

Complexity and interprofessional working in children's services

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Thesis submitted for the degree of Doctor of
Philosophy

January, 2013

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Declaration of Authorship

I, Rick Hood, hereby declare that this thesis and the work presented in it is entirely my own. Where I have consulted the work of others, this is always clearly stated.

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Abstract

Interprofessional working can be regarded as both a response to complex problems and a source of additional complexity. In the context of children's services, there has been little research into what complexity actually means for practitioners working together in the team around the child. Drawing on the results of a qualitative research study, this thesis explores the phenomenon of complexity as something that is experienced by practitioners in complex cases, and constructed in their accounts of collaborative casework. For the study, core groups in two complex child protection cases were approached within an outer London children's trust and seventeen practitioners agreed to take part in semi-structured interviews. Interview transcripts were analysed using two different qualitative methods: interpretative phenomenological analysis (IPA) and critical discourse analysis (CDA). The findings reveal complexity to be a multi-faceted phenomenon. It is shown how the dynamics of complex systems feed into relationships, processes of assessment and intervention, and the management of risk. Practitioners' accounts of complexity are built on the conflict and congruence between different orders of discourse relating to professional and interprofessional practice. The findings enable a critical re-engagement with the literature on integrated children's services and child protection. The implications of complexity are discussed in terms of socio-technical systems and the question of how best to facilitate interprofessional working in the team around the child. Some suggestions are made for policy and practice in this area.

Some of the material contained in Chapter 2 and Chapter 3 has been published in the following papers:

Hood, R. (2012) 'A critical realist model of complexity for interprofessional working', *Journal of Interprofessional Care*, 26 (1)

Hood, R. (2012) 'Complexity and integrated working in children's services', *British Journal of Social Work* (early online)

Table of contents

Abstract.....	3
Table of contents	5
List of Figures	10
List of Tables	11
List of Abbreviations	12
Acknowledgments.....	13
1. Introduction	15
1.1 The policy context	15
1.2. What is interprofessional working?.....	17
1.3 Encountering complexity.....	18
1.4 Aims of the research	19
1.5 Research design and approach.....	19
1.6 Structure of the thesis	20
2. Literature Review	22
2.1. Introduction	22
2.1.1. Related terms and definitions	22
2.1.2 Search strategy and inclusion criteria.....	24
2.2. Policy background to integrated children’s services	27
2.2.1 Integration and fragmentation	27
2.2.2 Modernisation and managerialism.....	28
2.2.3 Child protection and child abuse inquiries	28
2.2.4 Social investment and safeguarding	29
2.2.5 Every Child Matters and the Children Act 2004.....	30
2.2.6 Targeted services and the ‘team around the child’	32
2.2.7 Outcomes of integrated services	36
2.2.8 Critiques of integration.....	38
2.2.9 Integrated services and the ‘complex case’	39
2.2.10 Summary	40
2.3 Perspectives on interprofessional working	42
2.3.1 Professions and professionalism	42
2.3.2 Interprofessionalism: ethics, education and practice.....	44
2.3.3 Processes of interprofessional working.....	45
2.3.4 Context of interprofessional working	47
2.3.5 Summary	50
2.4 Complexity and the ‘complex case’ in child protection	51
2.4.1 Perspectives on complexity	52
2.4.2 Complex systems.....	53

2.4.3	Risk and risk management.....	54
2.4.4	Uncertainty and professional judgement	55
2.4.5	Group dynamics.....	56
2.4.6	Summary.....	57
2.5	Conclusion	58
3.	Theoretical framework	60
3.1	Introduction.....	60
3.2	Theories of complexity	60
3.2.1	Complexity theory	60
3.2.2	Key features of complex systems.....	61
3.2.2.1	Non-linearity.....	61
3.2.2.2	Emergence and dissipation	61
3.2.2.3	Self-organisation.....	62
3.2.2.4	Attractors.....	62
3.2.3	Complexity and social systems	63
3.3	A critical realist model of complexity.....	64
3.3.1	Bhaskar’s critical realism and complexity	64
3.3.2	A critical realist view of complex needs.....	66
3.3.3	Complexity and interprofessional working.....	69
3.4	Summary.....	71
3.4	Conclusion	71
4.	Methodology	72
4.1	Introduction.....	72
4.2	Development of the research question	72
4.3	Theoretical basis.....	73
4.3.1	Research paradigm	73
4.3.2	Methodological approach.....	75
4.3.3	Study design	76
4.4	Interpretative phenomenological analysis (IPA).....	78
4.4.1	Background to IPA	79
4.4.2	Rationale for use of IPA	80
4.4.3	Methodological procedures.....	81
4.4.4	Limitations of IPA.....	82
4.5	Critical discourse analysis (CDA)	83
4.5.1	Background to CDA.....	83
4.5.2	Rationale for use of CDA.....	85
4.5.3	Methodological procedures.....	85
4.5.3.1	Genre	86
4.5.3.2	Intertextuality	86

4.5.3.3	Assumptions	86
4.5.3.4	Representation of events	87
4.5.3.5	Style	87
4.5.3.6	Interdiscursivity	87
4.5.3.7	Corpus analysis	88
4.5.4	Limitations of CDA	88
4.6	The research process	89
4.6.1	Ethical considerations	89
4.6.1.1	General principles of ethical research	89
4.6.1.2	Confidentiality and anonymity	91
4.6.1.3	Informed consent	92
4.6.1.4	Affecting casework	93
4.6.2	Access to research sites	93
4.6.3	Sampling strategy	94
4.6.4	Overview of cases and participants	95
4.6.5	Data collection and pilot interviews	97
4.6.6	Conduct of the interviews	98
4.6.7	Transcription	99
4.6.8	IPA analysis	100
4.6.9	CDA analysis	103
4.7	Quality in qualitative research	106
4.7.1	Reflexivity	106
4.7.1.1	Personal reflexivity	107
4.7.1.2	Epistemological reflexivity	108
4.7.2	Credibility	109
4.7.2.1	Principles of good research practice	110
4.7.2.2	Independent audit	110
4.7.2.3	Triangulation	111
4.7.3	Transferability	111
4.8	Summary	112
5.	Interpretative phenomenological analysis	113
5.1	Introduction	113
5.2	Causality	114
5.2.1	Exploration of cause and effect	115
5.2.2	Lack of control over events	119
5.2.3	Summary	122
5.3	Relationships	123
5.3.1	Dynamics of acceptance and rejection	124
5.3.2	Managing the relationship	127

5.3.3	Perceptions of conflict	131
5.3.4	Summary.....	134
5.4	Assessment.....	135
5.4.1	The significance of information	136
5.4.2	Emotional resonance of the case.....	139
5.4.3	Processes of understanding and explanation	143
5.4.5	Summary.....	148
5.5	Intervention.....	149
5.5.1	Balancing care and control	150
5.5.2	Negotiating one’s contribution.....	153
5.5.3	Striving for progress.....	157
5.5.4	Functioning of the network	160
5.5.5	Summary.....	164
5.6	Risk.....	165
5.6.1	Acuteness of need	165
5.6.2	The struggle for control	169
5.6.3	Summary.....	173
5.7	Conclusion	174
6.	Critical discourse analysis.....	178
6.1	Introduction.....	178
6.2	Genre.....	179
6.3	Intertextuality.....	182
6.4	Assumptions	187
6.5	Representation of social events.....	193
6.6	Styles and identities.....	199
6.7	Interdiscursivity	204
6.8	Conclusion	210
7.	Discussion.....	216
7.1	Introduction.....	216
7.2	The phenomenon of complexity.....	217
7.3	Managing complexity through the socio-technical system.....	221
7.4	Interprofessional working in the team around the child	227
7.5	Assessment and the reflexive network.....	231
7.6	Intervention and the distribution of expertise	235
7.7	Risk, accountability and communication	241
7.8	Conclusion	244
8.	Conclusion	247
8.1	Introduction.....	247
8.2	Limitations of the study	247

8.3	Contribution of the thesis	249
8.3	Implications for policy and practice.....	249
8.4	Areas for future research	252
8.5	A final reflection... ..	252
	Bibliography.....	254
	Appendices	281
	Appendix 1: List of key search terms.....	281
	Appendix 2: Database searches	283
	Appendix 3: Manual searches	285
	Appendix 4: Evaluation of empirical studies of interprofessional working in children’s services	286
	Appendix 5: Glossary of terms relating to integrated services.....	292
	Appendix 6: Glossary of terms relating to critical discourse analysis.....	294
	Appendix 7: Research ethics approval	295
	Appendix 8: Participant information sheet	296
	Appendix 9: Participant consent form.....	298
	Appendix 10: Research information sheet (families)	299
	Appendix 11: Consent form (families).....	300
	Appendix 12: Research information sheet (children and young people)	301
	Appendix 13 Consent form (children and young people).....	302
	Appendix 14: Interview schedule	303

List of Figures

Figure 2a	The 'onion' model: cooperative arrangements under children's trusts	32
Figure 2b	Targeted services and tiered intervention	34
Figure 2c	The 'windshield' model: additional and complex needs	34
Figure 2d	The team around the child	35
Figure 2e	Perspectives on complexity	52
Figure 3a	Two views of complexity using Bhaskar's domains	66
Figure 3b	A 'simple realist' disaggregation of complex needs	67
Figure 3c	Complex causality: necessary and contingent relations	68
Figure 3d	Complexity and interprofessional working	69
Figure 4a	Study design	78
Figure 4b	Flowchart of research process (ethics and access)	90
Figure 4c	Interpretative phenomenological analysis in ATLAS.ti	101
Figure 4d	IPA themes in Excel table	102
Figure 4e	Critical discourse analysis in ATLAS.ti	104
Figure 4f	Word list for Case 1 interviews, using Wordsmith	105
Figure 5a	IPA findings: how professionals experienced complexity	174
Figure 6a	CDA findings: orders of discourse in the construction of complexity	212
Figure 7a	Interprofessional working at the 'sharp end' of a complex system	225

List of Tables

Table 2a	Summary of literature review: topics and material	26
Table 4a	Final sample of cases	96
Table 4b	Participant codes and contribution to interviews	97
Table 4c	Notation of transcripts	100
Table 5a	Overview of cases	114
Table 6a	Overview of cases	179
Table 6b	Ten most frequently occurring pronouns (by case)	183

List of Abbreviations

CAF	Common assessment framework
CAMHS	Child and adolescent mental health service
CDA	Critical discourse analysis
DCSF	Department of children, schools and families
DfE	Department for education
DoH	Department of health
ECM	Every Child Matters
FIP	Family intervention project
FRP	Family recovery programme
GP	General practitioner
ICS	Integrated children's system
LCSB	Local child safeguarding board
IFA	Independent fostering agency
IPA	Interpretative phenomenological analysis
IPE	Interprofessional education
IPW	Interprofessional working
SFL	Systemic functional linguistics
REC	Research ethics committee
TAC	Team around the child
YOT	Youth offending team

Acknowledgments

This thesis could not have been written without help from a number of people. I have had the privilege of being supported by four excellent supervisors: Ravinder Barn, Ray Jones, Tony Evans and Jan Fook. At different stages in the research process they have been there to listen patiently, contribute ideas and lend a word of advice. I am also grateful to colleagues and friends, both within and outside the field of social work, for their insights and encouragement over the years. Thanks in particular to Jonathon, for many an interesting discussion. I am grateful as ever to my family, to Mum and Chris, Dad and Sybille, for all of their help over the years, and for the proofreading. Doing this PhD happily coincided with getting married, so special thanks to Vicki for her love, understanding and support (and for saying yes!). Finally, I would like to acknowledge the professionals and agencies who agreed to take part in the study. Their time and effort is much appreciated.

For Clifford, who knew the value of study

1. Introduction

This thesis explores complexity in the context of interprofessional working in children's services. It is a topic that has been arrived at in two steps. Firstly, professionals often have to work together in order to meet the needs of vulnerable children and families. As a result, collaboration – variously defined – has become a significant theme in policy and practice guidance over the years. Secondly, interprofessional working is particularly important in what might be termed 'complex cases', which in broad terms are those presenting with multiple, interlinked problems that do not fit easily within institutional or organisational boundaries. In this study, such cases are explored within the specific domain of child protection, in which the onus on professionals to work together, and the challenges involved in doing so, have often been highlighted.

Interprofessional working (IPW) may therefore be seen as doubly bound up with complexity, in that it constitutes a response to complex problems but is also a complex area of practice in itself. The question then arises: what exactly is meant by complexity? In general usage, the term serves as a metaphor of 'difficulty', while also suggesting something about what it is that is difficult. Indeed, a crucial assumption for this thesis is that complexity does mean something. In particular, complexity means something to professionals, who must deal with unfolding problems and events at the frontline of service provision. The study will examine how professionals experience complexity, and how they construct these experiences in their accounts of collaborative casework. In doing so, the aspiration is to add to the literature on interprofessional working, as well as to contribute to debates around policy and practice in the field of child protection.

1.1 The policy context

It has come to be widely accepted that collaboration between agencies and professionals can improve the quality of provision in children's services (Crawford, 2012; Hammick et al., 2009; Robinson et al., 2008; Lord et al., 2008; Atkinson et al., 2007). The shift towards integrated services also reflects a broader trend in public services, in which an ecology of autonomous professions is giving way to a more fluid, interdisciplinary world of practice (Carnwell and Buchanan, 2005). This is particularly the case in the conjoined sectors of health and social care,

where both demographic and political changes have made it necessary to deliver a range of specialist services in various 'person-centred' combinations (Koubel and Bungay, 2008). The integration agenda has spurred a large number of studies into interagency working over the past decade (Sloper, 2004, Percy-Smith, 2005, Brown and White, 2006, Atkinson et al., 2007, Lord et al., 2008, Robinson et al., 2008). While the literature provides consistent messages about barriers and facilitators to collaboration, evidence about its benefits for service users has remained 'sparse' (Atkinson et al., 2007: 2).

One of the key principles behind the reforms enacted in the 2004 Children Act was that services ought to work around the child's needs, rather than prioritising organisational or professional boundaries (DCSF, 2007a). Other policy drivers included the refocusing debate of the mid-1990s, the modernisation of public services, a succession of inquiries into deaths caused by child abuse, and the idea of social investment in disadvantaged groups and communities (Fawcett et al., 2004, Featherstone, 2006, Spratt, 2009). Every Child Matters, the Government Green Paper that led to the 2004 Act, sought to unite these concerns into a vision of services that would work together to promote positive outcomes for all children, building on protective factors and counteracting risk factors by targeting additional needs with specialist interventions (Parton, 2006b). The cooperative arrangements set up under children's trusts were accompanied by an expansion of multiagency service provision, while efforts were made to bolster safeguarding practice through more robust information-sharing, assessment and case management procedures. During this period, government guidance has promoted the 'team around the child' (TAC) as a generic concept for delivering services to children with additional or complex needs (Limbrick, 2004). The TAC is not an integrated multiprofessional team, but a collaborative network coordinated by a 'lead professional'. In cases requiring child protection plans, the statutory social worker is the lead professional within the TAC, or core group.

Interprofessional working is often associated with the principle of putting the user at the heart of service provision (Irvine et al., 2002). Crucially, the concept of 'child-centred' services is also a 'needs-focused' approach, drawing on ideas of social investment and the 'preventative state' (Fawcett, Featherstone and Goddard, 2004; Spratt, 2009). These suggest that services should try to build on protective factors and counteract risk factors in a child's individual, familial and social background, by targeting them with supportive or assertive interventions, based on need, as early as possible in their childhood development. One of the key questions raised in the literature is

how to improve outcomes for families with the most complex needs, who may be described as 'hard to reach' by preventative services with voluntary access, or 'hard to change' by statutory services with a mandate for intervention (Brodie, 2010, Edwards et al., 2006, C4EO, 2009, Wilkin et al., 2008, Tisdall et al., 2005, Utting et al., 2007). These are precisely the kind of cases in which interprofessional working is most required, yet which also pose the greatest resistance to professional remedies.

1.2. What is interprofessional working?

As always in this area there is a problem of terminology: how to define collaboration as well as the group that collaborates? For the first part, the preferred term in this thesis is 'interprofessional working' (IPW), to indicate a focus on practitioners working together on cases where there is a joint interest. This is a slightly different emphasis from 'interprofessional collaboration', which is increasingly found in the literature as an superordinate concept covering organisational and educational interventions, as well as interprofessional practice (Leathard, 2003; Reeves et al., 2011). As for the second part, it has already been noted that official guidance refers to the 'team around the child' (DCSF, 2008) when it comes to children with complex needs, or to the 'core groups' who implement child protection plans (DCSF, 2010). Neither term really refers to a 'formal' team as such, since members are usually employed and managed by different agencies, and coalesce on an ad-hoc basis around specific cases. Indeed often they will be based in more formal teams within their own agencies. Ovretveit (1993) uses the term 'network association' for this kind of arrangement in his typology of adult mental health teams, while Warmington et al. (2004), drawing on Engestrom's (2001) activity theory, suggest 'knotworking' instead. Here the preference is for 'interprofessional network', which captures a sense of practitioners being situated at the intersection of multiple, interacting systems, rather than within a stable and defined team structure.

IPW can refer to specific forms of collaborative activity, encompassing processes and structures alike, but as a concept it also draws our attention to the contested nature of professionalism and the professions. The sociological literature broadly divides into functionalist and conflict-oriented interpretations of what 'makes' a professional (Macdonald, 1995). The former perspective would seek to identify the general 'traits' of a profession, e.g. a specialised knowledge-base, formal system of accreditation, ethical code of practice (Evetts, 1999). It is through these traits that

professionals can fulfil their designated role in society by providing a reliable and trustworthy service for their clients. The latter perspective, on the other hand, would focus on the way some occupational groups pursue a self-interested strategy of becoming professions, e.g. in order to acquire a state-sanctioned monopoly over particular areas of economic activity (Larson, 1977). The contrast between these two perspectives has implications for IPW. Most obviously, it makes it difficult to categorise who should and should not count as a 'professional' without drawing on the idea of traits or deciding whether a 'professional project' has been accomplished or not. While professionalism is arguably about creating boundaries, e.g. between competences, remits and roles, being interprofessional is to some extent about crossing those boundaries (Hammick et al., 2009). For this reason, this study adopts a broad interpretation of what makes a professional while recognising that the term is a contested one. For the most part, 'practitioner' is used to refer to participants in the empirical part of the study, who were all employed by services to work with vulnerable children and families.

1.3 Encountering complexity

It has already been suggested that complexity is associated with cases in which there are multiple, interlinked problems that require the involvement of a number of professionals. In the two chapters which follow, the definition of complexity will be expanded to encompass a number of theoretical and practice-related perspectives, emerging from the literature. The crucial point is that complexity is not an abstract or arcane concept. On the contrary, it is something encountered by practitioners in their everyday work.

My own experiences of working with vulnerable children and families have informed my interest in this topic. It is an area of practice that will always offer unique challenges and rewards. Nonetheless, I have often found that some parts of the work – certain people, situations, events – have seemed to stand out from the rest. Certain problems have consumed my time and energy, caused anxiety and confusion, and exposed gaps in my knowledge and expertise. After training as a social worker, I became used to thinking about my work in terms of cases. I started to hear and use the term 'complex case'. When such a case was being handed over to me, colleagues might warn me not only about all the work that had to be done, and all the needs that had to be addressed – but also about the problematic relationships and emotional strain that the case was likely to entail. Like most practitioners, I accepted the term 'complex' as shorthand for a whole

range of potential difficulties, on the basis that I would soon be finding out what the actual difficulties were. This thesis represents an effort to go back to the original term, on the hypothesis that at least some of the difficulty might arise in the encounter with complexity itself.

1.4 Aims of the research

Complexity is a significant issue for interprofessional working, since collaboration tends to be linked to efforts to resolve multiple, interrelated problems. Nevertheless, complexity is rarely presented as a phenomenon in its own right, rather than just as a convenient metaphor for difficulty. Furthermore, policies to promote integrated services have often overlooked the lived experience of practitioners in favour of organisational structures and procedures. For this reason, the aims of the research focus on what practitioners experience and discuss in relation to the shared complex case. The general research question may therefore be expressed as: what does complexity mean for practitioners working together on complex cases? Based on the overarching topic, two main objectives have been formulated to guide the research design, data collection and analysis:

- a) To explore how practitioners experience complexity when working together on complex cases.
- b) To examine how practitioners construct complexity in their accounts of collaborative casework.

These objectives present two angles on the research question, the first a hermeneutic exploration of how professionals experience the phenomenon of complexity *in* their work, the second a critical exploration of how an account of complexity is constructed by professionals talking *about* their work. Combining these two approaches is intended to provide a complementary analysis of the data and enrich the subsequent discussion of findings.

1.5 Research design and approach

This study has been designed to explore complexity in line with the research aims presented above. There is a focus on interprofessional practice in ongoing child protection cases. This has allowed the study to learn from the experiences of participants, and to build a picture of

complexity in the context of frontline casework. The study design is accordingly based on the professional networks in two purposively sampled cases. The study site consisted of agencies within a single children's trust in outer London. Two cases were chosen rather than one in order to provide some grounds for comparative analysis, to broaden the diversity of experience sampled in data collection and enhance the transferability of findings to contexts outside of the study. Data were collected from semi-structured interviews with practitioners in the networks in each case. There are two complementary strands of data collection and analysis, which link to the research aims. The two approaches, interpretative phenomenological analysis (IPA) and critical discourse analysis (CDA), complement a hermeneutic focus on lived experience with a critical perspective on how such experiences are linked to discursive practices.

