence?   **IDEOLOGICAL CONSENSUS**

DOMAIN CONSENSUS

9. What are your views about your partner agencies and their involvement in the development of the service?

Motivation   **POSITIVE EVALUATION**

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Trust
Polivy?
Performance?
Finance/savings?

10. What would be your key messages for those planning inter-agency services designed to meet the needs of children and young people with emotional, behavioural and mental health difficulties.

How to build on facilitation forces
How to overcome barriers

Appendix E

PRACTITIONERS FOCUS GROUP SCHEDULE

1. Introduction to purpose of focus group
   Rules of the focus group and explain confidentiality.

2. Construct a vignette of a 'typical care pathway' for a client progressing through the team/service from referral to closure.

Decision making processes
Team processes
Roles and responsibilities

3. Place questions on flip chart.

Discuss:

- Describe the benefits of professionals working together in your service/team for that client.

   At the conclusion of the discussion ask practitioners to individually rate their views to the following question:

   What level of agreement is there in your team in relation to the ways in which the work of the team should be organised to meet the needs of children and families? Rating 0-5. **Work Coordination:**

- Describe the difficulties of professionals working together in your service/team.

   At the conclusion of the discussion ask practitioners to individually rate their views to the following question:

   How positive are your views of the contribution of other professional groups to the work of the team. Rating 0 (not very positive) 5 (extremely positive) **Positive Evaluation**

   Benefits for self and clients
   Difficulties for self and clients
   Seek group consensus over order of priorities of benefits and difficulties.
   Power
   Employment terms and conditions
   Professional isolation/deskilled
   Improved skills and knowledge
   Improved communication
   Better for children and families – in what ways?

- What is the role and contributions of your professional group to the Team/service?

  At the conclusion of the discussion ask practitioners to individually rate their views to the following question:

  What level of agreement is there within the team in relation to what the tasks are? Rating 0 (no agreement) – 5 (full agreement) **Domain consensus**

- What is the role and contribution of the other professional groups to the team/service?

  At the conclusion of the discussion ask practitioners to individually rate their views to the following question:

  What level of agreement is there within your team in relation to the how tasks are undertaken? Rating 0 (no agreement) - 5 (full agreement) **Ideological consensus**

  Roles
  Values
  Culture
  Skills and knowledge

Appendix F

MANAGERS FOCUS GROUP SCHEDULE

1. Introduction to and purpose of a focus group
   Rules of the focus group and explain confidentiality.

2. Please discuss your views on the Governmnents agenda to encourage public services for children and families to be more integrated.

Benefits
Drivers
Resources
Conflicting policies and targets

3. Place questions on flip chart.

Discuss:

- (Quote from individual an interview) "There are different cultures and you realise that people have different experiences and the way they are organised means they have to do thing in a set way."

     Culture/agency/professional
     Language
     Terms and conditions
     Aligning working practices eg management and practice supervision.
     Better for children and families – in what ways?

     At the conclusion of the discussion ask practitioners to individually rate their views to the following question:

     What level of agreement is there in relation to the ways in which the work of the services should be organised to meet the needs of children and families? Rating 0 (no agreement) – 5 (full agreement) **Work Coordination**

- What would be your views in relation to the contributions of partner agencies in taking forward the partnership agenda in children's services?

     At the conclusion of the discussion ask practitioners to individually rate their views to the following question:

     How positive are your views of the contribution of your colleagues in health or social care in taking forward the partnership agenda in children's services. Rating 0 (not positive) - 5 (extremely positive) **Positive Evaluation.**

     Benefits for self and clients

Difficulties for self and clients
Seek group consensus over order of priorities of benefits and difficulties.
Power
Improved skills and knowledge
Improved communication

- When considering the development and operation of Interagency Northern and Interagency Southern, was there agreement about what tasks where and what the contribution was of the respective agencies to achieve the tasks? Please consider your views in terms of the initial planning stages and subsequently when the services became operational.

  At the conclusion of the discussion ask practitioners to individually rate their views to the following question:

  What level of consensus was there within in relation to identifying what tasks the teams should be undertaking? Rating 0 (no consensus) - 5 (full consensus) **Domain consensus**

- How much agreement was there about how the services would deliver their services?

  At the conclusion of the discussion ask practitioners to individually rate their views to the following question:

  What level of agreement is there in relation to how tasks are undertaken when planning and overseeing the operations of the services? Rating 0 (no agreement) – 5 (full agreement). **Ideological consensus.**

  Roles
  Values
  Agency and professional Culture
  Skills and knowledge
  Power