1.6 Structure of the thesis

The chapter which follows this introduction will clarify terms and definitions and review the literature relevant to an understanding of the research topic. This includes an outline of the policy context to integrated children's services, an exploration of perspectives on the professions and interprofessionalism, and a discussion of complexity in relation to complex cases in child safeguarding.

Chapter 3 will look more closely at theories of complexity and set out a theoretical framework specifically geared towards the operation of interprofessional networks in complex cases. This model of complexity will inform the gathering and analysis of data in relation to the research question.

Chapter 4 will set out the methodological approach used in this study. The rationale for a case-based, mixed qualitative design will be set out in relation to ontological and epistemological assumptions. Practical and ethical issues in relation to data collection and analysis will be discussed, along with some of the principles of good research practice.

Chapter 5 will present the findings of an interpretative phenomenological analysis (IPA) of interview transcripts. The analysis will explore how the participants experienced complexity, and made sense of that experience, in the context of working together on the two child protection cases sampled for the study. The chapter will present the experience of complexity from a number

of angles, looking at causality and relationships, processes of assessment and intervention, and issues around risk.

Chapter 6 will present the findings of a critical discourse analysis (CDA) of interview transcripts. The qualitative material is the same as that used for the IPA analysis, but is explored through a different analytical lens. From the perspective of CDA, participants' accounts are viewed as texts *about* complexity, which have been constructed during the course of an interview. The chapter will look at how participants used language and drew on a variety of discourses to build an account of the case.

Chapter 7 will draw together the results from the two findings chapters in order to present an overall account of the phenomenon of complexity and examine its implications for the field of child safeguarding. The discussion will revisit some of the critical themes and issues that emerged from the literature review, in order to draw the thesis to a conclusion.

Finally, Chapter 8 will present some general conclusions and reflections from the study, setting out its key contributions and limitations, and outlining some recommendations for future research in the area.

2. Literature Review

2.1. Introduction

This chapter will review the current state of research around complexity and interprofessional working in children's services in the UK. The introduction will clarify related terms and definitions and set out the search strategy and inclusion criteria for the material reviewed. The main part of the chapter will present an overview of the background literature, proceeding along three contextual strands. Firstly, there is the political and historical development of children's services, looking particularly at the increasing emphasis on collaboration as a way of dealing with the complex problems faced by vulnerable children and families. Secondly, the concept of interprofessional working is examined in greater depth, drawing on sociological perspectives on the professions, aspects of organisational theory and models of collaboration. Thirdly, there is a discussion of complexity itself, particularly as it pertains to the field of child protection. In the process, a number of critical themes will be drawn out of the literature in order to establish the rationale and scope of the study.

2.1.1. Related terms and definitions

The move towards integrated children's services has been associated with a proliferation of related terms, sometimes described as a 'terminological quagmire' (Leathard, 1994: 5, Lloyd et al., 2001). These terms are not interchangeable, since they have been employed differentially in models and typologies, for example to denote stages along a continuum of greater or lesser 'integration' or 'collaboration' (Horwath and Morrison, 2007, Whittington, 2003). Such typologies have sometimes followed the Latin meanings of common prefixes such as 'multi' (many), 'inter' (between), and 'trans' (across) to describe the variety of ways in which agencies and professionals may collaborate (Fitzgerald and Kay, 2008). Atkinson et al. (2007) acknowledge that the profusion of definitions and meanings can make cross-comparison of studies difficult, although as Leathard (2003b: 5) sensibly points out, 'what everyone is really talking about is simply learning and working together'.

For the purposes of this study, 'integrated children's services' is taken to be the overall context for policy and practice, while 'collaboration' is used as a general term for practitioners and agencies

who are working together in various ways. The nature of collaboration is held to be 'interagency' when occurring between agencies, and as 'interprofessional' when occurring between practitioners. The distinction points to the emphasis in this study, which is on interprofessional working in the sense of case-based practice, rather than on organisational structures or strategic and operational planning. However, it has not been assumed that these meanings are assigned elsewhere in the literature and for this reason a broad range of key terms was used in the search strategy (see below). Hyphens have been dispensed with for three commonly occurring terms: interagency, multiagency and interprofessional. A glossary of terms relating to integrated services can be found in Appendix 5.

As observed in the introduction (Section 1.2), usage of the term 'professional' is a contested subject in its own right. In this study, professional is broadly used to mean people working in the field of children's services, who belong to a variety of occupations with different qualification and accreditation routes. It is not the purpose of this thesis to enter into the question of what does or does not constitute a 'profession', or to present a distinction between 'professionals' and 'non-professionals'. It is instead proposed to use the 'practitioner' as a general term to refer to participants in the study, who were all employed by services to work with children and families. However, this is not to overlook the significance of professional socialisation, or of differences in authority and status between practitioners; for instance, the approach taken here will explore how power relations emerge and develop at the level of the case (see Chapter 6, Section 6.8). This chapter takes account of professional tribalism as a potential barrier to collaboration (see Section 2.2.7) and makes some relevant links to the sociology of the professions (Section 2.3.1), as part of the context to the study.

It is also worth noting the distinction between 'child protection' and 'safeguarding', given the prominence of both terms in the literature (Parton, 2011). Both may be characterised as a general remit of all services with any involvement with children, as well as a more specific category of provision for children seen as particularly vulnerable or at risk. Safeguarding, as Parton has argued (2006b, 2011), is a more general concept that seeks to locate protection within a broader spectrum of services designed to promote overall welfare and development. The basis for safeguarding is the idea of a 'preventative system' (DCSF, 2007a), in which a combination of universal and targeted services intervene as early as possible to support children with additional needs, and prevent problems from escalating. Child protection, on the other hand, tends to have a

somewhat narrower definition. It usually denotes a category of cases in which some degree of maltreatment has been identified by professionals and the emphasis is on preventing its recurrence, and on remedying its impact on the child in question (Davies and Ward, 2012). Child protection may involve investigations into reported or suspected maltreatment, measures to protect children including the implementation of child protection plans, or statutory interventions such as removal of children from families and initiation of care proceedings. In a more procedural sense, child protection cases are those where services are provided under the aegis of a child protection plan, which is established and reviewed through multiagency case conferences prescribed by statutory guidance.

Finally, the focus of this study is on a particular type of child protection case, i.e. a 'complex' case. The obvious question here is 'what makes a case complex?' and in a sense it is the purpose of this thesis to answer that question. However, there is the pitfall of starting off with a tautological definition of complexity as being that which is experienced or construed in relation to a complex case. It is therefore worth clarifying what might generally be understood by a complex case, in advance of the discussion of findings in later chapters. An initial working definition is supplied by the sampling criteria outlined in Section 4.6.3, which in turn are derived from the literature explored throughout this chapter. These criteria include a large and diverse interprofessional network, and the assessment of multiple, interrelated needs. A more theoretical discussion of complexity is provided in Chapter 3.

2.1.2 Search strategy and inclusion criteria

Review topics for the literature search are summarised in Table 1 on the next page. The areas covered were:

- The policy background to integrated children's services,
- Perspectives on interprofessional working, and
- Complexity and the 'complex case'.

The aims of the review were to contextualise and refine the research question by identifying critical themes and areas for further enquiry. The search strategy was designed in line with

Neuman's suggestion that a literature review should be 'selective, comprehensive, critical and current' (2006: 123). Initial search parameters were decided in relation to the key terms discussed above (see Appendix 1). A systematic search of academic databases was undertaken using specialised online platforms available through the British Library (see Appendix 2). In addition, a manual search was conducted of relevant journals, government websites and research foundations (see Appendix 3). The resulting bibliographic data, including abstracts, were imported into Endnote reference management software, for an analysis of relevance to the review topic. Once duplicates and unsuitable entries had been deleted, a selection process applied inclusion criteria to the remaining papers in order to determine a key body of literature. Preference was given to the following:

- Government papers, reviews and statutory guidance published after 1997, when the first New Labour government took office, which provide the main policy context to the development of integrated children's services
- Overviews of the literature on integration and collaboration published after 2000, which incorporate and synthesise a wide range of earlier reviews as well as empirical studies, and which synthesise results in terms of theories and models of integration, barriers and facilitators, or outcomes and impact
- Empirical studies published after 2000 and concerning practice within the UK, falling into two main categories: evaluations of programmes based on interagency collaboration, e.g. Sure Start, or the Children's Fund; and field studies focusing on collaboration in particular areas of practice, e.g. child protection, or children with disabilities
- Empirical studies published before 2000, or concerning practice outside the UK, judged to have particular relevance, e.g. whose findings are often cited in later studies, or employing a distinctive methodology or theoretical perspective adding breadth to the overview
- Critical commentaries on themes related to the research topic, e.g. interprofessional education and ethics, safeguarding, child protection, social policy and organisational theory
- Theoretical background: books and articles widely cited in the above material, which proved essential to an overall understanding of the areas covered in the review.

Table 2a. Summary of literature review: topics and material

Policy background to integrated services	<i>Government documents</i>	Legislation and statutory guidance, policy reviews and reports, commissioned research on departmental websites.
	<i>Systematic reviews</i>	Reviews of the literature covering models of integrated services and interprofessional working, barriers and facilitators, outcomes and impact.
	<i>Empirical studies</i>	Evaluations of multiagency programmes, e.g. Sure Start, and findings on collaboration in particular areas of provision for children.
	<i>Critical reviews</i>	Papers offering a commentary or critique on the development of integrated services and collaboration in the field of child safeguarding.
Perspectives on interprofessional working	<i>Sociology of the professions</i>	Key texts on the history and characteristics of the professions, particularly those relevant to children’s services.
	<i>Interprofessionalism</i>	Papers relating to interprofessional ethics and education, and the processes of interprofessional working.
	<i>Theoretical background</i>	Theories relevant to the context of interprofessional working, e.g. organisational theory and activity theory.
Complexity and the ‘complex case’	<i>Complexity theory</i>	Scientific frameworks of complexity and their application in the social sciences and to the delivery of public services.
	<i>Risk</i>	Papers relating to the management of risk in health and social care settings, particularly in the field of child protection.
	<i>Uncertainty</i>	Papers relating to the way professionals make judgements in conditions of uncertainty.

	<i>Group dynamics</i>	Theories of group interaction, decision-making and problem solving, applicable to the activity of interprofessional networks.
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Following this screening process, the full text versions of articles, reports and other publications were either downloaded or obtained from the library. A critical appraisal tool for qualitative research (Public Health Resource Unit, 2006) was mainly used to evaluate the relevance and quality of empirical studies, reports and reviews. In the case of mixed methods evaluations, which sometimes analysed quantitative data alongside qualitative information on outcomes, a different evaluation tool was used (Health Care Practice and Development Unit, 2003). A summary of the evaluation of key empirical studies is provided in Appendix 4.

2.2. Policy background to integrated children’s services

2.2.1 Integration and fragmentation

Evolution of the post-war welfare state was accompanied by increasing specialisation of its constituent professions. This led to concerns about services becoming fragmented if they continued to be organised around professional expertise (Crawford, 2012, Carnwell and Buchanan, 2005). This gave rise to periodic reforms designed to reorganise services, based on managerial principles of efficiency and cost-effectiveness, and ethical principles of user-centred care and accountability (see Sections 2.2.2 and 2.3.2). At the same time, some divisions were reinforced, such as those between health and social services, and between children’s social care and education (Parton, 2009b). Three decades later, in the aftermath of the Laming Inquiry, the latter two were reunited under the aegis of local authority children’s services. Yet this in turn involved the separation of services for adults and children, potentially undermining a holistic focus on the family unit (Social Exclusion Unit Task Force, 2007, 2008, Cabinet Office, 2008). Such concerns illustrate the shifting terrain of integration and fragmentation as services have been periodically restructured to reflect changing government priorities. Since 2010, the trend of coalition government policy has been to emphasise early intervention and the need to target services, rather than integration as such (Lord, 2011, Allen, 2012), alongside an agenda to promote localised

service delivery. It is too early to say whether this will mean a lessening of collaborative endeavours, although there are some concerns that financial austerity might put pressure on resources needed to maintain existing partnerships (Davies and Ward, 2012).

2.2.2 Modernisation and managerialism

Cochrane (2000) describes how reforms undertaken in recent decades have attempted to make the professional bureaucracies originally established by the post-war welfare state more 'business-like'. He also associates the modernisation agenda with the desire to make local planners and professional groups more accountable to service users and taxpayers. Modernisation of the welfare state has therefore been linked to the ideology of managerialism (Pollitt, 1993).

Managerialism involves the use of corporate structures and management techniques derived from private sector organisations to run public sector bureaucracies on a rationale of economic efficiency and value for money (Poole, 2000). Clarke et al. (2000a) explicitly contrast managerialism with the alternative approach of professionalism, which represents the equivalent claims of professional groups to manage their own activities based on their specialist knowledge and expertise (see also Freidson, 2001).

The view of managerialism as an oppositional discourse to professionalism is widely supported in the literature (Owens and Petch, 1995, Freidson, 2001, Clarke et al., 2000b, Dominelli and Hoogvelt, 1996, Chard and Ayre, 2010). For example, Owens and Petch (1995) describe how the introduction of general management in the NHS in 1983 was resisted by the nursing profession, partly because the new managerial hierarchy replaced consensual decision-making bodies, in which nurses, health visitors and midwives were represented alongside doctors. The cumulative effect of changes such as the allocation of budgets to services and the purchaser-provider split was to 'dismantle traditional professional hierarchies and radically to change accepted patterns of care' (Owens and Petch, 1995: 37), in the process creating a degree of fragmentation and specialisation in welfare services. This in turn led to a greater onus on collaboration and partnership between agencies, a theme developed by the New Labour government in its reorganisation of the health and social care sectors (Leathard, 2003b).

2.2.3 Child protection and child abuse inquiries

Over the last three decades, a succession of public inquiries into deaths from child abuse have identified deficiencies in interprofessional communication and collaboration (DHSS, 1974, DHSS, 1985, DHSS, 1987a, Laming, 2003, 2009). These findings have been a significant driver of government policy, which has yielded an ever-increasing array of protocols for working together (DoH, 1991, 1999, DfES, 2006). The effect of public inquiries has also been felt in other ways. During the 1980s, growing pressure to prevent child deaths led to concerns that social workers were intervening too readily in private family life (DHSS, 1987b), which fed into a strengthening of parental rights in the 1989 Children Act. Moreover, the onus on investigating child protection cases continued to divert resources from more supportive and preventative work (Munro, 2004), leading to calls for a rebalancing of priorities and resources (DoH, 1995, Utting, 1995). The refocusing of children's services towards prevention has been linked to the shift towards closer integration and interagency working in the wake of the 2004 Children Act (Parton, 2004, 2006a).

Defensive practices in child protection have seen agencies rely on procedures and protocols to minimise the risk of being blamed for adverse outcomes (Ayre and Preston-Shoot, 2010). Yet the emphasis on managerial systems to monitor the performance of children's professionals has arguably overlooked the importance of emotional and psychological factors in dealing with cases of child abuse (Horwath, 2007, Munro, 2010). In some cases, such factors may even contribute to lapses in judgement, communication and decision-making (Cooper, 2004, Reder and Duncan, 2004). In response, the government has tried to promote children's welfare through networks of collaborating specialists. This has involved expanding the role of education, health and non-statutory services in delivering earlier intervention and preventative services, while statutory social workers have come to specialise in complex case management and investigating child abuse (Morris, 2010). As a result, child protection has been subsumed to some degree within the broader category of 'safeguarding'.

2.2.4 Social investment and safeguarding

Social investment strategies are designed to mitigate and pre-empt the impact of social exclusion on vulnerable groups (Featherstone, 2006, Fawcett et al., 2004). They adopt a more targeted approach than traditional welfare policies, which seek to address general problems such as levels of poverty or ill-health, As Spratt (2009) notes, the rationale for targeted intervention applies particularly well to children, for whom 'the benefits of investment are repaid over an extended

time in economic productivity and reduction in cost to society through decreased demands on services' (Spratt, 2009: 438-39, see also Scott et al., 2001). New Labour's initial approach to social investment was to identify problematic sub-populations through locality-based indicators of poverty and exclusion, for example by setting up Sure Start Local Programmes (SSLPs) in deprived neighbourhoods. SSLPs housed multiagency partnerships that were subsequently expanded in the form of local authority 'children's centres' as a form of universal service provision. Interim evaluations suggested that hard-to-reach families would not necessarily use facilities in their area (Jack, 2005, Allnock et al., 2006), so that targeting 'the most needy' families became an increasing priority. This has continued to be the case after a new Coalition Government was elected in 2010 with an agenda to trim the cost of public services (Lord, 2011). From an initial focus on deprivation of *locality*, identifying need has therefore become associated with assessment of *individual* risk factors and 'multiple problems' in families (Spratt and Devaney, 2009, HM Treasury and DfES, 2007, Cabinet Office, 2008).

Social investment has informed a notion of safeguarding that encompasses but is not limited to cases of child abuse; one that acknowledges the multiple associations between childhood experiences and outcomes in later life, and emphasises the importance of prevention rather than remedial action (Mason et al., 2005). The concept of prevention can be seen to cover the whole spectrum of possibilities between adversity and protection, vulnerability and resilience, with services designed to address risk factors and enhance protective factors on the level of individuals, families, peer-groups, schools and communities (Edwards et al., 2006, Ghate et al., 2008, Prior and Paris, 2005, Utting et al., 2007). Ghate et al. (2008) suggest that the increasing recognition of resilience has encouraged a more positive, strength-based approach to intervention. On the other hand, it could be argued that the emerging 'preventative state' has contextualised services within similar technocratic systems of surveillance and risk management found in child protection (Parton, 2006a). The safeguarding agenda may therefore reflect the shift from professional to managerial control that was discussed earlier.

2.2.5 Every Child Matters and the Children Act 2004

Every Child Matters (DfES, 2003, 2004), and the subsequent reforms of the 2004 Children Act, built on earlier legislation and policies aiming at closer interprofessional and interagency collaboration (see McInnes, 2006, Percy-Smith, 2005). An important precursor was the Quality Protects

programme from the late 1990s, which tried to improve the provision of coordinated services for vulnerable children (DoH, 1998). Other initiatives, such as multiagency youth offending teams, were also based on the principles of partnership and joint working (HMG, 1998). Schools became a key site of efforts to tackle social exclusion through 'joined-up' service provision aimed at vulnerable children, often focused on levels of attendance and expulsions, or on behavioural outcomes (Milbourne, 2005, Webb and Vuillamy, 2004, Halsey et al., 2005). A further catalyst for change came with the public inquiry into the death of Victoria Climbié (Laming, 2003), whose recommendations were incorporated into Every Child Matters (ECM). The 2004 Children Act, which proceeded from ECM, unified children's services by merging education authorities with children's social services departments. It also required all the agencies involved with children and young people to put in place formal partnership arrangements under the umbrella of 'children's trusts' (DCSF, 2010a: 7).

Children's trusts are not legal entities and member organisations retain responsibility for discharging their roles and functions. The trusts are partnerships which are set up and maintained by the local authority through a statutory body called the children's trust board. The guidance distinguishes between agencies designated as 'relevant partners' in the Children Act 2004 (as amended by the ACSL Act 2009), who have a statutory 'duty to cooperate', and other partners, including 'third sector' organisations, who are included in the cooperative arrangements and may be represented on the children's trust board (DCSF, 2010a: 18). The children's trust board also liaises with other local partnerships, including multiagency public protection arrangements (MAPPAs) and local child safeguarding boards (LCSBs). A well-known model of the children's trust is illustrated below in Figure 2a:



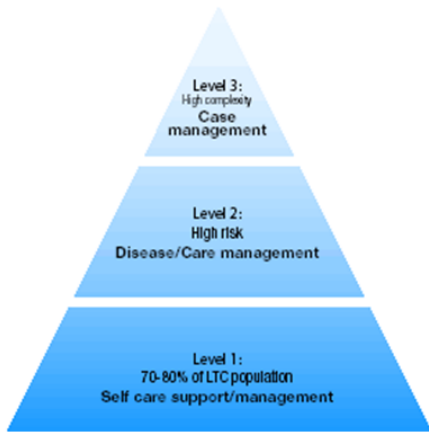
Figure 2a. The 'onion' model: cooperative arrangements under children's trusts (DCSF, 2010a: 8)

The model envisages children's trusts as a type of ecological system of care (Bronfenbrenner, 1979), whose purpose is to integrate all the services needed for children in their local communities. At its centre is a 'microsystem', representing outcomes for children and families. This is then embedded within various layers of 'exosystem', consisting of professionals, frontline services and strategic partnerships within the community. The model of nested systems conveys the dual emphasis on containment and control that is characteristic of a safeguarding approach, in that collaborative arrangements serve to protect children as well as to shape their developmental outcomes. Indeed, government policy at this time envisioned a 'preventative system' (DCSF, 2007a: 92) designed to address problems as early as possible in children's development. To this end, practitioners involved in delivering these services, collectively known as the 'children's workforce', would have a 'common core' of knowledge, values and aspirations, including a commitment to integrated working, while new procedures and tools were developed in order to facilitate collaboration and information sharing. These included the common assessment framework (CAF), and IT-based case management systems such as the integrated children's system (ICS), which will be discussed below.

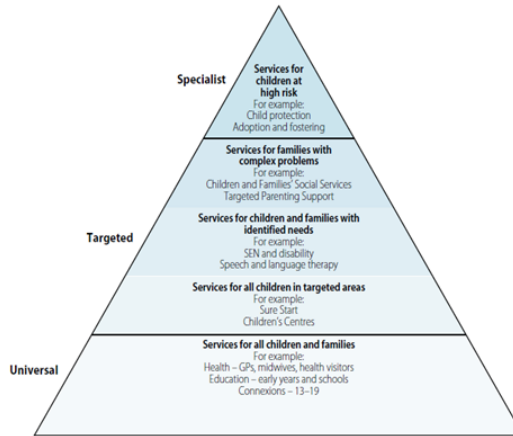
2.2.6 Targeted services and the 'team around the child'

In practice, the concept of integrated services envisaged by children's trusts draw on a pyramidal model of tiered intervention that was already prevalent in the health and social care sectors (Hardiker et al., 1991). The parallels are illustrated in Figure 2b, which shows how a 'case management' approach to chronic illness (Department of Health, 2007) is replicated by the concept of targeted services outlined in Every Child Matters (ECM) (2003). At the base of the ECM pyramid, universal services such as schools and GP clinics cater for all children, most of whom have no additional needs. Other services are available to provide extra support to children whose needs cannot be met fully by universal services. This is where targeted support, e.g. from an education psychologist, or speech therapist, is brought in to remedy the gap in provision and hopefully enable the child to thrive alongside his/her peers. At the 'top' of the scale, there are cases of 'high complexity', or 'high risk', which must be managed by a range of practitioners from different specialisms. It is worth noting that the ECM model implies that complex cases involve a greater degree of collaboration, since neither universal services nor individual specialist agencies, will be able to deal with the problems that such cases present.

The pyramid can also be represented as a continuum of services, as in the 'windshield' model shown in Figure 2c, which is taken from government guidance on integrated working (DCSF, 2007b). It shows how collaboration ensues with the allocation of extra resources to children on the basis of need. Additional needs are identified via a 'common assessment framework' (CAF) designed to be used by all professionals working with children. In cases of complex need, the CAF is meant to help provide integrated support via a range of specialist services, coordinated by a 'lead professional' (Easton, 2012). At the furthest end of the scale, the most acute cases, involving potential harm to children, require statutory services to be brought in. At this point the statutory agency will usually take over as the lead professional in order to coordinate multiagency assessment and intervention.



The Kaiser Permanente Triangle
DH (2007)



Targeted services within a
universal context
Every Child Matters (2003)

Figure 2b. Targeted services and tiered intervention

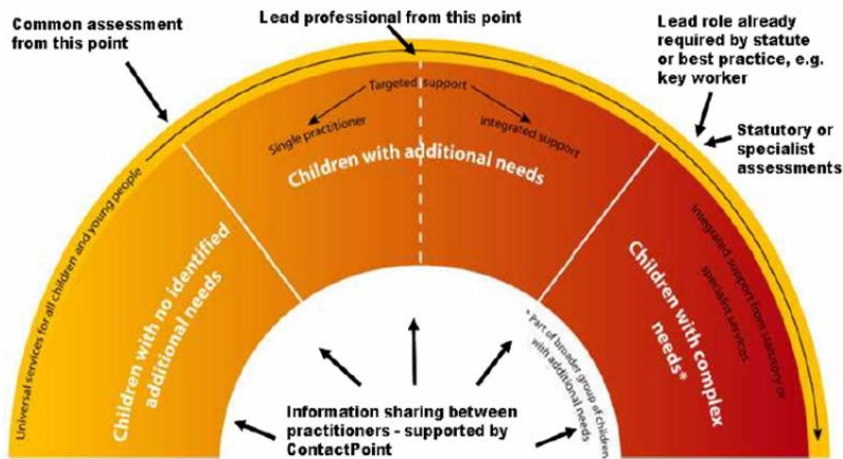


Figure 2c. The 'windshield' model: additional and complex needs
(DCSF, 2007: 11)

In other words, the model of tiered intervention suggests that complex cases are managed by groups of practitioners who collaborate across universal and specialist services. The question then arises whether such groups should be conceptualised as teams. Official guidance refers to the ‘team around the child’ (TAC), which helps to support children with additional needs (DCSF, 2008, 2010a, Limbrick, 2007), as well as to the ‘core groups’ who implement child protection plans (Department for Education and Skills, 2006). It could be argued that neither term really refers to a formal team as such, since members are usually employed and managed by different agencies, and coalesce on an ad hoc basis around specific cases. Indeed, often they will be based on more formal teams within their own agencies. Ovretveit (1993) uses the term “network association” for this kind of arrangement in his typology of adult mental health teams. Warmington et al. (2004), drawing on Engestrom’s (2001) activity theory, suggest ‘knotworking’ instead. The latter term attempts to capture a sense of practitioners being situated at the intersection of multiple, interacting systems, rather than within a stable and defined team structure. Nonetheless, the ‘team around the child’ (TAC) has become an official designation for the groups of practitioners who undertake collaborative safeguarding work. The TAC model is illustrated below in Figure 2d:



Figure 2d. The team around the child (DCSF, 2008)

As Edwards et al. (2006: 11) observe in relation to Hardiker’s (1991) model of tiered services, categorising an ‘overall’ level of need for a child might actually conflate separate areas of need that are different in their degree and urgency. It is also interesting to note that with an increasing level of need, the team around the child may well become less integrated – in other words less like

a 'team' in the senses discussed earlier – both due to the increase in number of practitioners as well as the type of specialist agencies that may become involved. For example, a young child may initially be seen at a children's centre, where a range of practitioners form part of a permanent multiagency team under unitary management. However, if the need arises, staff may contact and work together with practitioners who are managed and employed by other agencies. Child protection concerns might require the expertise of statutory social workers, who will also involve the police and health services if necessary. The complexity of the multiagency response therefore is likely to rise alongside the complexity of the problems which are identified.

2.2.7 Outcomes of integrated services

Researchers have endeavoured to find out whether collaborative models of service provision are effective at improving outcomes for children and young people (e.g. Lord et al., 2008, Atkinson et al., 2007, Brown and White, 2006). Ironically, given the aim to develop more child-centred services, research findings are much clearer in regard to what works for professionals and agencies than what works for service users (Atkinson et al., 2007). There is the methodological challenge of evaluating outcomes in relation to an array of multi-faceted variables that are interacting over time in very mutable contexts. Nationwide initiatives such as Sure Start and Children's Fund have actually consisted of a very diverse number of individual projects, which have been influenced by local conditions and contingencies. Programmes and their objectives have also been buffeted by continual policy changes (Bachmann et al., 2009). Operational models that were seen to be effective during pilot phases, when backed by intensive resources and motivated staff, may become less so when rolled out on a wider basis with varying levels of implementation fidelity (Anning et al., 2006). Meanwhile, the use of quantitative methods to determine whether an intervention has 'worked' invariably raises questions about whether the chosen indicators, e.g. school exclusions, or numbers on child protection plans, appropriately reflect outcomes for the children involved (Edwards et al., 2006).

Nonetheless, there is evidence that families do benefit from integrated services. Lord et al. (2008: 5) summarise these benefits as 'early identification and intervention; easy access to services and to information about available provision; ongoing, respectful and reliable support; and the greater understanding of their child's needs' (see also Tisdall et al., 2005, Wilkin et al., 2008, Bachmann et al., 2009, Townsley et al., 2003). Robinson et al. (2008) note further outcomes in terms of the

impact on practitioners of integrated working, such as a better understanding of clients' issues, greater awareness of other agencies' work and the role of networks, increased workload and more leeway for developing local solutions. On the other hand, when it comes to very disadvantaged families, those with a long history of involvement with services, or with significant and multiple problems, it seems to be harder to produce sustainable outcomes (Davies and Ward, 2012, Brodie, 2010, Edwards et al., 2006, NESS, 2008, C4EO, 2009, Wilkin et al., 2008, Tisdall et al., 2005, Utting et al., 2007). Evaluations of government programmes have reported qualified progress in achieving specified objectives through collaborative ventures, e.g. to reduce school exclusions and improve pupil attainment (Halsey et al., 2005, Webb and Vuillamy, 2004), to reduce criminal activity and improve behaviour and parenting (Ghate et al., 2008), or more broadly to tackle social exclusion (Edwards et al., 2006). Sylva et al.'s (2004) study of the effect of pre-school education on child development, while not specifically oriented around collaboration, found that integrated settings were more effective in improving developmental outcomes. Conversely, Glisson and Hemmelgarn's (1998) study in the United States used a quasi-experimental research design to examine what organisational characteristics affected outcomes for children entering state custody, and found that internal organisational climate was more important than the quality of interagency links.

In contrast to the somewhat equivocal evidence on outcomes, there is a considerable body of research concerning the processes of collaboration, in the form of 'barriers and facilitators' (Sloper, 2004), or 'challenges and enablers' (Robinson et al., 2008) to various forms of interagency and interprofessional working. To take one well-known review, Atkinson et al. (2007) see 'working relationships' as one of the main factors influencing what they call 'multi-agency activity', along with adequate funding and resources, good communication, shared objectives, and effective leadership. The main ways of fostering better working relationships were found to be clarifying roles and responsibilities, ensuring that there is commitment at all levels, building up trust and mutual respect, and 'fostering understanding between agencies', for example through joint training. Similar findings are evident in other reviews (Sloper, 2004, Robinson et al., 2008, Percy-Smith, 2005, Brown and White, 2006, Lord et al., 2008).

Of course, the apparent consistency of research messages on barriers and facilitators to collaboration masks some differences in emphasis. Studies of multidisciplinary teams (Anning et al., 2006, Halsey et al., 2005), for example, have yielded information about the issues driving

interprofessional dynamics, such as role clarity, status, identity, stereotyping, and theoretical models of practice. Larger scale evaluations provide a picture of policy implementation in which interagency structures and protocols, leadership, commitment and communication, are able to drive forward collaboration and to some extent control those dynamics. There may be tensions between managerial and professional perspectives, such as the challenge of balancing genericism and specialism, or the problem of role blurring in interprofessional contexts (Rushmer and Pallis, 2002). While issues of power and status emerge when different practitioners are required to work together, they are also relevant for the relationships between organisations and even sectors, when it comes to participating in collaborative arrangements (Tunstall et al., 2007, Ghate et al., 2008).

2.2.8 Critiques of integration

One effect of the ‘barriers and facilitators’ discourse in the literature has been to reinforce the idea that interprofessional working is a problem to be solved through improved systems, structures, procedures and technology – already a longstanding trend in the field of child protection (Ayre and Calder, 2010, Wastell and White, 2010, Munro, 2010). This functionalist tone is reflected in government guidance on integrated services, epitomised by the ‘onion’ model illustrated earlier in Figure 2a, in which the different layers of the interagency system are designed to ‘wrap around’ service users, emphasising security and equilibrium. There is little scope for conflict or instability in this model, since the potential for discord has theoretically been dealt with in the outer layers by creating the right conditions for effective collaboration. Outcomes are produced and maintained at the centre, suggesting that integrated services, if constituted correctly, will have a built-in tendency to produce the desired result. Such assumptions have attracted scepticism and has been seen by some as based on ‘an implicit ideology of neutral, benevolent expertise in the service of consensual, self-evident values’ (Challis et al., 1988, cited in Warmington et al., 2004: 19).

Hudson (2007) suggests that there is a pessimistic streak in the literature, which attaches too much significance to the problems caused by distinctiveness and differentiation in the by-now familiar categories, e.g. knowledge, power, status, accountability. As an alternative, he proposes an ‘optimistic model’, based on commonality and compatibility, in which a new kind of professionalism is built on a foundation of reflective practice, interdependent decision-making and

collective responsibility. This is along similar lines to Wenger's (1998) concept of communities of practice and is echoed in references to 'hybrid professionals' (Atkinson et al., 2002), for example, or to the need to develop a 'common language' (Horwath and Morrison, 2007). However, Daniels et al. (2007) argue that such approaches tend to see conflict as a 'barrier' to be overcome, whereas in fact instability and contradiction are the driving forces of any kind of change. They observe that services have had to become much more adaptive and customised, putting the emphasis on emergent networks of agencies, professionals and clients, rather than through monolithic organisational or team structures. Expertise in such settings is distributed across services and agencies, with collaboration having to be improvised in focused, time-limited bursts of activity around particular cases. They therefore see activity theory (Engeström, 1999b, 2001) as providing a more appropriate framework. Collaboration is understood as coalescing around the 'object' of the activity system, i.e. what practitioners are working on together, a nexus of different perspectives, practices and expertise in which change and innovation is a constant factor.

Studies adopting a psychodynamic perspective point to another crucial but often overlooked factor in collaboration, namely the unpredictable effects of emotions and interpersonal relations. Research has shown how defensive coping mechanisms, originating in factors in the client family and feeding into the interaction between service users and professionals, can undermine interprofessional collaboration (Conway, 2009, Woodhouse and Pengelly, 1991, Menzies Lyth, 1988, Granville and Langton, 2002). Similarly, stress and anxiety have long been known to have a distorting effect on both individual and organisational behaviour in the field of child welfare, although this has been consistently overlooked in the official response to child death inquiries (Reder and Duncan, 2003, Morrison, 1996, Parton, 2004, Ayre and Calder, 2010, Munro, 2004, Hallett, 1989). These findings point not only to the limitations of an overly functionalist and bureaucratic approach to collaboration, but also to the fact that the day-to-day experience of practitioners has been consistently overlooked in the policy debate surrounding child welfare (Preston-Shoot, 2010).

2.2.9 Integrated services and the 'complex case'

The changes brought about by Every Child Matters were meant to shift children's services towards prevention while continuing to protect children from abuse and neglect (Parton, 2006a). However, as Morris (2010) points out, while time-limited funding streamed into new preventative models of

service delivery, the 'core' duties and practices of statutory services remained largely unchanged. Indeed, the child protection system continued to suffer from longstanding flaws identified in successive reports and inquiries (Munro, 2011). While the extra resources allocated to prevention seems to have benefited families able to access the 'one stop shop' embodied by children's centres and extended schools, those families who remained 'hard to reach' for such services (Tunstall et al., 2007) continued to be dealt with by statutory services. As a result, the integration of children's services has made disappointingly little difference when it comes to complex cases involving multiple needs and risks to children (Davies and Ward, 2012, Farmer and Lutman, 2012, Ward et al., 2012, Wade et al., 2011, Daniel et al., 2011, Thoburn and Brandon, 2008). This is somewhat disconcerting, given that it is complex cases that put a premium on collaborative casework (see Section 2.2.6).

Warmington et al. (2004: 7) point out that interagency working has conventionally been assumed to offer a 'virtuous solution to "joined-up" social problems'. What this means on a macro-level, is that the complex problem of social exclusion can be addressed by integrating the range of services provided to communities, and on a micro-level, that individual cases of complex need can be dealt with more effectively by teams of collaborating professionals. At the same time, current models of integration have not entirely addressed the 'faultline' in provision between prevention and protection, which the shift to safeguarding was meant to resolve. The push to get agencies and practitioners to collaborate by adopting IT-based workflow and performance management systems, such as the Common Assessment Framework (CAF), and Integrated Children's System (ICS), has met with some scepticism (Parton, 2009a, White et al., 2011, White et al., 2009). According to critics, such tools are part and parcel of a 'dystopian picture' of children's services, in which the skills of practitioners are being 'blighted by ill-designed technology' (Wastell and White, 2010: 112). Whether or not one accepts this interpretation, the ongoing debate about failings in the child protection system suggests that integrated children's services have not so far managed to solve complexity in the way that was hoped.

2.2.10 Summary

In summary, the development of children's services in England, and in other parts of the UK, has formed part of broader trends in public service provision, in which the world of separate, autonomous professions is slowly giving way to the more fluid, networked realm of

interprofessional practice. Another way of putting this is that the increasing complexity of social problems has been matched by the increasing complexity of provision. This is reflected in the sheer diversity of services for children, encompassed by the conjoined sectors of health, education, social care, youth justice, mental health, and so on. Policies designed to improve accountability, and prevent costs from spiralling out of control, have sought to bring the activity of professionals under the control of administrators and managers. Such tendencies have been amplified in children's services by the concern with managing risks to children and the impact of public inquiries into child deaths. In turn, legislation and guidance have emphasised the need for agencies and professionals to work together to investigate referrals and intervene in child protection cases. At the same time, the shift towards integrated services has also been bound up with ideas of social investment and early intervention, aiming to promote a more preventative approach to the problems experienced by vulnerable children and families (Sharp and Filmer-Sankey, 2010, Allen, 2012).

Collaboration is particularly crucial in cases where a child's needs cannot be met by individual practitioners and their agencies. In such cases, practitioners from universal services make referrals to access support from more specialist services, establishing a 'team around the child' whose activity is coordinated by a lead professional. This system of tiered intervention allows specialist provision to be matched to need. Government guidance emphasises structures and processes, designed to create the conditions for effective interprofessional working in the team around the child. Studies of interprofessional working have therefore often focused on ways of identifying 'barriers' and 'facilitators' to interprofessional working, in order to find ways of improving integrated structures and processes. Such approaches are generally congruent with a functionalist view of children's services, i.e. as a system whose equilibrium state is one in which positive outcomes can be consistently achieved. However, research on the outcomes of integrated services remains ambivalent about their effectiveness for children and families with complex needs. High-profile failings in the child protection system have also continued to influence policymakers.

These issues will be revisited in the final section of this chapter, which will focus on complexity in the context of the child protection case. Before this can be done, it is proposed in what follows to look more closely at interprofessional working, which has emerged as a key conceptual and organisational issue in the field of children's services.

2.3 Perspectives on interprofessional working

The previous section examined how collaboration between agencies and professionals has become a touchstone of policy and practice in the field of children's services. This section will further explore some of the literature around interprofessional working. It will be shown how 'interprofessionalism' both intersects and contrasts with professionalism as a perspective on work, and how this impacts on professional socialisation and ethics. A further link is made with the discourse of managerialism and the question of control over professional work. The section will then move to a discussion of relevant theoretical perspectives, including learning theories, organisational theories and their implications for models of collaboration. The discussion will further develop the themes of consensus, conflict and negotiation that have already emerged in the policy literature.

2.3.1 Professions and professionalism

Sociological analyses of the professions have varied over the years. The conventional approach was to enumerate the traits of an ideal-type profession and match them up against the attributes of a real-world occupation (Macdonald, 1995). As Evetts (1999: 120) points out, most pragmatic definitions would still be along these lines, distinguishing professions through their specialised knowledge and expertise, entry through a university-accredited qualification, and adherence to an ethical code of public service (see also Freidson, 2001). However, sociologists have also drawn attention to professionalisation as a social strategy, through which certain occupations try to turn themselves into professions in order to increase their market power, autonomy and social status (Freidson, 1970, Eraut, 1994, Johnson, 1972, Larson, 1977). As part of their 'professional project' (Larson, 1977), professions will negotiate with the state for a monopoly over their jurisdiction of activities (Abbott, 1988), as well as competing with similar or complementary occupations in their field. The ultimate goal is 'social closure' (Murphy, 1988), in pursuit of which professions may even attempt to exclude certain groups of people from performing particular kinds of work and therefore contribute to existing structures of inequality or discrimination in society (Witz, 1992). A more positive account is given by Halliday (1987), who argues that professional bodies can also use their special relationship with the law in order to act in the public interest.

The academic critique of the professions has to some extent been reflected in more sceptical public and political attitudes. Professionals are perceived to have mixed motives for providing services that enhance their own economic and social advantage (Carrier and Kendall, 1995). As discussed earlier, government policy has had the effect of bringing professionals in the public sector under the control of managerial systems designed to ensure accountability and choice for service users. Some commentators have seen a trend towards a 'new professionalism' based on clinical governance rather than autonomy (Irvine, 1999, Taylor, 2002). At the same time, expectations of public services continue to rely on the assumption of altruistic and ethical practice, as reflected in the New Labour government's efforts to modernise the 'children's workforce' by uniting disparate professions around a 'common core' of knowledge and values (Garrett, 2008).

Abbott and Wallace (1990) define a small group of occupations as the 'caring professions', which share a particularly altruistic idea of vocation based on providing personalised care for their clients. The caring professions are predominantly female, and deliver many of the frontline public services for children, such as teaching, nursing and social work. These occupations have also been categorised as 'semi-professions', in contrast to 'ideal-type' professions along the lines of doctors and lawyers (Etzioni, 1969). Etzioni (1969) ascribes their lesser status to a shorter training period, an insufficiently specialised knowledge base, lower public legitimacy and less freedom from managerial or societal control. On the other hand, Abbott and Wallace (1990) point out that traditionally female occupations such as nursing and midwifery have often had to opt for professionalisation as part of their struggle to avoid being subordinated to the male-dominated medical profession. The caring professions, along with the medical profession, have also been criticised for helping to manufacture needs and erode people's ability to look after themselves (Illich et al., 2005), or for propagating patriarchal attitudes about the subordinate role of women (Lorentzon, 1990).

Seen as a whole, these accounts and critiques of the professions seem to reflect more general sociological debates about the nature of social existence (Giddens, 2009). For example, the activity of professionals might be interpreted from a functionalist perspective as contributing to the stability and welfare of the community, or from a conflict-oriented perspective as a struggle between different groups with multiple goals and interests. Similar ambiguities are evident in the attitude of policymakers, who seek to harness the expertise of professionals to address social problems, while at the same time endeavouring to make professional activity more accountable

and less autonomous. It is an attempt to resolve these ambiguities that may be characterised by efforts to shift from professionalism to 'interprofessionalism' (Carrier and Kendall, 1995, Irvine et al., 2002) – a concept that will be examined further below.

2.3.2 Interprofessionalism: ethics, education and practice

Hammick et al. (2009) define 'being interprofessional' almost as a state of mind, an internalised attitude that enables practitioners to understand, respect and communicate with colleagues from different backgrounds. Professionalism on its own, they suggest, is no longer enough in a world of complex problems that make working together not just preferable, but essential. Whereas professionalism creates boundaries, between competences, remits and roles, interprofessionalism is about crossing them. Studies have also developed the idea that interprofessionalism is underpinned by a shared value base. Professional ethics, usually formalised as standards of practice, often focus on the relationship between service providers and service users, aiming to mitigate power imbalances, manage expectations and create trust (Hall, 2003). Differences between professional cultures result in different value-perspectives, for example about confidentiality or informed consent when it comes to information sharing (Reeves and Freeth, 2003), or about resource management and access to care (Leathard and McLaren, 2002). The shift towards interprofessional collaboration in health and social care has therefore led to an emerging field of interprofessional ethics (Clark et al., 2007). Efforts have been made to establish a common ethical framework based on the 'primacy of the client's needs and interests' (Irvine et al., 2002: 208), and to design interdisciplinary courses accordingly (Stone et al., 2004). However, as Hall (2003) points out, it is not always feasible to distil different professional codes of practice into a single 'pan-professional' code. Furthermore, the shift towards more flexible working and crossovers in practice also create the potential for a relativist attitude in which ethics are reduced to what is perceived as useful in a given context or decision.

These issues suggest that interprofessionalism is not something that can be taken for granted in situations when collaboration is required. Instead, the requisite skill-sets and mind-sets must be incorporated into the training and socialisation of professionals if they are to become part of their everyday practice. In their scoping review, Reeves et al. (2011) note the conceptual (and terminological) ambiguity between interprofessional education (IPE) and interprofessional collaboration (IPC). As Zwarenstein et al. (1999: 418) point out, the rationale for IPE (and IPC)

assumes a 'causal chain' between better teaching methods, more effective collaboration in practice, higher quality care and ultimately improved outcomes for service users. The increasing prominence of IPE for developing teamwork in medical settings has led to several systematic reviews of available studies, with somewhat inconclusive results (Hammick et al., 2007, Reeves et al., 2009, Clifton et al., 2007). As with the research on integrated services, benefits in terms of process outcomes for participants have often been easier to establish than eventual improvements in service delivery or efficacy of care (Freeth et al., 2002).

Recent years have also seen renewed efforts to create a coherent theoretical basis for interprofessional education and practice. Barr (2012) summarises some of the main perspectives that have been used to understand IPE, many of which have been developed via studies of practitioners at work as well as in educational settings. Such theories also lend themselves to the type of collaboration examined in this study, which is about how complexity is experienced and constructed by the interprofessional networks in child protection cases. Drawing on Barr's analysis, a distinction can therefore be made between theories about the various *processes* that might shape interprofessional working, and theories about the *context* in which interprofessional working takes place. Examples of the former might include theories of reflective practice (Schön, 1991), communities of practice (Wenger, 1998), intergroup contact (Allport, 1954), social identity (Brown, 1984), and psychodynamic theory (Woodhouse and Pengelly, 1991). Examples of the latter include the sociology of the professions (see above), general systems theory (Loxley, 1997), complex systems theory (of which more later), activity theory (Engeström, 1999b), and organisational theory (Argyris, 1992). Some of these perspectives have already been discussed, while others will be explored in what follows.

2.3.3 Processes of interprofessional working

Interprofessional working highlights the nature of relationships between collaborating practitioners – what Hudson (2002) calls 'interprofessionality'. Dynamics of conflict, consensus and negotiation have been much discussed in the literature, informing debates about roles, responsibilities, status, knowledge, information sharing, learning strategies and communication (Anning et al., 2006, Leathard, 1994, 2003a, Wenger, 1998, Engeström, 1999a, 2001, Hudson, 2002, Rushmer and Pallis, 2002, Challis et al., 1988). These studies show that professional socialisation, through its formative influence on the construction of personal and group identity,

can sometimes make it difficult for people from different professional backgrounds to collaborate. This could be attributed to mutual stereotyping, perceived changes in status, 'tribal' instincts, reluctance to do generic rather than specialist work, or ambivalence about developing a new professional identity. Interprofessional working is clearly a difficult arena in which individual and group psychology and the dynamics of personal interaction combine uneasily with managerial efforts to define roles, boundaries, competencies and task allocations within multidisciplinary teams and networks (Rawson, 1994).

Collaboration is often presented as a learning process, in which practitioners must embark on a transitional journey to new forms of identity and reflective action. As Barr (2012: 2) notes, the implication of social identity theory is that we derive our sense of self through belonging to social groups, and so are inclined to evaluate members of the 'in-group' more positively than those outside the group (Brown, 1984). Some IPE programmes have therefore drawn on intergroup contact theory in order to generate the right conditions for practitioners to learn about and from each other in 'simulated' practice settings (Mohaupt et al., 2012). Such conditions have been said to include equality between the different groups involved, shared goals, a cooperative rather than hierarchical approach, positive expectations, appreciation of differences as well as similarities, and a perception that other practitioners are 'typical' rather than 'exceptional' of their group (Mohaupt et al., 2012: 2). Indeed, some of these conditions are reproduced in the findings on 'facilitators' of interprofessional working in integrated services (see Section 2.2.7). However, evaluations of the 'contact hypothesis' (Carpenter, 1996) have had mixed results, and have been largely limited to educational interventions (Barr, 2012).

For Wenger (1998), new professional identities are actively constructed by practitioners collectively participating in what he calls 'communities of practice', through a cumulative process of shared interaction, experience and representation. Inevitably this is a process that generates conflict and, as Engestrom (1999a, 2001) emphasises in his theory of 'expansive learning cycles', disagreements and contradictions must be dealt with openly if they are to be superseded or synthesised into new ways of working. Some research sounds a cautionary note about how apparent consensus in interprofessional networks can in fact conceal underlying anxieties about status or accountability (Skjorshammer, 2001, Stevenson, 1994). The impact of stress and anxiety on practitioners is a significant factor in itself and can operate institutionally or in particular cases (Morrison, 1996, Reder and Duncan, 2003). Several studies have used a psychodynamic

perspective to explore how defensive coping mechanisms, originating in the organisation or client network and feeding into the interaction between individual practitioners, can problematise interprofessional working (Conway, 2009, Menzies Lyth, 1988, Woodhouse and Pengelly, 1991, Granville and Langton, 2002). On the other hand, studies of group processes (Wheelan, 1994) have also shown that while some conflict may be inevitable at certain stages in a group's development, communication and task-allocation can eventually orient itself towards collective decision-making and problem-solving. The issue of group dynamics will be returned to later in this chapter (Section 2.5.5).

As practitioners come together to work on complex cases, they will be facing problems that eclipse the expertise and remit of single-agency interventions. It has been argued that professionals need to work in a 'reflective' way for dealing with complex situations, which by definition do not lend themselves to a routinised or technical response (Schön, 1991, Pietroni, 1992). Reflective practice can mean different things, of course, depending on whether the focus is on professional action and its effectiveness, issues of power and emancipation, or on the experiential and emotional dimension of practice (Ruch, 2007, D'Cruz et al., 2007). Canavan et al. (2009) draw on this literature to argue for the importance of reflective practice for integrated working in children's services. In doing so, they point out the difference between a 'blueprint-focused' approach to evidence-based practice, often embraced by planners and policymakers, and a 'practitioner-focused' approach that emerges organically when practitioners apply their experience and knowledge to individual contexts. Taken to an extreme, the former could result in an overly rigid and prescriptive form of practice, while the latter might lead to overly subjective assessments and interventions. Instead, Canavan et al. advocate a pluralistic use of reflective practice, along the lines proposed by Ruch (2007), to enable practitioners and their agencies to achieve a balance between these extremes.

2.3.4 Context of interprofessional working

The context of interprofessional working can be taken to mean the different systems in which the activity of families, teams and networks in individual cases takes place (Barr, 2012). One common way of conceptualising such relationships is as part of an ecological system of care (Bronfenbrenner, 1979), as observed earlier in relation to children's trusts (Section 2.2.5). Alternatively, Pincus and Minhan (1973) discuss various 'helping systems' in relation to social

work, distinguishing between the 'change agent system', meaning professionals and their agencies, and the 'client system', meaning the people, families and communities involved in working with the change agent system¹. Looked at from a broader perspective, the context might be said to include the system of the professions (Abbott, 1988) and the shift to interprofessionalism that was discussed earlier.

The organisational context of professional work is also important. Many of the practitioners involved in child protection cases work within large organisations such as local authorities and the NHS. Not only does this mean that much of their activity is circumscribed and monitored by managerial bureaucracies, it also means that the conditions for *interprofessional* collaboration are often determined by *interagency* protocols and agreements (Hudson, 2002). Organisational theory is therefore relevant for considering the underlying rationale for collaboration from the perspective of service providers (Rogers and Whetton, 1982, Hanf and Sharpf, 1978). From an exchange perspective (Levine and White, 1961, Cook, 1977), collaboration can be seen as a rational, voluntary act based on the negotiation of 'domain consensus' and the achievement of respective goals and objectives. Alternatively, a power and dependency perspective would see organisations as open systems that seek to reduce uncertainty in a complex environment and establish control over scarce resources (Aldrich, 1972, 1976). Other approaches might be concerned with the important role of legal frameworks and especially the state in mandating particular forms of collaboration (Hall et al., 1977), or with analysing collaboration between organisations in terms of political economy (Benson, 1975).

The policy context is clearly important for children's services, which have to comply with legislation and implement government guidelines around partnership and collaboration. On the other hand, it has been observed that local partnerships may be driven as much by interpersonal relationships as by statutorily ordained structures (Hallett and Birchall, 1995). Such observations link into a related body of research on policy networks (Klijn, 1996, Rhodes, 1990) and implementation (Schofield, 2001, Puelzl and Treib, 2007). A networks approach would focus on the strategies and interaction patterns of the actors involved in a policy process, acknowledging that these dynamics can have unpredictable consequences. Similar questions arise in the literature

¹ Pincus and Minhan (1973) also distinguish between the 'target system', people whose behaviour is directly targeted by the change agent system, and the 'action system', which may include those whose help is enlisted, e.g. extended family or friends. They also note that these may or may not be equivalent to the 'client system' in a specific case.

on implementation, in which the classic 'top-down' approach is to formulate clear policy objectives and identify how and whether outcomes are achieved (Pressman and Wildavsky, 1973, Sabatier and Mazmanian, 1980). Alternatively, 'bottom-up' approaches have emphasised the importance of frontline practitioners, or 'street-level bureaucrats' (Lipsky, 1980), in how policies actually get implemented (Hjern, 1982, Thompson, 1982). Efforts have been made to synthesise the two perspectives into hybrid theories, often linked to the concept of policy networks, in which central directives are influential but subject to processes of negotiation and adaptation as they emerge as distinct practices on a semi-autonomous periphery (Sabatier, 1986, Goggin et al., 1990).

Another approach has been to explore and classify the degree to which professionals and their agencies work together in practice. Armitage's (1983) 'taxonomy of collaboration' is one example, describing the transitional stages from lesser to greater degrees of collaboration, which has been utilised and adapted in various studies (e.g. Gregson et al., 1992, Hallett and Birchall, 1995, Bond et al., 1987, Farmakopoulou, 2002). In such typologies, agencies range from operating in isolation to embarking on a full organisational merger (Frost, 2005), while professionals range from barely communicating or encountering each other to working together in multi-disciplinary settings (Ovretveit, 1996). A different schema is presented by Webb (1991), who draws a distinction between 'routinised coordination', emphasising procedural cooperation, and 'radical coordination', which is more innovative and far-reaching but presents a 'disturbance of the existing order' (Webb, 1991: 231). Robinson et al. (2008) performed a meta-analysis that grouped models of integrated working under four main dimensions: the extent of integration, integration of structures, integration of processes, and the reach of integration. Each dimension was associated with different challenges, enablers and impacts, with overarching themes that largely coincide with the findings of other reviews (Brown and White, 2006, Sloper, 2004). Leathard (2003c) distinguishes between models dealing with professionals working together and organisations working together, with integration representing a kind of 'culmination' of both.

Other studies have drawn on the concept of teamwork to explore how boundaries of expertise and knowledge intersect with team attributes such as roles, competencies, decision-making, management structures and personality types (Rawson, 1994, Rushmer and Pallis, 2002, Ovretveit, 1996, Payne, 2000, Engels, 1994). Of course, the question remains as to how to designate the activity of groups of practitioners who work together across organisational and disciplinary boundaries, with separate lines of supervision and management. Do such groups constitute a

team, a network, or some other descriptive category? As noted previously, such arrangements are often the case for the practitioners constituting the 'team around the child' in children's services, and especially the core groups who implement child protection plans. Stevenson (1994) adduces Hallett and Stevenson's (1980) findings to suggest that there are often 'inner' and 'outer' circles of practitioners in such groups, associated with very different levels of contact and involvement. Again this may lead us to be wary of labelling all such collaboration as 'teamwork', even when the group is labelled as a team (see Section 2.2.6).

2.3.5 Summary

In summary, this section has examined the concept of interprofessional working (IPW) from a number of perspectives. Many sociologists have been sceptical of the claims made by and for the professions, drawing attention to the power struggles between occupational groups as they attempt to establish control over particular areas of knowledge and expertise. According to this analysis, there is always tension between a view of the professions as self-interested, competitive and powerful, or as impartial, ethical and helpful. In some ways, the shift towards interprofessionalism could be seen either as mitigating or accentuating this tension, depending on whether the conditions and incentives for working together are met. In the most optimistic view, the ethical imperative of person-centred practice should be enough to spur collaboration between agencies and practitioners alike. A more pragmatic stance would be that effective IPW means changing not only the way professionals are educated and trained, but also the organisational context in which they undertake their work. The emphasis on integrating children's services has therefore spurred interest in the structures and processes through which practitioners are brought together in cases of complex need. Following the reforms in the 2004 Children Act and its associated guidance, a plethora of research studies were undertaken in order to evaluate and improve the new collaborative arrangements. Such studies have endeavoured to find out what factors promote and hinder IPW, and where possible to link process issues to successful outcomes for children and families. Such approaches have often taken their cue from educational and psychological theories, which help us to understand how practitioners learn and develop their expertise, and how groups orient themselves towards decision-making and problem-solving.

A number of key themes emerged from the discussion, which will be taken forward into the next section. Firstly, there is the ambiguity and tension between functionalist and conflict-oriented

perspectives. The former would see professionals and their agencies as playing their part in ensuring that the overall system (i.e. the safeguarding system) fulfils its overall purpose of protecting children and promoting their welfare. The latter would see the divisions between professionals as part of a broader context of power struggles and inequalities between different social groups, e.g. professionals and service users, front-line practitioners and managers, medical and non-medical staff, and so on. Models of collaboration tend to assume that such conflicts are reconcilable given the necessary conditions, invoking the ethical basis for working together (e.g. person-centred care) as a way of negating the existence of inequalities (e.g. of remuneration and status). Another question is whether models of collaboration should assume interprofessional relationships to be shaped primarily by interagency processes and structures (a broadly functionalist view), or as the product of local contingencies and events. A crucial issue is how collaboration in a general sense, as configured by the 'system', intersects with the collaborative practice that emerges from, or is demanded by, the complex case.

2.4 Complexity and the 'complex case' in child protection

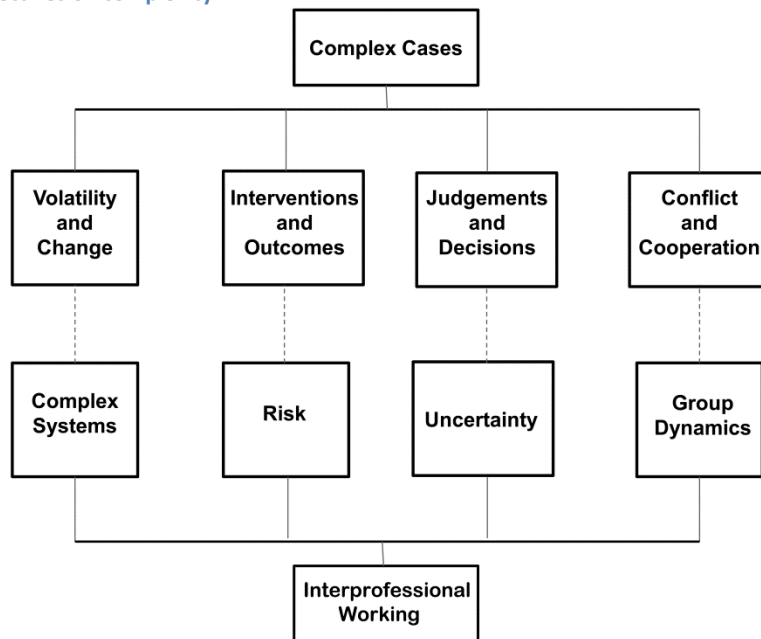
The previous two sections examined how services have tried to adopt a collaborative response to the complex problems experienced by vulnerable children and families. Government policies have encouraged a tiered system of intervention, based on a spectrum or pyramid of need, with a host of specialist services attaching themselves to the more complex end, or 'tip' of the pyramid. However, interprofessional working comes with its own complexity, raising issues of coordination, communication and conflict. Models of collaboration have therefore sought to address both forms of complexity, trying to get practitioners and agencies to work together effectively so that they might better address the needs of children and families. On this basis, it is proposed in what follows to take a closer look at complexity as a phenomenon in its own right, rather than just as a convenient metaphor of difficulty. This has its precedents in the literature, particularly in the field of child protection, where there has been increasing interest in the implications of complex systems behaviour (Fish et al., 2009, Stevens and Cox, 2008b). Some of the language associated with complexity theory can convey an impression that complexity means a set of rather impersonal forces whose 'dynamics' govern cause and effect. Yet complexity in the context of child welfare is hardly impersonal, it is something that is experienced, perceived, interpreted and communicated. In complex social systems, interactions between system entities are the relationships between people. This section will therefore provide an overview of the literature on

complexity, as it pertains to the experience of practitioners working directly with children and families.

2.4.1 Perspectives on complexity

So what is complexity? The following review will look at four interrelated areas: complex systems, risk, uncertainty and group dynamics. These not only provide an outline of complexity in terms of what ‘complex cases’ might mean for practitioners and services, but also allow us to explore some of the theoretical ideas which underpin those meanings. The starting point is complexity theory – a set of theories about behaviour in complex systems. Complexity theory can tell us about the dynamics of cause and effect in cases where multiple factors are at play, and which practitioners may experience as volatile and unpredictable. Second, complexity in the causal sense is often bound up with perceptions of risk, and strategies to manage risk in the face of uncertain (and potentially adverse) outcomes. Third, the nature of the professional task – which to some extent involves controlling and predicting outcomes – puts a premium on making judgements in conditions of uncertainty. Finally, as in any social system, it is human relationships and interactions that drive the dynamics governing complexity, so that patterns of conflict and cooperation in the group can play a vital role. These ideas are summarised in Figure 2e below, which shows how interprofessional working comprises a response to the different challenges presented by complex cases:

Figure 2e. Perspectives on complexity



2.4.2 Complex systems

Professional services can be seen as complex (social) systems operating within other complex systems (Byrne, 1998). Among other things, this has implications for causality: events and relationships unfold in unpredictable ways and actions can have unintended consequences (Haynes, 2003). These insights stem originally from complexity theory, which derives from mathematical models used in the natural sciences to explore the basic principles underlying the behaviour of such systems (Reed and Harvey, 1992, Prigogine, 1996, Coveney and Highfield, 1995). The best known principle is 'non-linear dynamics', which basically means that there is no regular relationship between cause and effect; instead, events are generated semi-chaotically by a constant flux of interactions and feedback (Cilliers, 1998). Because these systems are open, they are also sensitive to influences from outside the system itself. Therefore, unlike 'classical', closed systems, complex systems do not settle into an equilibrium determined by a finite set of rules; instead they continually adapt and evolve, organising themselves into a state of critical imbalance before shifting suddenly to new patterns of behaviour. Theories of complexity are discussed further in Chapter 3.

These insights allow us to explore the significance of the 'complex needs' and 'multiple problems', which are typically targeted by multiprofessional service provision. From an organisational point of view, complex needs are simply indicative of a 'higher level' of vulnerability, characterised by problems that overlap organisational and disciplinary boundaries, and which should be addressed by coordinating expertise from a number of agencies and professions. What complexity theory adds to this picture is a view of the difficulties this type of case can present in relation to causality, prediction and change. After all, services are not only in the business of assessing what is going on in a system, they are also expected to change things for the better, or at the very least stop things getting worse. Yet as Hallett and Birchall (1995: 257) observe, the 'pace of change in turbulent families' can disrupt care planning and collaboration. Volatility itself can be a cause for concern, since in some cases it may erupt into violence (Brandon, 2009). What seems a pressing issue one day may pale into insignificance the next; assessments and care plans quickly become out of date as new information comes to light and circumstances change. Initial hypotheses and assessments might turn out to be incorrect, something that can be difficult for practitioners to recognise (Munro, 1999).

Complexity principles have been used to inform systemic approaches to accident analysis, developed initially in the field of engineering (Rasmussen, 1997, Reason, 1997), and applied in recent years to serious case reviews (Fish et al., 2009). Unfortunately, the explanatory power of complexity theory appears to be more useful in hindsight than in foresight. For frontline practitioners, the implications of complex causality are doubly disconcerting, highlighting both the difficulty of achieving positive outcomes, as well as the risk of negative outcomes ‘emerging’ unpredictably out of a critical situation (Stevens and Hassett, 2007). For this reason, although Thelen and Smith (1994) have optimistically mooted the possibility of testing for such critical states, Nybell (2001) considers that dwelling too much on complex causality might have a paralysing effect on interprofessional networks. Moreover, the difficulties of managing and achieving change in complex systems lead to an understandable preoccupation with risk.

2.4.3 Risk and risk management

Complexity is often seen as a kind of warning sign about ‘acute need’, a combination of problems that may herald risks to a child’s welfare or safety (DfES, 2006). Of course, one difficulty of assigning an overall level of severity to a case consisting of multiple problems is that not all of the latter may be acute - it is the interrelationship between them that makes the case complex. Whether risk is considered in terms of immediate threats to a child’s safety, or as longer-term influences on a child’s development or later life chances, ‘negative outcomes are the end-product of the complex relationship between a large number of inter-related factors’ (Hansen and Plewis, 2004, cited in Spratt, 2009: 440). In that sense, the idea of tiered intervention matching an overall category of need may be misplaced. Nonetheless, concerns about abuse and neglect understandably receive the highest priority in children’s services, represented by cases of what Every Child Matters calls ‘children at high risk’ (DfES, 2003).

The concern that families with complex needs may be a locus of risks to children obviously puts great pressure on assessment and decision-making. For practitioners, assessing risk has become part of the normal landscape of practice. Risk assessments vary between ‘qualitative, open-ended information’, assembled for analysis as part of a case-planning tool, and ‘discrete and objective data’ presented in the form of a checklist of risk factors (Murphy-Berman, 1994: 193). The preoccupation with managing risk has been seen by some as emblematic of a wider reframing of professional work as a rational-technical activity. Crawford (2004) has analysed ‘risk rituals’ in

medicine as part of a discourse of predictability and manageability, which in fact only serves to generate new forms of uncertainty in 'an escalating spiral of control and anxiety' (2004: 506). This has long been a theme in the field of child protection work (Munro, 2009), and has also been observed in other politically sensitive areas such as adult mental health (Holloway, 2004, Petch, 2001). When it comes to safeguarding practice, efforts to reduce risk through ever-more stringent procedures have played a part in increased professional and public anxiety about deaths from child abuse (Ayre and Preston-Shoot, 2010). In this sense, risk can be seen as a cultural phenomenon (Zinn, 2008), which does have a bearing on what happens in complex cases because of its potentially distorting effect on professional and organisational behaviour.

2.4.4 Uncertainty and professional judgement

Complexity for professionals also means having to deal with uncertainty. Complex, or 'wicked' problems are those in which it is hard to say definitively what is going on and what the right response should be (Rittel and Webber, 1973). In that sense, cases labelled as 'high risk' may not be perceived to be as complex as others lower down on the spectrum of need, provided there is a reasonable degree of certainty about the issues and the appropriate response. Conversely it may be uncertainty, and the accompanying lack of consensus, that stops cases being perceived as high-risk and action being taken, particularly when concerns are accumulating over a period of time and subject to constant reassessment or 'start-again syndrome' when new workers are appointed (Brandon, 2009, Thoburn and Brandon, 2008). Yet abuse is often difficult to determine, and definitions change over time as they are constructed by society in relation to what is considered normal or acceptable (Dingwall et al., 1983). At the same time, the higher the level of uncertainty, the more weight is placed on professional analysis and judgement (White, 2009b). Indeed, professional expertise is valued precisely because experienced practitioners can adapt and draw on different kinds of knowledge in order to act decisively in complex situations (Fook et al., 2000).

The lessons from accident analysis are that mechanistic and procedural responses to complex problems are often counterproductive, since they erode the ability to respond to unanticipated situations (Rasmussen, 1997, Reason, 1997). Professionals can use the best evidence available to them to inform their judgement, but will not be able to base their decisions entirely on guidelines. What Higgs and Jones (2008) call 'clinical reasoning' is a social as well as cognitive process, an amalgam of various professional skills: 'autonomy, responsibility, accountability and decision-

making in conditions of uncertainty' (2008: 4). As the degree of uncertainty rises, there may be a greater need for discussion and reflection, as opposed to an instant or routine response, but the degree of deliberation will also depend on other factors such as time pressure or individual expertise (Eraut, 2007). Nor is it possible to eliminate uncertainty, however much knowledge or skills are available to practitioners. According to Beresford (1991), professional judgement aims for a kind of 'practical certainty', which leaves room for error but also for 'choice and action' (1991: 10). Professionals will also have to develop what Eraut (2007) calls 'meta-cognition', the ability to evaluate one's own actions from an ethical, theoretical and experiential perspective, to manage emotions and engage constructively with others under stressful circumstances.

2.4.5 Group dynamics

In the present context, group dynamics could be regarded as the 'human face' of complexity. Complex cases often involve relationships which practitioners experience as stressful and demanding, and which disrupt collaboration within the interprofessional network (Packman and Randall, 1989). There is the emotional toll of dealing with distressed children and families, as well as the practice dilemmas that can ensue, for example, from balancing responsibilities for care and control, or respecting the needs of vulnerable parents while staying focused on what matters for their children. Anxiety stemming from the pressures on practitioners can have a distorting effect on decisions and behaviour (Reder and Duncan, 2003). Interprofessional conflicts are one possible manifestation (Conway, 2009, Woodhouse and Pengelly, 1991). Another is the way that protocols and procedures stipulating a 'correct' way to deal with a case assume the rather perverse function of insulating practitioners and their agencies from 'institutional risk' (Rothstein, 2006). Defensive practice may be one result of the way that complexity is experienced by practitioners and then managed in a multi-agency context.

Any group, however constituted and for whatever purpose, will be subject to unpredictable dynamics, shaped by the interaction of diverse personal and contextual factors. Arguably this is the sphere of complexity theory, but it is unclear how such a theory can account for human agency and cognition. After all, members of a team are aware of their own behaviour and hopefully are motivated to focus on shared objectives. This is where there is a potential congruence between functional models of group development (Wheeler, 1994) and models of integration (Robinson et al., 2008). Both assume that some conflict is inevitable, especially in the initial stages of

collaborative activity, but suggest that it can be constructive given the right combination of organisational and professional input. Against this one could argue that groups of practitioners often form in ad-hoc ways around specific pieces of work (Engeström, 2008), which are urgent in nature; such groups may not have the luxury of going through developmental phases. In addition, while most functional models focus on how groups come to make decisions and solve problems, professionals must also collaborate on questions of fact, conjecture and value, which are more difficult to address in a functional way (Gouran, 2003, cited in Griffin, 2009: 232). What this suggests is that the socio-emotional dimension of collaboration can neither be overlooked nor reduced to a set of 'obstacles' (e.g. rivalry, tribalism) to be resolved by integrated structures and processes. Instead, the challenge is to equip practitioners to recognise and deal with group dynamics in whatever form they assume in each individual case.

2.4.6 Summary

This section has looked at various aspects of complexity faced by professional networks that deal with complex cases in children's services, such as the core groups who implement child protection plans. As a starting point, complexity theory offers a conceptual framework to describe processes of change in complex open systems; for example, internal feedback or externalities can give rise to unintended consequences, while outcomes may emerge suddenly from a critical state of transition, rather than conforming to stable, predictable patterns of cause and effect. However, one of the lessons of complexity is that such patterns are usually evident only with the benefit of hindsight. Professionals therefore have to grapple with an unavoidable degree of uncertainty in making their decisions and manage the risk of adverse outcomes. Furthermore, the dynamics of complex social systems are shaped by the relationships and interactions between people, so that the behaviour and social psychology of groups has a bearing on system behaviour.

An emerging theme in the analysis was how the desire to reduce and master complexity intersects with the dilemmas and ambiguities that are thrown up by complex casework. This can be reframed as a tension between two different concepts of system. On the one hand there is the expert system, with its penchant for stability, predictability and control; on the other hand, we have the complex system: volatile, self-organising and inherently unstable. Referring back to the discussion of integrated children's services, it could be argued that the model of the children's trust illustrated in Figure 2a (DCSF, 2010a: 8), is an example of the expert system. It deals with

complexity by representing systems as nested layers within an ecological system of care, whose interactions serve to direct the system's activity towards what happens at the centre. One question this raises is whether current models of collaboration, which are designed to be generalisable enough to guide policy and practice, have ended up assuming this sort of system (the stable and controllable expert system) while frontline practitioners have been dealing with another sort (the unstable and adaptive complex system). This inconsistency has then fed through into specific areas such as risk assessment in child protection, where a raft of guidelines to ensure best practice have struggled to improve either the standard of safeguarding or the ability to predict outcomes in cases where complexity is an issue.

2.5 Conclusion

This chapter has reviewed the political and theoretical background to complexity and interprofessional working in children's services. Collaboration has been posited as a response to complexity, in that services have sought to overcome the fragmentation of professional specialisms in order to tackle 'joined-up' social problems. Governments have also been keen to modernise public services in order to increase accountability and improve efficiency, which has increasingly brought professional work under statutory and managerial control. Models of integrated children's services have largely adopted a functionalist approach to collaboration, typified by the institutional structures and processes of the children's trust. However, other perspectives on interprofessional working have emphasised the potential for conflict and the extent to which collaborative activity is shaped by organisational and institutional contexts, and by the exigencies of the complex case. In the field of child protection, a 'team around the child' (TAC) is assembled via referrals from universal to specialist agencies, although these teams, or 'core groups', are more akin to coordinated networks than formal teams under unitary management.

It has been argued that a discrepancy exists between the complex situations encountered in practice and the assumptions underlying the expert systems designed to deal with them. There appears to be a rather technocratic culture in children's services, based on the view that complex systems can be managed by (and therefore transformed into) expert systems. The 'new managerialism' of welfare (Clarke et al., 2000a) envisages a cumulative cycle of improvement in which guidelines for best practice, incorporating the empirical evidence produced by research, are implemented in organisations by managers focused on compliance via inspection reports and

performance indicators. In this model, evidence of 'what works' can be fed back into the managerial loop via internal feedback or on a larger scale through 'scientific' evaluations of particular programmes and service models. Yet in order to build 'double-loop' learning into the organisations that deliver services (Argyris, 1999), there needs to be greater understanding of what is experienced by practitioners in the type of complex case that demands collaboration. It is by way of advancing the theoretical and empirical understanding of this complexity that the thesis presented here will seek to contribute to the literature.

3. Theoretical framework

3.1 Introduction

This chapter will set out a theoretical framework for complexity, in the context of interprofessional working in children's services. In the previous chapter, it was argued that collaboration becomes necessary in order to deal with complex problems that defeat the expertise and knowledge of individual agencies and professionals. At the same time, collaboration can be undermined by complexity arising from characteristics of the team or network itself. Studies have pointed to a range of factors which enable and impede interprofessional working. This knowledge has led policymakers to try and design expert systems that can secure positive outcomes in 'complex cases', and on a broader scale address a range of 'joined-up' social problems. An example of this approach is the 'children's trust' (see Chapter 2, section 2.2.6), in which successive layers of multi-agency arrangements are envisaged as a quasi-ecological system of care, with 'better outcomes for children' at the centre (DCSF, 2010: 8). For many frontline workers, the result has been a shift away from individual casework and towards case management and systemic practice. As such, complexity has become an increasingly important concept, and there has been some interest in using theories of complex systems to guide interprofessional education and practice. However, it is debatable whether complexity theory on its own encapsulates the unpredictability of human affairs, the uncertainty of our judgements and the dynamics of social interaction (see Chapter 2, section 2.4). This chapter will aim to formalise this argument, re-examining the principles of complexity from a critical realist perspective and exploring the application of such a framework for interprofessional working.

3.2 Theories of complexity

3.2.1 Complexity theory

Complexity theory seeks to explain the behaviour of complex systems. Its origins are in chaos theory, which developed in the natural sciences, particularly in the fields of mathematics and computational biology (Coveney and Highfield, 1995). Chaos theory is most often associated with

a feature of certain mathematical equations called 'sensitivity to initial conditions' in which very small changes in the starting value of variables can produce disproportionately large differences in the eventual outcome (Waldrop, 1994). However, complex systems are not chaotic. They are composed of a large number of interconnecting parts, which between them generate a constant flux of interactions and feedback that generates instability (Cilliers, 1998). Unlike 'classical' systems, complex systems do not settle into equilibrium (Warren et al., 1998), but continually adapt and evolve, organising themselves into a state of critical imbalance that is 'far from equilibrium' (Cilliers, 1998: 4). Complexity is therefore a distinct concept, which has also been described as 'metatheory' (Stewart, 2001: 330) and a 'scientific amalgam' (Thrift, 1999), because it has evolved in a range of academic disciplines to describe the general properties of different types of complex system. Some of these properties are described below.

3.2.2 Key features of complex systems

Complexity theory can therefore be understood as a conceptual framework for the behaviour of complex systems. Its main features are summarised here under four headings: non-linearity, emergence and dissipation, self-organisation and attractors:

3.2.2.1 Non-linearity

Elliot and Kiel (1997: 66) define non-linear behaviour as 'feedback in which internal or external changes to a system produce amplifying effects'. Non-linearity implies that change in complex systems occurs unpredictably as a result of the interaction of many interconnected elements, including other systems. Events cannot be manipulated by changing a given number of known variables in order to produce a particular outcome, as would be the case in a closed system. In contrast to 'classical' systems, which are assumed to gravitate towards a state of equilibrium, complex systems are in a constantly dynamic state, driven both by external contingencies as well as internal feedback. This lack of predictability does not mean that we cannot explain the behaviour of complex systems, but the task is to understand the 'constellation of structured choice and accident' (Reed and Harvey, 1992: 364).

3.2.2.2 Emergence and dissipation

The non-linearity of complex systems means that patterns of behaviour often emerge unexpectedly from the multiple interactions of its constituent units, or from the knock-on effects of inputs from outside the system (Mihata, 1997). Emergence refers primarily to new structures or patterns of events within the system as a whole, arising from the dynamics between elements on a localised level. The interlinked nature of open systems means that changes in one can have unexpected side effects in another (Klein, 2004). Open complex systems have also been termed 'dissipative systems', because the evolution of new structures and patterns signals the system's success in countering the dissipation of the energy needed for self-organisation (Harvey, 2009).

3.2.2.3 Self-organisation

Awareness in complex systems is said to be local, in that no single element of the system is able to control or predict consequences for the system as a whole. Change comes from an array of contingent factors operating through a myriad of relationships and interactions. A complex system is therefore said to be 'autopoietic', or self-organised (Prigogine and Stengers, 1984), in that it adapts to its environment in ways that make new structures evolve spontaneously. Social groups can also be regarded as self-organising in the sense that people's relationships with each other transform single events or actions into effects that multiply out through the rest of the group, though often not in the way that is anticipated (Haynes, 2007).

3.2.2.4 Attractors

The concept of attractors refers to the possibilities and limitations of trying to predict what happens in complex systems. Such systems exist in a state between deterministic order and chaotic disorder, or what has been termed 'self-organized criticality' (Mackenzie, 2005: 46). The way in which their structures emerge and dissipate loosely obeys a 'rule' of complexity, in that the interactions of the system, as it adapts to changes in the environment, create a movement towards a moment, or period, of heightened instability and tension. Here various possibilities of change present themselves, points of 'bifurcation' at which the system will organise itself into a more stable configuration. While this new configuration cannot be predicted exactly, it has been theorised that there are limits, or 'boundaries of instability', to the behaviour that will emerge (Haynes, 2003). Attractors roughly demarcate the boundaries of possibility arising at the point of bifurcation, setting out the likely pattern of outcomes (Stevens and Cox, 2008a: 1236).

3.2.3 Complexity and social systems

The conceptual language of complexity theory has influenced the study of systems in the social sciences (Byrne, 1998, Kiel and Elliot, 1996, Stewart, 2001, Eve et al., 1997). However, applying complexity concepts to social systems raises a number of issues. It cannot be assumed that social systems simply replicate the behaviour of physical or biological systems, or that such behaviour can be observed and represented in the same ways (Carter and Sealey, 2009). One way in which social systems differ from systems in the natural world is in the role played by human subjectivity, intention and agency. There is a danger of reification, or 'treating humanly produced conventions, institutions and historically complex events as though they were natural objects governed by recurrent processes and universal laws' (Harvey and Reed, 1996: 314). Carter and Sealey (2009) draw on Archer's discussion of reflexivity, which not only refers to a passive act of deliberation but also an active one of constitution, definition and identification (Archer, 1995, Archer, 2007). Researching the social world involves a greater degree of reflexivity than the physical world, not just because of the onus on the interpretative activity of the researcher but also because of the capacity of social actors to shape the world around them. In other words, complexity in a social context has ontological as well as epistemological implications.

Interest in the 'emerging science' of complexity (Waldrop, 1994) has been linked to longstanding philosophical debates, such as the nature of social action, the relationship between social structure and human agency, and the competing claims of determinism and discretion (Harvey, 2009). Some have seen complexity theory as presenting a challenge to the positivist method of generating scientific knowledge (Waldrop, 1994, Prigogine, 1996, Coveney and Highfield, 1995), or even as heralding a paradigm change towards a new kind of 'postmodern' science (Cilliers, 1998). Against this, Eve (1997) points out that in the natural sciences the classical, or 'Newtonian' view of the world was dethroned long ago by the alternative perspectives of relativity and quantum theory (see also Barad, 2007). Complexity theory itself is also not without its critics. For example, Stewart (2001) criticises its use in models such as the one proposed by Harvey and Reed (1996) as perpetuating the assumption that society as a system, which he associates with functionalism. It can also be criticised for being descriptive rather than explanatory, lacking testable hypotheses that might help us to predict and control behaviour in complex systems.

Some social researchers have advocated the adoption of a 'complex realist' approach to the study of social phenomena (Byrne, 2009b). This perspective attempts to fuse complexity theory with the insights of 'critical realism', based on Bhaskar's early work (Bhaskar, 1978, 1979). This is the standpoint that will inform the theoretical framework for this study, for reasons that will be set out below.

3.3 A critical realist model of complexity

The previous sections have outlined some theoretical concepts in relation to complexity and the behaviour of complex systems. In what follows, these ideas will be incorporated into a model of complexity for interprofessional working in children's services. The term 'model' has been chosen deliberately in preference to 'theory', as it is not proposed here to advance a scientific theory in the sense of claiming predictive power, or of developing empirically testable hypotheses. The approach is instead similar to Harvey and Reed's description of a model as a heuristically useful framework of ideas, analogies and metaphors (1996: 309). In doing so, it is recognised that although complexity does challenge the idea of a deterministic, linear relationship between cause and effect, this does not mean that complexity is somehow 'anti-science' or 'anti-realist' and therefore equivalent to postmodernism (Price, 1997). Instead it could be argued that complexity exerts pressure on the 'unhappy dualisms' of method in the social sciences (Danermark et al., 2002: 2), in a similar way to the debate explored in the previous chapter between the technocratic assumptions of an 'expert system' and the situated complexity of professional practice (see also Chapter 6, Section 6.8). The methodological implications of this tension will be examined further in the next chapter. Here the emphasis will be on setting out a conceptual framework to guide the analysis and discussion in the chapters to come.

3.3.1 Bhaskar's critical realism and complexity

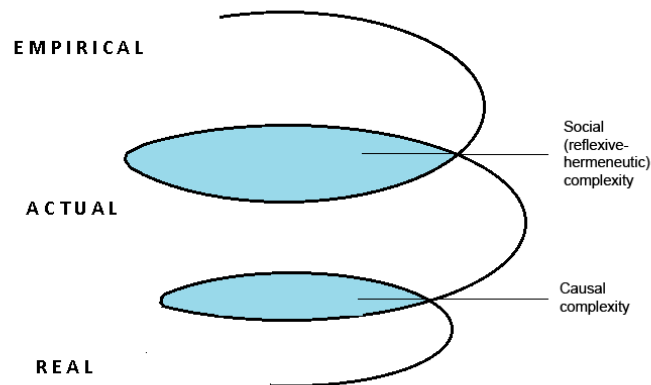
Critical realism is based on the work of the philosopher Roy Bhaskar (especially 1978, 1979). Bhaskar elaborates on the distinction between ontology (notions about the nature of what exists) and epistemology (the nature, conditions and limits of our knowledge). Critical realist ontology posits a reality that exists outside our perception of it, differentiated into three levels: the empirical, the actual and the real. The empirical consists of what we experience through our

senses; the actual comprises all events, regardless of whether they are observed or experienced; and finally the real, which contains the underlying causal mechanisms that generate events. These mechanisms may not be directly observable on the empirical level, but they are nonetheless real because they cause things to happen, e.g. natural forces such as electromagnetism. Importantly, cause and effect are transmitted through discretely structured but open systems; the interactions of one causal mechanism will influence the operation of others, so that the outcomes of any intervention are never entirely predictable: mechanisms produce only 'tendencies' that can be counteracted by others. For example, the causal force of gravity can be temporarily overridden by other mechanisms such as the aerodynamic tendencies of aeroplane wings (Collier, 1994).

In the social world, human agency greatly increases the complexity of interactions and the difficulty of formulating causal explanations. Understanding social phenomena involves a 'double hermeneutic' of interpreting other people's interpretations (Danermark et al., 2002). Unlike the objects of natural science, people can actively transform their own social world, just as their actions and perceptions are shaped by pre-existing social structures. Because our knowledge is conceptually mediated, critical realism rejects the idea that scientifically conducted observation and analysis can enable us to arrive at an objectively 'true' picture of reality. Critical realism accepts that facts and observations, scientific or not, are dependent on interpretation. However, this does not mean that facts are determined by theory; because there is always an 'intransitive' object of science that is independent of our 'transitive' scientific account of it, some theories have more explanatory power and practical validity than others.

Other critical realist ideas, such as stratification and emergence, are not so relevant to the present discussion, although they also provide some conceptual links to complexity theory (Harvey and Reed, 1996). Here, the link between critical realism and complexity is taken to be a mutual concern with the issue of causality in open systems, which is then supplemented by critical realism's methodological insights into how we understand and explain how the world works. The implications for complexity can be expressed as two, interlinked areas, as illustrated in Figure 3a, which derive from Bhaskar's three domains (2008: 13).

Figure 3a. Two views of complexity using Bhaskar's domains

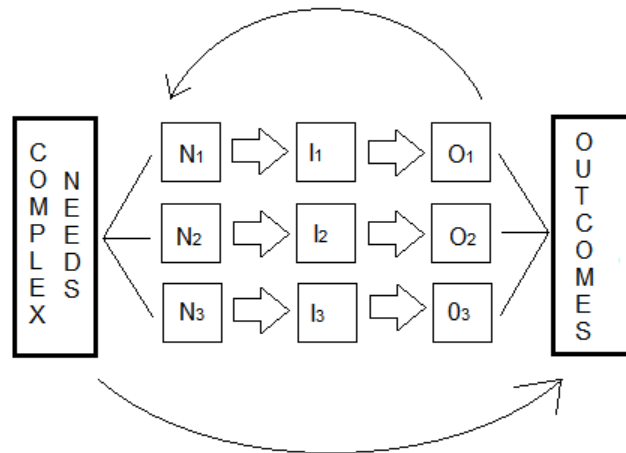


Complexity is conceptualised first at the intersection of the real and actual, where it relates to the operation of causal tendencies to generate effects in the world. This has been termed 'causal complexity'. Secondly, complexity occurs at the intersection of the actual and empirical, where a sub-section of actual events become concrete and meaningful to us, i.e. they are apprehended as empirical experiences and perceptions. This is a reflexive *and* hermeneutic activity – a social process mediated by language and our interactions with others, which has been termed 'social complexity'. In what follows, these ideas will be used as the basis for a model that can be applied to interprofessional working.

3.3.2 A critical realist view of complex needs

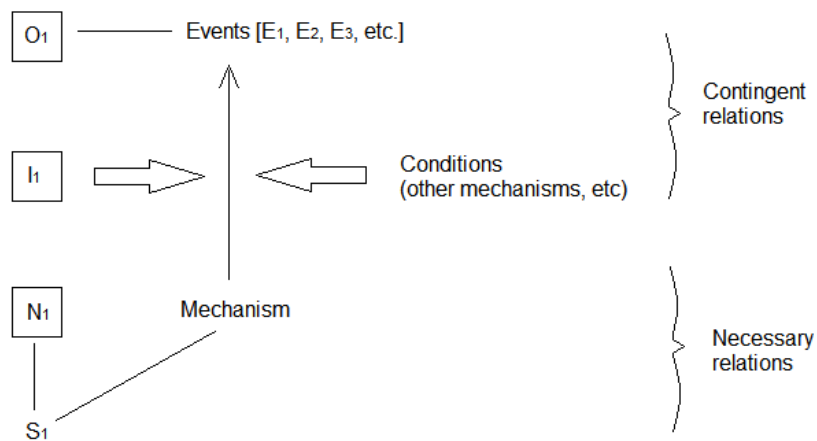
Going back to the initial premise that interprofessional working is a response to complexity in the shape of multiple and interrelated problems, Figure 3b (below) shows a 'simple realist' model of dealing with complex needs. They are disaggregated into separate needs (N1, N2, etc), which are then targeted by specific interventions (I1, I2, etc) delivered by the appropriate professionals with pre-defined outcomes in mind (O1, O2, etc). The results of each intervention are periodically reviewed and compared with the stipulated changes before being fed back into the overall planning and coordination of services, until eventually the desired outcomes have been achieved. On a larger scale, the model also shows how evidence can be accumulated about the effectiveness of interventions in achieving outcomes from initial presenting problems, especially if outcomes are measured in the form of quantitative indicators.

Figure 3b. A 'simple realist' disaggregation of complex needs



From a critical realist standpoint, there are a number of problems with this approach. By disaggregating complex needs into separate, profession-specific ones and treating these separately, causality is effectively treated as non-complex and linear. It assumes a series of closed systems in which individual needs are directly amenable to treatment by professional intervention. This is not to say that all interventions are assumed to be effective, but that cause and effect are assumed to be about regularity; if an intervention is observed to have the desired effect in one or more cases, there is a likelihood that it will work again in another case. In critical realist terms, this is a misrepresentation of how causality works. Social phenomena are the product of multiple, interacting tendencies at the underlying level of the 'real'. Their structural properties may well give them causal powers or 'liabilities' of their own, but these are not necessarily realised or even observed (Sayer, 2000). Thus an intervention such as counselling may well 'work' in the sense that its causal powers are invoked by someone attending regular counselling sessions, but other mechanisms will also be at work and may have a counteractive effect. In open systems, which social systems always are, any given object with its necessary (internal) relations of structure and mechanism will always be subject to contingent (external) relations with other phenomena, which have their own causal tendencies (Sayer, 2010; Danermark et al., 2002). Any given need, however disaggregated, will be complex in its own right. This is illustrated in Figure 3c, which is adapted from Sayer (2000: 15).

Figure 3c. Complex causality: necessary and contingent relations
(adapted from Sayer, 2000)

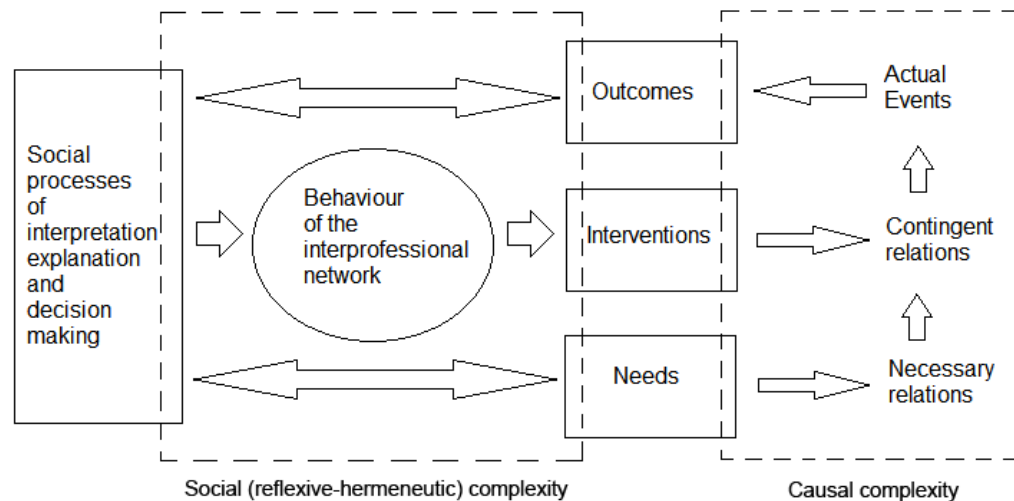


Here the ontological ‘depth’ offered by critical realism is used to show how events are generated from the interplay of causal tendencies, which are implicated in the necessary and contingent relations within and between different objects or entities in an open system. This contrasts with the ‘flat’ empirical approach offered by the simple realist model outlined earlier. Effective interventions might result from an informed conception of the structural properties (S₁) of a particular need (N₁) – possibly by aiming to counteract the causal mechanisms associated with that need. For example, it might be supposed that overcrowded housing conditions have a tendency to aggravate family disputes, and therefore a move to a bigger flat will help resolve a particular family’s problems in this regard. Another strategy might be to fund local community resources to keep the children occupied after school, hence counteracting the malign effect of overcrowding by engaging quarrelsome siblings in positive activities. However, whichever of these interventions is adopted (I₁) has only a contingent effect on what happens in the system. A wide range of other conditions exert an influence, including other needs and interventions, individual characteristics of the family and wider social structures, e.g. of poverty or deprivation. Furthermore, out of all the possible events that could and do take place (E₁, E₂, E₃ etc), only certain observations and experiences will be apprehended and recorded as the outcome for this particular intervention (O₁). It is in relation to these half-submerged processes of causal complexity that the interprofessional network conducts its business.

3.3.3 Complexity and interprofessional working

However, causal complexity is only half the problem. There are additional difficulties involved in acquiring and acting on knowledge about social phenomena. This process has been described as social or 'reflexive-hermeneutic' complexity, in an attempt to encapsulate the active way in which we make sense of our experience of the world, as filtered through our cognitive and conceptual schema, and through our relations with others. For professionals as for scientists, knowledge about the social world relies on a double hermeneutic of understanding; applying one's 'expertise' is as much a social as an individual process, shaped by a large number of factors, including what we have learned or are mandated to do, but also by our interactions with clients and other members of the interprofessional network. These considerations inform the model of complexity for interprofessional working illustrated below in Figure 3d. Referring back to the two types of complexity identified earlier, the model shows how causal complexity is responsible for change in the form of actual events on the right-hand side of the model, while reflexive-hermeneutic complexity shapes the behaviour of the interprofessional network in the centre, as it tries to understand and influence the nature of that change.

Figure 3d. Complexity and interprofessional working



Given the level of abstraction so far, it might be worth using a hypothetical case scenario to explain what the model is talking about. Consider the situation of an interprofessional network, or 'core group', involved with a young mother and her 18-month-old child, who is subject to a child protection plan. The main concerns are around the mother's inconsistent parenting as well as reports of domestic violence involving her (non-resident) partner. Causal complexity here relates both to immediate risks to the child as well as to longer-term developmental outcomes. While needs may be partly based on 'empirical' events (e.g. police being called to the property because of a violent dispute), they are also defined in relation to frameworks of interpretation. For example, there will be a medical diagnosis of the child's health, based on the GP's and health visitor's judgements as well as evidence-based templates, e.g. height and weight charts, developmental milestones. Other frameworks, such as theories of attachment, may be deployed in order to evaluate parental responsiveness and bonding. In addition, the mother's level of engagement with services, her acknowledgement of concerns and readiness to act on professional advice, may influence how needs (and therefore risks) are perceived. Decisions made on the basis of these judgements may lead to different kinds of intervention – for example, a residential parenting assessment, a 'written agreement' about who is allowed in the home, funding for a nursery placement, a referral for counselling or family support. Similar processes occur in relation to outcomes – for example if, after a few months, staff at the nursery report the child to be thriving, how much is this down to an improvement in parental care-giving? Outcomes may be interpreted as confirming or refuting hypotheses, or as signalling a type of change occurring in the system.

Complex causality points to the potential volatility of events, which is a key consideration for risk assessment. At the same time, an understanding of causal mechanisms is crucial if interventions are to have a longer-term influence on outcomes. Services may function well in terms of monitoring a child's welfare, but may not necessarily be targeting the underlying causes of need. In addition, once services are in place, the behaviour of the network is subject to unpredictable dynamics of its own. In complex cases such as the one outlined above, interprofessional networks usually perform complementary duties of care and control. This may be manifested as a 'split' in the way family members perceive and treat different professionals – typically with the social worker as an authority figure in contrast to others who are perceived as more benign and

supportive. How the network deals with these dynamics will vary on a case-by-case basis, but may be crucial for collective action and decision-making. Since everything the network does will feed into the contingent relations that help to generate outcomes, its behaviour should be viewed as a whole, and not as an agglomeration of 'separate' interventions.

3.4.4 Summary

Complexity theory provides a conceptual basis for understanding the behaviour of complex systems. These concepts derive from the natural sciences, but have increasingly been applied within the social sciences, in the process contributing to methodological and philosophical debates. When it comes to researching the social world, some of the limitations of complexity theory have been addressed through an engagement with the philosophical ideas of critical realism. Its relevance for investigating behaviour and events in social systems has led to the development of a 'complex realist' perspective for this study. A model of complexity based on Bhaskar's domains of reality has been presented, which focuses on the implications of open systems, complex causality and contingency. The model's role in this thesis is to provide a theoretical framework for exploring how professionals come together to respond to the complex needs of children and families.

3.4 Conclusion

In the previous chapter, it was shown that interprofessional working in children's services can be seen as a response to complexity. It was argued that current models of collaboration, such as the children's trust, seem to be associated with a rather technocratic approach to multiple, interacting problems (see Section 2.5). The alternative offered here is a complex realist standpoint, which explores the implications of causal and social complexity for interprofessional networks. The next chapter will draw on this framework to design an empirical study of what complexity means for practitioners working together on complex child protection cases.

4. Methodology

4.1 Introduction

This chapter describes the methodological approach adopted for this qualitative study. The aims of the study are set out by way of research questions suggested by the literature review and informed by the theoretical framework in the previous chapter. Ontological and epistemological assumptions are discussed in relation to research paradigms and the case made for a critical realist standpoint. An outline of the study design is followed by a discussion of the two research methods that were used to explore the research question. These are interpretative phenomenological analysis (IPA) and critical discourse analysis (CDA). For each method, the research process will be illustrated using examples from the study to show how findings were reached from the data. The chapter concludes with a consideration of principles for ensuring the quality of research.

4.2 Development of the research question

The literature review in Chapter 2 explored complexity as a significant issue for interprofessional working (IPW). It was seen that collaboration was often driven by efforts to resolve multiple, interrelated problems, but at the same time was associated with such problems in its own right. Despite the link between them, complexity as a topic has not been adequately theorised in relation to IPW, nor subjected to much empirical research. In addition, policies aimed at integrating services and improving IPW have often adopted a procedural approach that emphasises organisational structures and processes. Arguably as a result, there has been insufficient attention paid to the context in which IPW is experienced by practitioners, i.e. the complex case. Taken together, these considerations gave rise to the research topic, which could be expressed as a simple question: *What does complexity mean for practitioners working together on complex cases?*

The question was formulated like this in order to emphasise the interrelationship between the phenomenon of complexity and its contextual basis, i.e. interprofessional working in complex

cases. As noted already, complex cases usually demand more in the way of collaboration, but this itself brings further complexity into play. The research question also carries the sense of consequence as well as significance, i.e. what *is* complexity, but also what are its implications for the way practitioners are able to work together? The context of integrated services and the team around the child will therefore be central to the discussion of findings. In terms of methodology and study design, the research question also points to a focus on the experiences and perspectives of *practitioners* as opposed to service users, managers or policy-makers.

Based on the overall research question, two main objectives were formulated to guide the research design, data collection and analysis. These were as follows:

- a) To explore how practitioners experience complexity when working together on complex cases.
- b) To examine how practitioners construct complexity in their accounts of collaborative casework.

These objectives present two angles on the research question: the first a hermeneutic exploration of how practitioners experienced these issues in their everyday work (Chapter 5); the second a critical exploration of discourse in the way that practitioners discussed and interpreted their experiences (Chapter 6). It was felt that a combination of the two perspectives would enable a richer analysis of the constraints on and possibilities for IPW in complex cases. Before setting out the methods used to explore these questions in more detail, it will be necessary to examine the theoretical basis for the research strategy, and to provide an outline of the study design.

4.3 Theoretical basis

4.3.1 Research paradigm

Basic assumptions about the nature of scientific research are sometimes discussed in terms of research paradigms, whereby each paradigm invokes a series of philosophical assertions, or 'a cluster of beliefs and dictates' (Bryman, 1988: 4). Guba and Lincoln (2005) list five such paradigms: positivism, post-positivism, critical theories, constructivism, and participatory. Neuman (2006) has

only three: positivist social science (PSS), interpretative social science (ISS), and critical social science (CSS). These paradigms have a bearing on the methodology and design of a study because of their assumptions about the nature of reality (ontology) and the nature and acquisition of knowledge (epistemology). Positivism is held to be the dominant approach in the social sciences, and indeed in science generally, with the others partly united in their hostility to some of its assumptions (Morris, 2006). In the sociological field, positivism might be said to presuppose the existence of social facts and laws, which can be investigated using the same empirical methods employed in the natural sciences (see Guba and Lincoln, 2005: 193-196). The division between positivist and non-positivist paradigms can also be linked to a number of other methodological dualisms, e.g. realism vs. constructionism, explanation vs. understanding, analysis vs. narrative, structure vs. culture, quantitative vs. qualitative and so on (Abbott, 2001, Harvey, 2009). As Mjoset (2009) points out, this does not mean that paradigms necessarily align themselves straightforwardly along such traditional divides; rather they maintain distinctive interpretations of these dualisms within their particular framework.

In social research such paradigmatic debates often seem to boil down to a choice between quantitative or qualitative methodologies. Quantitative approaches, which operationalise theoretical concepts in order to produce numerical data amenable to statistical analysis, are generally associated with the positivist paradigm (Neuman, 2006; Guba and Lincoln, 2005). Quantitative studies work by testing hypotheses and measuring variables across a large number of cases or subjects. They employ a largely deductive mode of inference. Qualitative methods explore how social reality and meaning are constructed through language and interaction, and are often associated with non-positivist paradigms. Qualitative studies focus on acquiring detailed information about a few cases or subjects, involving the researcher in a thematic analysis of largely textual data. Some studies, especially in the realm of applied research, use a mixture of quantitative and qualitative methods (Teddle and Tashakkori, 2003, Bryman, 2006). Such 'mixed methods' designs are increasingly common, but have also been criticised for potentially relegating qualitative methods to 'a largely auxiliary role in pursuit of the *technocratic* aim of accumulating knowledge of "what works"' (Howe, 2004, in Denzin and Lincoln, 2005: 9). Mixed methods are consistent with a pragmatist philosophy of scientific inquiry, which holds that research should not be inhibited by prior assumptions about what constitutes reality or truth and should focus instead on what best suits the purpose of the research, and on the desired consequences (Cherryholmes, 1992).

Byrne and Ragin (2009) collectively argue for a shift towards 'case-based' methods in social research, broadly endorsing critical realism as a meta-theoretical foundation for such research. This also fits in with the standpoint adopted in this study. One of their contributors, Harvey (2009), goes further and suggests a 'complex realist' paradigm for studying what he calls the 'case object' in social science, drawing on similar principles as the theoretical framework set out in Chapter 3. In relation to the aforementioned dualisms, critical realism posits an ontological position from which a number of methodological approaches can make equal sense. In other words, critical realism enables a degree of 'methodological pluralism' (Danermark et al., 2002), as will be further elaborated below. As a scientific philosophy, it is therefore possible to place critical realism in various camps; for instance it is associated by Guba and Lincoln (2005) with 'post-positivism' and by Neuman (2006) with critical social science (CSS). On the one hand, critical realism takes issue with positivist approaches for conflating the observable and causal levels of reality, and for ignoring the interpretative lens through which social reality is constructed. However, it also criticises 'pure' forms of social constructionism for being relativistic and denying the human potential to transform unjust social practices and power relations. Critical realist researchers would argue that social science *can* be explanatory, i.e. make generalising claims that go beyond the idiographic account, but that it *cannot* establish universal social laws (Byrne, 2009a).

Drawing on the foregoing discussion, the research strategy in this thesis will be founded on a critical realist ontology and epistemology. There are two main reasons for this. Firstly, critical realism is well suited to the meta-theoretical implications of complexity, as set out by Harvey (2009) and instantiated to some degree in Chapter 3. Secondly, the research questions generated for the study have implications for the study design, such as the idea to carry out a case-based study, as well as to undertake separate forms of analysis to look at situated experience and discursive practices. It will be argued that both ideas are conducive to the scientific 'underlabouring' provided by critical realist philosophy (Bhaskar, 1989). Nevertheless, while it does not stipulate a particular research method, critical realism does not imply a methodological free-for-all. The next section will therefore examine the potential for a pluralist qualitative approach within the critical realist paradigm.

4.3.2 Methodological approach

In their exposition of critical realist social research, Danermark et al. (2002) advocate 'methodological pluralism', mainly to try and reconcile the traditional dichotomy between quantitative and qualitative methodologies. They re-envisage these as compatible methods of exploring social phenomena, relabeling the former as 'extensive' and the latter as 'intensive' approaches to a given research topic. In common with the pragmatists, they take issue with the assumption that research methods should be dictated more by the research paradigm than by what is actually being researched (Teddlie and Tashakkori, 2003). The study conducted here will therefore use an intensive, i.e. qualitative methodology, but one which will adopt a pluralist approach in line with the research questions set out earlier. Another reference point is the integrative approach outlined by Saukko (2005) in relation to cultural studies, which in her view creatively combines three distinct perspectives:

'[I]t combines a hermeneutic focus on lived realities, a (post)structuralist critical analysis of discourses that mediate our experiences and realities, and a contextualist/realist investigation of historical, social and political structures of power' (Saukko, 2005: 343).

Saukko argues that the philosophical and political tensions between these approaches can be addressed by regarding them as different 'validities', or modes of interpretation and analysis, which should be complementary and mutually reinforcing. A study that sets out to explore and understand a particular lived experience, such as anorexia, for example, can be enriched by also addressing the discourses and social processes that help to shape it, and which individual understandings in turn help to reproduce, transform or subvert. Equally, a study that attempts to carry out a deconstructive analysis of a given belief system can benefit from a hermeneutic sensitivity to people's own accounts, so as not to 'reduce the local experiences to props for social theories' (Saukko, 2005: 345). Moreover, reflexive and dialogic forms of research are not self-sufficient but must be situated in the context of broader social processes and structures. In this thesis, the latter has been undertaken in chapters devoted to the literature review, theoretical framework and discussion of findings. The study design is therefore concerned largely with the first two modes of inquiry: the hermeneutic exploration of experience and the critical exploration of discourse.

4.3.3 Study design

The study was designed to conduct an intensive, case-based exploration of what complexity means for interprofessional working in children's services. In order to build a multi-faceted picture of how collaboration was experienced in front-line practice, the focus was on active cases rather than closed or historic ones. In critical realist terms, the study of exceptional or 'pathological' cases can be seen as a strategy for learning about structures and mechanisms that are usually hidden from view but which become more visible during periods of crisis or transition (Collier, 1994, cited in Danermark et al., 2002: 104). However, the research question might also have been approached in other ways. For example, the study might have been designed around ethnographic fieldwork within a multiagency team, or used interviews with practitioners about their experience of interprofessional working in general, rather than in relation to a specific case. Each of these approaches would have had its strengths, but also limitations when it came to addressing the research question. The main problem with an ethnographic approach would have been the tendency for complexity to generate a more dispersed professional network (as in the child protection core group). This would then have restricted the settings in which collaboration could be observed to sporadic and rather formalised multiagency meetings. Alternatively, using a non-case-based design, i.e. interviewing a sample of practitioners from different sites about the research topic, could have diluted the focus on complexity and perhaps led to a replication of already well-known findings on barriers and facilitators to collaboration (see Chapter 2, Section 2.2.7). Finally, it was felt that using past cases would not yield the same immediacy of experience as asking practitioners about active ones – for example, because of the effort of recollection and the influence of knowledge about outcomes.

The actual study design is illustrated below in Figure 4a. It is described as 'case-based' rather than as a 'case study'. This is mainly to avoid confusion between professional and academic understandings of the term 'case', given that the focus of enquiry is the experiences and discourse of practitioners in relation to their collaboration on a particular case, rather than on collecting data about the case itself. In other respects, the research design could readily be construed as a qualitative case study in the sense of being 'an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context' (Yin, 2009: 18), or 'the intrinsic study of a valued particular' (Stake, 2005: 448). Case studies usually involve selecting a small number of cases to explore a topic in detail. They are often concerned with theory-building to link events in micro level settings with larger scale social structures and processes (Walton, 1992), producing what Stake calls 'naturalistic generalisation' (2005: 454) based on detailed analysis of a case's

unique characteristics and properties. This is all congruent with the aims of the study. Insights from the literature on case study research have therefore informed the methodological approach taken here.

Figure 4a. Study design

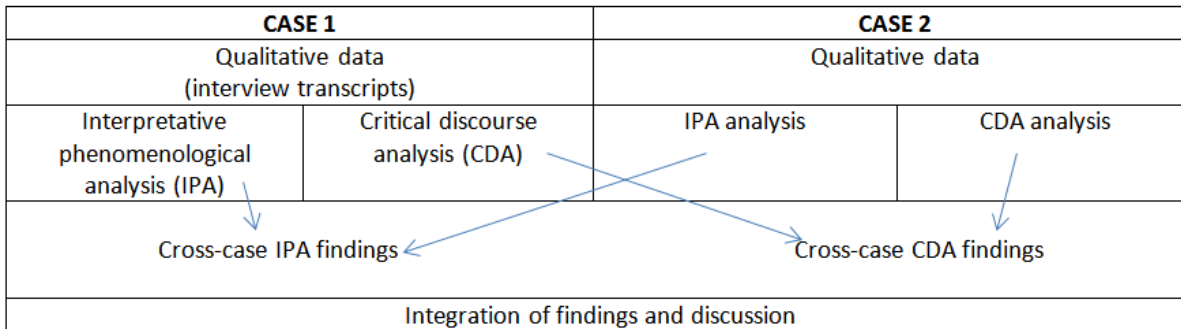


Figure 4a outlines a pluralist methodological approach involving participants from the professional networks in two purposively sampled cases. Two cases have been chosen rather than one in order to provide some grounds for comparative analysis, to broaden the diversity of experience sampled in the data, and to enhance the transferability of analytic conclusions to contexts outside of the study. Obviously it would have been preferable to examine several more cases, but this was not possible within the constraints of time and resources available to the researcher. The research process, including sampling and data collection, will be explained fully in a later section. For now, the focus will be on the theoretical basis of methods used to answer the research question. In line with the dual focus outlined earlier, two different strands of analysis were applied to the qualitative data collected in each of the two cases. These methods complement a hermeneutic focus on lived experience with a critical perspective on how experience is constructed through discourse. These two approaches, interpretative phenomenological analysis (IPA) and critical discourse analysis (CDA), are discussed in greater detail below.

4.4 Interpretative phenomenological analysis (IPA)

This section will examine the theoretical background to IPA, outline the rationale for its use in this study, describe the general procedures used for carrying out IPA, and discuss some conceptual and

practical limitations of the method. An illustration of how IPA was used in this study to analyse data and produce findings can be found later in this chapter in Section 4.6.8.

4.4.1 Background to IPA

Interpretative phenomenological analysis (IPA) is an approach to qualitative inquiry that was originally developed in the field of health psychology by Jonathan Smith (1996). It has since been extended and applied in a range of healthcare and social care settings (Biggerstaff and Thompson, 2008, Shaw, 2001, Willig, 2008). A comprehensive guide to IPA is provided by Smith et al. (2009). As its name suggests, IPA draws on the philosophical movement of phenomenology, chiefly associated with Husserl and Heidegger. Phenomenology is concerned with the essential nature of the world as it appears to human consciousness. Husserl's dictum to 'go back to the things themselves' meant a project to discover the essence of phenomena as they are perceived and experienced, rather than to surmise the objective nature of things when consciousness is removed (Larkin, 2006). A phenomenological approach therefore explores the way people understand and make sense of the world around them. Smith et al. (2009: 40) describe the phenomenological element of IPA as 'understanding personal lived experience and thus with exploring persons' relatedness to, or involvement in, a particular event or process'. There is accordingly an idiographic emphasis in IPA, which values the contribution to knowledge provided by detailed description of a particular case.

Alongside its allegiance to phenomenology, IPA acknowledges that as a research method it necessarily presents an interpretative account of the phenomenon in question. IPA researchers are interested in the unique meanings that people assign to a certain experience, but also in how those meanings relate to the person's individual and cultural context, and to the similar experiences of others (Shaw, 2001). This necessitates a two-stage process of interpretation, reflecting the 'double hermeneutic' referred to in the previous chapter (see Section 3.3.1). In other words, IPA researchers are trying to make sense of people making sense of their own experiences. The emphasis on the interpretation of meaning links IPA to the symbolic interactionist strand of social research, following Blumer (1969), as well as the hermeneutic theorists such as Schleiermacher, Heidegger and Gadamer (see Smith et al., 2009: 21-28). Through its incorporation of symbolic interactionism, IPA acknowledges that the meanings people assign to their experiences arise through social processes, i.e. through people's interactions with each other, which in turn are based on the exchange of symbols. Even our subjective understanding of the

world is tied up with our relationships with others, and as such is both facilitated and limited by the possibilities offered by language. This connects with the hermeneutic phenomenology of Heidegger, in which the conditions for understanding lie in our existential state of being 'thrown' into a world composed of pre-existing physical, cultural and social entities and their relations. This mode of being, 'dasein', or *being-there*, means that our experience of the world is always situated and relational, and therefore always demands a method of interpretation – the 'hermeneutic turn' (Hoy, 2006).

An important aspect of Heidegger's hermeneutic phenomenology is the role of preconceptions, as in prior experiences, viewpoints and assumptions (Smith et al., 2009: 25). A strictly Husserlian phenomenological approach would involve trying to 'bracket out' preconceptions in order to get at the essential nature of the phenomenon as it appears to the person (Moustakas, 1994). A Heideggerian view would be that any act of interpretation will necessarily invoke at least some preconceptions, but it is not possible to predict in what way this will occur, nor indeed whether or how our assumptions might themselves be altered by the new experience. In the critical realist sense, our interpretations are almost certainly informed by theory but not determined by theory. A related premise is that of the 'hermeneutic circle', which has been conceptualised by Gadamer (1975) and others in terms of the interpretative interplay between the whole and individual parts of a text. Smith et al. (2009) apply this concept to the research process, pointing out that research is rarely (if ever) a simple, linear movement from data to results, but constitutes a reflexive and dynamic process of engagement: not only with one's own aims, theories, and preconceptions, but crucially with participants and their accounts of lived experience. IPA therefore adopts both an 'empathic *and* questioning' stance in order to get an 'insider's perspective' on the phenomenon in question, while it also seeks to move towards deeper levels of analysis and understanding (Smith et al., 2009: 36).

4.4.2 Rationale for use of IPA

As noted earlier, IPA has gained increasing currency in public health research, finding particular application in studies of the psychological impact of illness, rehabilitation, and other significant health-related phenomena. There is some precedent for using IPA to look at relationships between different practitioners, for example in general healthcare settings (Hughes and Mccann, 2003, Jones, 2006), community mental health teams (Donnison et al., 2009), and in

interprofessional education (Rees et al., 2003). The main rationale for using IPA in this study lies in its epistemological suitability for addressing the research topic, and in particular the question of how practitioners experience complexity in complex cases. IPA lends itself very well to an exploratory question of this nature, which seeks to elicit both the unique and common elements of people's experiences, and focuses on how people understand and make sense of their experiences.

IPA should also be consistent with an overall positioning of the study within a critical realist social ontology. Given its diverse theoretical heritage, IPA can arguably be oriented towards either a constructivist or critical realist paradigm (Fade, 2004). While it emphasises the validity of the individual's subjective understanding of a phenomenon, it also accepts that people may attach different meanings to the same phenomenon. This recalls the critical realist distinction between the transitive and intransitive objects of scientific inquiry (see Chapter 3, Section 3.3.1). The methodology of IPA suggests that there is (or can be) a valid hermeneutic link between the experience, the person's account of that experience, and the researcher's account of their account. IPA's interpretative process also gives some scope for drawing on theoretical perspectives from 'outside' the reported experience of participants in order to provide insight into underlying meanings. All of these ideas are consistent with a critical realist rather than a strongly constructivist position. Finally, Smith et al. (2009: 196) note that IPA complements the approach taken by discourse-oriented methodologies, since the former provides insights into people's lived experience, while the latter focuses on 'the resources available to the individual in making sense of their experience'. An example of an empirical study employing IPA in tandem with Foucauldian discourse analysis is Johnson et al. (2004), in the field of health psychology. The complementarity of IPA with discourse analysis is necessary for the study design employed here (see above).

4.4.3 Methodological procedures

According to the approach described by Smith et al. (2009:), data for IPA research are usually collected via semi-structured interviews, although unstructured interviews may also be conducted by more experienced researchers. The sample of participants tends to be quite small, and studies can even consist of one long interview, due to the detailed and intensive nature of the analysis. Interviews are generally recorded and transcribed by the researcher. The analysis of transcripts proceeds via an idiographic commitment to work with one case at a time, one step at a time.

Written interview transcripts are analysed in successive stages, starting with immersion in the data through reading and re-reading, followed by a detailed exploratory analysis of 'semantic content and language use', including descriptive, linguistic and conceptual comments (Smith, 2009: 88). The next step consists of developing emergent themes by analysing connections and patterns in the exploratory notes. In the final stage of individual analysis, the researcher tries to fit together the different themes, building them into a structure that illustrates 'the most interesting and most important aspects' of the participant's account (Smith, 2009: 99). After this has been done for all cases, the researcher looks for patterns across cases, recognising superordinate themes but also 'unique idiosyncrasies' that are revealing of individual experiences. This largely inductive form of theorising is then supplemented with a deeper level of interpretation to move beyond the descriptive, for example by conducting a micro-analysis of a particular extract to explore themes emerging from the interview as a whole, or by drawing on relevant theoretical accounts to assist interpretation.

4.4.4 Limitations of IPA

Like all research methods, IPA has its conceptual and practical limitations. According to Willig (2008: 66), these can be summarised as: 'the role of language, the suitability of accounts, and explanation versus description'. The first objection has to do with issue of whether language is seen as representative or constitutive of people's efforts to make sense of the world. IPA aims explicitly at exploring an 'insider's perspective' (Conrad, 1987), and in doing so relies on the person being able to describe their subjective understanding of a phenomenon *through* language. As we have seen, such an assumption is not problematic from a critical realist perspective, as long as the distinctions resulting from ontological stratification are acknowledged. Moreover, discourse analysis can be used to supplement an IPA perspective, so allowing the possibility for individual self-positioning within the constraints of socio-linguistic context. The second objection raised by Willig has to do with the extent to which participants are able to communicate to another person (the researcher) the rich and vivid nature of their 'inner' experience. Taken at face value, this is a difficult objection to counter, but itself raises the question of what criteria are being used to judge an 'articulate' response, or respondent? Indeed, it could be argued that researchers need to be careful to allocate interpretative effort to material that does not immediately appear as eloquent or striking, and this falls into the general requirement to conduct high-quality research. The third criticism in Willig's account concerns IPA's idiographic emphasis, which might lead to an overly descriptive focus on 'appearances' (in the phenomenological sense) rather than causes or origins.

The explanatory value of any small-scale qualitative study rests on its overall credibility and transferability, and these issues are discussed in Section 4.7.

4.5 Critical discourse analysis (CDA)

Following the same schema as the previous section on IPA, the aim in what follows will be to describe the theoretical basis of CDA, explain the reasons for its use in this study, outline the main methodological procedures, and discuss their limitations.

4.5.1 Background to CDA

Critical discourse analysis (CDA) has a diverse theoretical background, mainly in applied linguistics and social theory. This lends itself to an interdisciplinary approach and a degree of conceptual and methodological variation (Van Dijk, 1993, Locke, 2004, Weiss and Wodak, 2003, Fairclough, 2009). CDA is particularly associated with the work of Norman Fairclough (e.g., 2003, 2009, 2010) and his approach has informed how key concepts have been understood and applied here. CDA looks at the connection between language or language use, what Fairclough calls ‘semiosis’ (2010: 202), and social structures and practices. It is especially concerned with aspects of ideology and power that are embedded in conventional, institutional or ‘common-sense’ uses of language. A major influence on CDA is Foucault’s poststructuralist reading of knowledge-power (e.g. Foucault, 1972, 1977). Foucault considers how power relations emerge over time from the interaction between multiple interests and sites of control, notably in the form of ‘disciplines’ – bodies of knowledge that inculcate self-regulation, e.g. of behaviour, identity and thought. In other words, power is, or can be, interiorised through ideological effects conveyed via rules governing the ‘domain of statements’ (Foucault, 1972: 80). Language therefore goes beyond just representation (e.g. of things, or thoughts) and can be seen as a constitutive social practice, i.e. discourse.

When it comes to conceptualising discourse, there is a distinction between a general sense of discourse as ‘language use in speech and writing’ (Fairclough and Wodak, 1997: 258) and a more specific concern with ‘sense-making stories’ (Locke, 2004: 5) that circulate in society and influence how people understand and perceive the world. An example of the latter might be ‘medical discourse’, which both produces and emerges from particular types of interaction involving medical professionals, such as the characteristic manner in which a doctor might present a case to

other practitioners (Anspach, 1988). Some related terms commonly employed within CDA are also worth clarifying. According to Fairclough (2010: 95-96), 'discursive events' are particular instances of language use, which produce texts (written, verbal or visual) for the purpose of conveying meaning to others. He also defines 'genres' as use of language associated with a particular social activity, e.g. the genre of 'case presentation', as discussed by Anspach (1988) in relation to medical discourse. Texts can be constituted from a variety of discourses and genres, an attribute that Fairclough calls 'interdiscursivity', or 'intertextuality' (see below). A glossary of the main terms relevant to the version of CDA used in this study is provided in Appendix 6.

As a research method, CDA is chiefly concerned with the analysis of 'texts', in order to explore and establish links to discursive and therefore social practices. A text constitutes a specific instance of language use, and in practice usually refers to 'concrete oral utterances or written documents' (Wodak and Meyer, 2009). CDA is a form of socio-linguistic analysis and as such has a basis in linguistic theory that is concerned with the social character of texts, rather than with the properties of language as an abstract system. A particular reference point is the systemic functional linguistics (SFL) associated with Michael Halliday (Halliday and Matthiessen, 2004), which supplies many of the analytic categories adapted and developed by Fairclough (2003). The starting point for SFL is that any text can be viewed both as a 'specimen' and as an 'artefact' of the overall linguistic system (Halliday and Matthiessen, 2004: 3). As specimens, texts simply illustrate the meaning-making resources (e.g. lexis, grammar) provided by the system in a functional context. However, when considered as artefacts, the context itself is of interest because it reveals why particular meaning-making resources have been selected and deployed in the text. Furthermore, texts are multifunctional, in that they enable speakers/writers to construct meanings in relation to identity, role, relationships, experience, and so on. This interplay between the different functions of texts underpins the orientation towards language in use that lies at the heart of CDA. It also implies a pluralist approach to the traditional Saussurian divide between *langue* (the language system shared by a community) and *parole* (the language behaviour of individuals). As Stubbs (2002: 230) points out, texts and the language selections they embody can be interpreted against the body of other texts to which they relate, and other selections that could have been made. Discourse analysis is therefore aimed at deconstructing these choices and examining their role in wider social practices and structures.

4.5.2 Rationale for use of CDA

The deconstructive possibilities offered by CDA have found many applications for the study of professional and interprofessional practice in health and social care settings (Crowe, 2000, McIntyre et al., 2012, Pollard, 2011, Mancini, 2011). From an epistemological point of view, it is therefore well suited to exploring the second strand of the research question posed in this study, which asks how complexity is constructed in professional discourse about working together on complex cases. Its compatibility with IPA as a research method has already been mooted at various points in this chapter. The strength of CDA lies in its emphasis on the socio-linguistic analysis of texts, so that in this study it can be used supplement the hermeneutic interpretation, the 'insider's perspective' of practitioners' experiences, with a critical interpretation of the discursive elements within practitioners' accounts. CDA also allows space for a positive critique in the sense of exploring the possibilities of transformation that might be evident in practitioners' accounts. Clearly such judgements relate back to the researcher's own reflexivity and critical stance (see Section 4.7.1).

4.5.3 Methodological procedures

CDA involves the collection and analysis of texts as a way of accessing the processes of meaning-making associated with particular discourses. Texts may be written or oral and can include visual or observational data, or transcripts of verbal conversations. A number of texts that have been assembled for analysis may collectively be termed a 'corpus'. In this study, the texts consisted of transcripts of interviews with practitioners. For analytical purposes these could be treated as individual texts, as a single corpus, or as two separate corpora based on the two cases. There are many different methods of discourse analysis, but the approach used in this study is adapted from the framework set out by Fairclough (2003). The method essentially consists of a detailed qualitative analysis based on different textual elements, which are in turn linked to various analytical concerns. Since CDA can be (and often is) used to look at single texts or even extracts from texts, some of the procedures described by Fairclough go to a level of grammatical detail that would be impractical for analysing an entire corpus of interview transcripts. The adapted framework retained the following analytical categories:

4.5.3.1 Genre

Genre has been defined by Swales (1990) as ‘a class of communicative events’. Individual texts fall into such categories by virtue of having developed from similar social practices. For example, the texts examined in this chapter could be considered as part of the genre of ‘interview transcripts’, in that they were generated through a series of one-to-one interviews as part of a qualitative research study. However, as Fairclough (2003) points out, it may be misleading to try and classify texts in a generic way, since individual texts will often draw on a variety of sub-genres (e.g. stories, reports, presentations).

4.5.3.2 Intertextuality

Intertextuality refers to the incorporation and treatment within a given text of other texts. The latter could mean verbal quotations, e.g. from conversations, or the content of written documents such as reports and assessments. Intertextuality has the potential to bring different voices into the text, which may support, balance or even contradict the voice of the speaker. Drawing on Bakhtin’s notion of ‘dialogicality’ (Bakhtin, 1981), texts may be viewed as more or less dialogical depending on the degree to which different voices are present and how they are represented by the author. Fairclough links this concept to the way texts treat ‘difference’, not only differences of opinion between people but also people’s awareness and acceptance of divergent or competing perspectives.

4.5.3.3 Assumptions

Assumptions refer to the implicit meanings contained within texts, as opposed to what is explicitly stated or discussed. Fairclough (2003) notes that assumptions represent the least dialogical part of a text, since their content is neither attributed nor contested. In other words, whereas intertextuality increases the possibility of difference by bringing other voices into the text, assumptions reduce difference. For example, particular viewpoints might be represented as objective facts or universal truths. Assumptions can therefore play an important ideological role in perpetuating social structures and power relations, by shaping what is perceived as natural or commonsensical.

4.5.3.4 Representation of events

Social events can be represented in various ways, and tend to be re-contextualised and re-imagined in speakers' accounts (Fairclough, 2003). This offers scope for critical analysis of what is prominent or backgrounded in particular 'versions' of events, of whether evaluations and value judgements are added or omitted, or whether social agents are seen as active or passive in particular situations. The level of abstraction and concreteness of the account may also be of interest.

4.5.3.5 Style

Fairclough defines style as 'the discoursal aspect of ways of being', referring to the inculcation of different forms of identity within (and through) texts. The process of 'identification' involves a dialectical interplay between the social and personal aspects of identity, in which people are able to invest their own personality into their social role or circumstances. Analysis of textual properties can indicate how features of this relationship are enacted in the style of a particular text.

4.5.3.6 Interdiscursivity

Interdiscursivity means looking at how different discourses are textured and layered within the sample of texts. As defined earlier, discourse may be treated as a kind of socio-linguistic practice, a way of 'representing the world' (Fairclough, 2003) that can be linked to an identifiable cluster of meanings, perspectives, and transformations. As such, discourses are not just about language and interpretation, but also about people and their relationships with each other, their projects and intentions, their role and status in society. However, as Fairclough points out, while there might be commonality within discourses, and a degree of stability, they are also heterogeneous and evolve over time. And each discourse will itself draw on a number of other discourses, which may be combined, embedded or reworked in different ways.

4.5.3.7 Corpus analysis

Corpus analysis is not an analytical category, but refers to a type of quantitative analysis derived from corpus linguistics (Stubbs, 2002, Baker, 2006), and which Fairclough suggests can be used to supplement the detailed qualitative work that is the main focus of CDA (2003: 6). Software packages such as Wordsmith (Scott, 2008) enable researchers to obtain statistical information about a corpus, such as word frequencies, to identify 'keywords' relative to a corpus of standard language use, such as the British National Corpus (BNC), and to look at patterns of 'collocation' between words. To take a simple example, a word-count of a report by Lord Laming on the state of child protection services in 2009 (Laming, 2009) will reveal that the verb 'to ensure' appears 102 times, and Wordsmith's keyword function will confirm that this is an unusually frequent usage compared to the BNC. On its own, of course, this is not very informative, but might be seen as relevant to a discussion of risk regulation regimes in the field of child protection (see Chapter 7, Section 7.7).

4.5.4 Limitations of CDA

CDA has been subjected to some criticism as a research method, mainly centred on the soundness of its theoretical foundations (Hammersley, 1997) and its claims to produce valid knowledge (Widdowson, 1995). Elsewhere Hammersley has expressed general scepticism about social research that uses the 'honorific title' of being critical as a way of adopting explicit political positions, and so obscuring the essential task of criticism, which in his view is about assessing the merits of competing knowledge claims (Hammersley, 2005). His examination of CDA follows similar lines, and he argues that in embracing a rather ambitious agenda of social change its tendency is to over-interpret findings and evaluate the resulting knowledge claims in terms of political implications rather than methodological validity (1997: 253). Widdowson goes further and charges CD analysts with 'replacing argument with persuasion and confusing cogency with conviction' (1995: 171). In considering some of these objections, Haig (2004) notes that many of the foremost exponents of CDA, including Fairclough, sometimes omit details of how texts were sampled, do not formally describe the detailed textual analysis that their method entails, and rely on skilful interpretations of texts for the effectiveness of their account. Some of these limitations, particularly with regard to sampling and methodological procedures, have hopefully been addressed in the account of the research process given in this chapter.

4.6 The research process

This section will describe the process through which the research was conducted. This is summarised in the flowchart in Figure 4b, which shows the various stages of ethics and access leading up to data collection and analysis. The preliminary process included academic upgrade and approval of study design, application for ethical and research governance approval, negotiation of access to research sites, deciding on a sample of complex cases and approaching practitioners for informed consent to participate in the study. Beginning with ethical considerations, these stages are described in what follows, before setting out how data were collected and findings were reached.

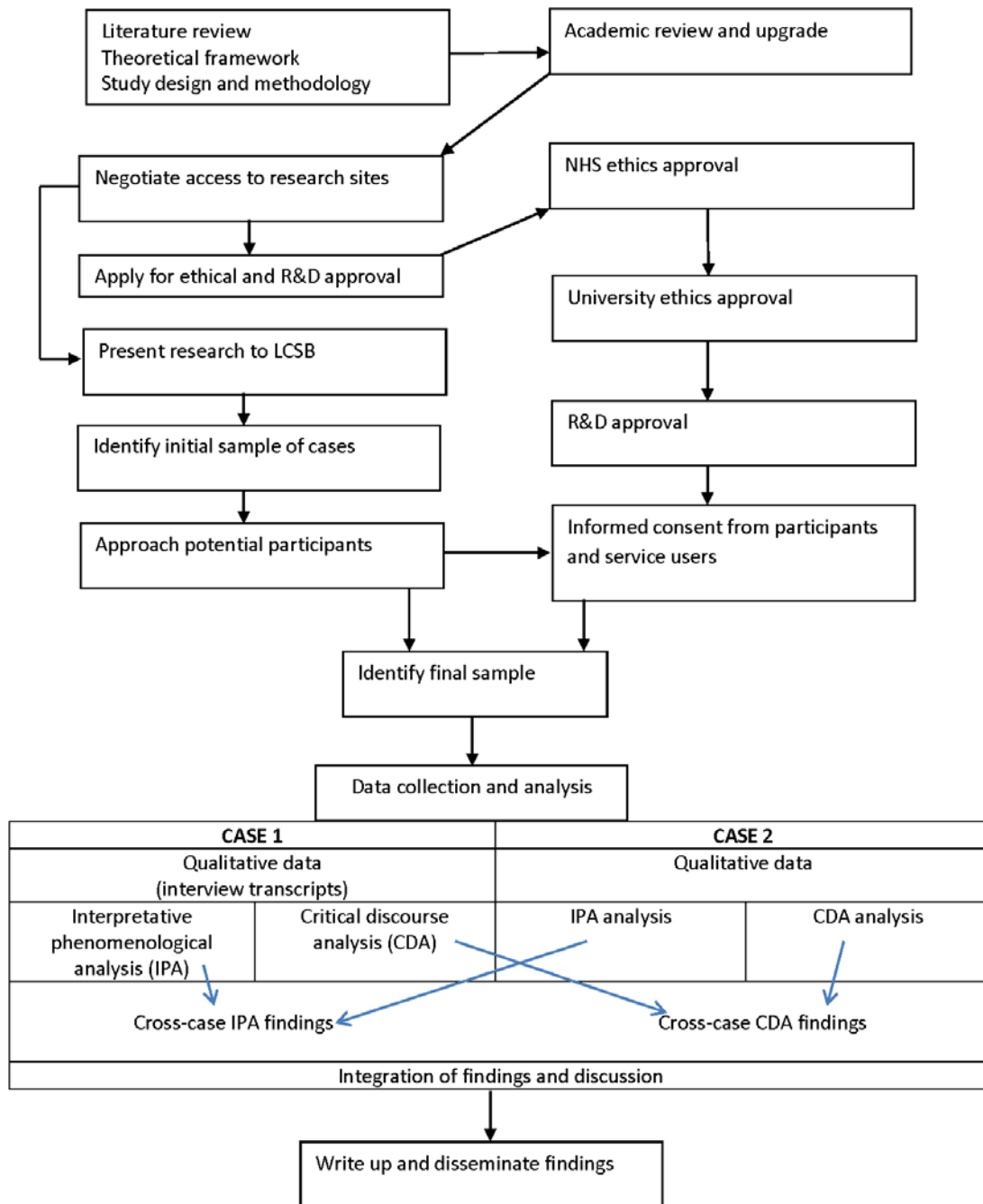
4.6.1 Ethical considerations

The following ethical considerations were relevant to the study and were addressed as detailed below:

4.6.1.1 General principles of ethical research

As Neuman (2006: 130) points out, ethical research depends to a large extent on the 'integrity of the individual researcher and his or her values'. One of the main tenets of the scientific community is a spirit of honesty and openness both when undertaking research and in reporting methods, results and findings, to guard against scientific misconduct or research fraud, such as distorting or falsifying data (Greenbank, 2003). Ethical research is also linked to the use of an appropriate methodology, conducted to high standards, with interpretations consistent with the data. Finally, and most importantly, research should not involve any harm, manipulation, coercion or deception of participants.

Figure 4b. Flowchart of research process (ethics and access)



In the spirit of maintaining ethical standards, various safeguards exist to monitor the research process (Mauthner et al., 2002). For this study, a detailed proposal was submitted to academic supervisors and approved at a PhD upgrade interview before making any applications for ethical approval. In line with regulations, two separate ethical review bodies were asked to consider the research: the NHS research ethics committee and Royal Holloway, University of London research ethics committee (REC).

On a reflective note, the process of obtaining ethical approval for this study was experienced as highly protocolised and bureaucratic. Both ethics committees required the submission of a large number of forms and documents detailing every aspect of the research. Responsibility for ethical decisions was not only dispersed across various bodies, but explicitly detached from the academic specialism to which the research belonged. To this researcher, with a background in local authority social work, it was reminiscent of the rational-technical approach to risk management that is prevalent in child protection (see Section 2.4.3). Interestingly, the field of research ethics, particularly relating to medical research, has also been the subject of a number of public scandals over recent decades (Sugarman et al., 2001). Some further parallels may be observed in the discussion of risk and dispersed accountability in Chapter 7 (Section 7.7).

The relevant approval letters from each REC can be found in Appendix 7. During the course of the research, regular meetings with three different academic supervisors were held in order to verify that research was being carried out in an ethical manner, with particular attention being paid to the following areas.

4.6.1.2 Confidentiality and anonymity

Precautions were taken to ensure that confidentiality and anonymity were maintained in relation to data obtained from interview participants and observations of meetings. This also included information pertaining to the families/service users, who were not participants, but whose cases were the basis for the practitioner experiences that were being studied. Transcripts and field notes always used codes to refer to individual staff, geographical locations, or service users. Data were held in the form of digital recordings and were securely stored on a password-protected computer. When writing up the research, care was taken to ensure that no individuals are identifiable, including the modification of personal information when necessary. The gathering and

use of information supplied by participants in this study is bound by the provisions of the Data Protection Act 1998 (Henn et al., 2009).

As this was a small-scale qualitative study complete anonymity was limited by the fact that people who are aware of the research would also have access to any published material, e.g. papers in academic journals. In addition, the information sheets explained that if any criminal behaviour were to be disclosed by participants, the researcher would have a duty of care to break confidentiality and to inform the appropriate authorities. As a registered social worker, the researcher would not necessarily be qualified to judge on the quality or competence of practice in other professions. However, it was possible (though unlikely) that an example of potentially dangerous or unethical practice might be disclosed during an interview. In this case the researcher would follow the protocols both of the university and the agency concerned, the first step being to relay his concerns to his academic supervisors and liaise with them about the appropriate action.

4.6.1.3 Informed consent

Written informed consent was sought from all participants. Practitioners in the multiagency networks from cases sampled for the study were provided with an information sheet about the study, which included contact details for the researcher and his supervisors. Service users, i.e. carers and children (depending on age) who were the focus of the selected cases, were also provided with age-appropriate information sheets and their consent obtained. Information sheets and consent forms for practitioners and families can be viewed in Appendices 8-13. Participants were free to withdraw at any time from the study, without giving a reason. They could do this by informing the chief investigator that they no longer wished to participate. Participants were also able to request at any point that any data obtained from them subsequently be destroyed and excluded from the analysis and findings. Likewise, service users (children and families) who were not participants, but whose consent had been obtained, were able to withdraw their agreement at any stage, without giving a reason. They could do this by informing their keyworker or one of the practitioners they are involved with, or by contacting the chief investigator directly. Were this to happen, all data and notes relating to this particular case (regardless of whether practitioners were still consenting to take part) would be destroyed and excluded from the analysis and findings.

4.6.1.4 Affecting casework

The research design involved the study of interprofessional networks that were actively engaged in ongoing cases, rather than looking back at closed cases. This raised the issue of the research possibly affecting the work done by practitioners and therefore influencing assessment and intervention. This risk was minimised as far as possible by restricting data collection to individual interviews with practitioners. Qualitative data consistent with an IPA/CDA approach might also have been obtained from focus groups, in which the interprofessional dynamics would be hard to control, or observations of meetings, in which the presence of a researcher taking notes might have affected the nature of the discussion. Clear ground rules were adopted for interviews in order to distinguish them from contexts such as critical reflection or peer supervision. For example, the researcher did not provide comments or critical feedback on what was said by participants, but confined his involvement to asking participants to expand or clarify points only insofar as this was relevant to the research aims and objectives.

4.6.2 Access to research sites

Following the granting of ethical approval, access was negotiated to partner agencies within a Children's Trust based in an outer London borough. The main reason for selecting this area was the existence of institutional links with the university that made it easier for the researcher to approach senior management. The local authority also maintains a centrally organised children's social care service, so that the pool of available cases had the advantage of being borough-wide rather than just based in one district or ward. The profile of the borough, according to its own information, is average for outer London in terms of ethnic diversity and indices of deprivation. After initial contact with the local authority, the next step to negotiating access involved presenting the research to a meeting of the Local Child Safeguarding Board (LCSB). General agreement was given by the partner agencies represented at the LCSB for the researcher to approach services in the area. Requests for research governance approval then had to be made separately for each agency that was likely to be involved in a child protection case, following the appropriate conventions for that agency. However, the research sites could not be finalised until a sample of complex cases had been decided on.

4.6.3 Sampling strategy

The study adopted a purposive sampling strategy in order to select cases that would be particularly informative for the research question (Neuman, 2006: 222). The priority for sampling was on theoretical richness rather than representativeness, since it would be hard to say whether one complex case was a typical example compared to others that might have been chosen (Seale, 2012). There was also an element of convenience to the sampling, since the agreement of many different parties was required for each case. There were two stages to sampling, the aim of which was to find two complex child protection cases whose professional networks were willing to participate in interviews with the consent of the families involved. The first stage was to discuss a purposive sample of cases with the children's social care agency responsible for organising child protection conferences and leading on child protection plans.

The main inclusion criteria for the initial sample were as follows:

- Ongoing active child protection (CP) case
- Children with current CP plans, with at least the initial CP case conference held
- Professional network with diverse representation from at least 4 occupational groups, including health, education and social work
- Assessment of multiple, interrelated needs

The main exclusion criteria for the initial sample were:

- Children considered likely to be removed from CP plans at next review conference (case seen as reducing in risk and complexity)
- Professional network less than 4 occupational groups (not diverse enough)
- Decision to initiate care proceedings already taken (sensitivity around consent of families, and case possibly seen as moving towards resolution)

In accordance with these criteria, an initial sample of six cases was identified. In the next stage, the children's social worker, the families and then the respective professional networks (and their managers) were approached in writing in order to inform them about the research project and ask

them whether they would like to participate. In the second stage, the initial sample was narrowed down to a final sample of two cases, based on the following criteria:

- Majority of practitioners in the network expressing interest and giving written informed consent to participate.
- Families (children and parents) giving written informed consent to practitioners being interviewed
- Inclusion criteria described earlier continuing to apply (e.g. no change in CP status)

The sampling strategy was extended slightly by the decision to hold two rounds of interviews at an interval of about three months between each one. The rationale for this was that people's perception of complexity might change according to developments in the case and it would be worth trying to capture some of this experience. In the event, it was not entirely successful due to turnover in the network, which meant only four people could be interviewed twice. However, it did mean that three new participants could be recruited for the second stage (see Table 4b).

4.6.4 Overview of cases and participants

An overview of the two cases in the final sample is shown below in Table 4a. Case 1 involved a fourteen-year-old boy, Martin, living at home with his mother, both of Black British-Caribbean heritage. Martin had been on a child protection plan for about eighteen months at the time the research took place. The main issues were his exclusion from mainstream education, involvement in youth offending and aggressive behaviour. He was adjudged to be out of parental control and at risk of being exploited by older peers in the community. Case 2 involved a seven-year-old boy, David, living at home with his parents and older siblings, all White British. David had recently been placed on a child protection plan, along with his siblings, due to concerns about neglect and lack of parental supervision, linked to specific concerns about David's aggressive behaviour and fire-setting. Both cases had an extensive network of practitioners, most of whom were willing to be interviewed for the research. An anonymised list of participants with their research codes and contribution to the interviews is provided further below in Table 4b. Since the sampling strategy was oriented towards *cases* rather than individuals, the only relevant characteristics of participants were: professional background, active involvement in the case, and informed consent, i.e. other demographic data were not collected.

Table 4a. Final sample of cases

	Case 1	Case 2
<i>Family make-up</i>	Mother, son	Mother, father, 3 sons, one daughter
<i>Ethnicity</i>	Black British Caribbean	White British
<i>Subject of child protection plan</i>	14 year old boy	7 year old boy ¹
<i>Duration of plan⁷</i>	18 months	2 months
<i>Main issues</i>	Out of parental control Out of education Involvement in criminal offences Vulnerability to abuse (in community)	Neglect and lack of supervision Fire-setting in the home (risk to siblings) Aggressive and sometimes violent behaviour towards family members
<i>Participating professionals in core group</i>	Social worker Youth worker Mentor YOT ² mentor CAMHS ³ psychiatrist YOT case worker School nurse FIP ⁴ worker YOT case worker School keyworker	Primary school head Fire prevention officer CAMHS specialty doctor Family support worker Young carers (manager) Social worker Family support worker ⁸
<i>Non-participating professionals</i>	GP ⁵	GP Social worker ⁶ School nurse

Notes:

¹Although all the children in this family were placed on child protection plans, the core group here was mainly focused on the youngest child, whose behaviour was associated with the highest level of need and risk.

²YOT: Youth Offending Team

³CAMHS: Child and Adolescent Mental Health Service

⁴FIP: Family Intervention Project

⁵GP: General Practitioner

⁶There was a change in social worker midway between the first and second stage of interviews, and the new social worker decided not to participate in the study

⁷At time of approaching the professional network

⁸Two family support workers from different agencies were interviewed in this case, one at each interview stage

4.6.5 Data collection and pilot interviews

The chosen method of data collection was the semi-structured research interview. As noted earlier, this is the most common approach within IPA (Smith et al., 2009). Interviews have often been preferred by IPA practitioners over other methods such as focus groups or diaries because of the opportunities they offer for dialogue and clarification, as well as privacy and confidentiality in the discussion of sensitive topics (Smith and Osborn, 2003). Within CDA, any text may be subject to analysis, including interview transcripts (Fairclough, 2003: 118). The purpose of the CDA was to provide a complementary perspective on the same qualitative material used for the IPA, so no additional data collection was undertaken for it. The final sample of two complex cases eventually yielded a total of 17 participants and 21 interviews. The breakdown of participants and their contribution is summarised below in Table 4b. The first round consisted of 13 interviews, of which eight were from Case 1 and five from Case 2. The second round produced eight interviews, four from each case, of which two from each case had also participated in the first round.

Table 4b. Participant codes and contribution to interviews

Case 1			
Participant code	Profession	First round	Second round
C101	Social worker	Yes	Yes
C104	Youth worker	Yes	No
C105	Mentor	Yes	No
C107	YOT mentor	Yes	No
C108	CAMHS psychiatrist	Yes	No
C109	YOT case worker	Yes	No
C110	School nurse	Yes	No
C111	FIP worker	Yes	Yes
C112	YOT case worker	No	Yes
C113	School keyworker	No	Yes
Case 2			
Participant code	Profession	First round	Second round
C201	Primary school head	Yes	Yes
C203	Fire prevention officer	Yes	Yes
C204	CAMHS specialty doctor	Yes	No
C205	Young carers (manager)	Yes	No
C206	Social worker	Yes	No
C207	Family support worker	No	Yes
C208	Family support worker	Yes	No

For semi-structured interviews in an IPA study it is sometimes advisable to develop an interview schedule (Smith et al., 2009; Smith and Osborn, 2003). The purpose of the schedule is to address principal areas of interest, set out a logical sequence of questions, consider any difficulties that may arise during the course of the interview, especially with regard to sensitive areas, and to formulate appropriate prompts and probes. However, the schedule is not supposed to be a checklist of questions to be strictly repeated for each participant. The interview schedule in this study was developed with the aid of pilot interviews before the final sample of cases had been identified. Pilots were carried out with two social workers, who were professional contacts of one of the researcher's supervisors. The pilots replicated the planned data collection and analysis. Each participant was asked to discuss a particular case, but since they worked in different teams it was not one they had in common. As a result of the interviews, it was felt that a relatively unstructured case discussion was best suited to allow participants the scope to explore their experiences. However, it was also helpful to have some prepared questions, firstly to make sure the discussion covered key areas, and secondly to prompt participants to explore critical incidents more fully. The final schedule of questions, not all of which were necessarily used in each interview, can be found in Appendix 14. The pilot interviews were also recorded, transcribed and analysed using both IPA and CDA, for the purpose of practising the methodology, but none of these data were used in the findings.

4.6.6 Conduct of the interviews

Interviews were mostly conducted in a meeting room at the participant's workplace. One participant preferred to be interviewed at home, and another on the phone. Interviews lasted between 40 and 60 minutes, depending on participants' work commitments and the detail of discussion. All consented to have their interviews digitally recorded, apart from one participant who preferred detailed notes to be taken but was happy to be quoted. At the beginning of the interview, participants were reminded of the purpose of the study, and that they could withdraw at any time, including after the interview itself. The interview style that was aimed for was non-directive and participant-led, with the researcher's contribution to the case discussion restricted as far as possible to occasional questions and prompts, for reasons noted above. The effect of the researcher's personal qualities on the interviews is discussed under the heading of 'reflexivity' in Section 4.7.1. As Willig (2008) points out, semi-structured interviews negotiate an ambiguous terrain between formal process and informal conversation. Like any other interpersonal

communication, interviews involve a level of rapport between researcher and participant (Keats, 2000). However, there is a fundamental inequality in the interaction, since the participant is required to 'reveal' more about him or herself than the researcher, who furthermore is using that information for their own purposes. An overly conversational style might therefore unwittingly unmask this power imbalance and lead participants to talk about things that later they feel uncomfortable at having disclosed.

In view of these issues, interviews sought to maintain a balance between establishing rapport and maintaining awareness of the formal research process in which both parties were engaged. In some ways, the moments of 'switching on' and 'switching off' the recorder were quite a useful way of marking the formal part of the interview, in which 'data collection' was happening, while either side of this boundary the interaction could be more equal and informal. The first question was always to ask participants to outline their official role and involvement in the case, gradually leading into a deeper exploration of their experiences. Active and empathic listening skills are obviously important for researchers as well as practitioners, and go beyond verbal cues and responses to include posture, tone of voice and facial expressions (Keats, 2000). It is also equally if not more important to manage the end of an interview as it is the start, so that participants are not left in a state of agitation or feeling that they have not had the chance to make all their points. Participants were therefore alerted in advance as interviews were coming to an end, and the final questions oriented towards any further reflections they wished to make, either on the case or the issues that had been raised. The interviews also encompassed an element of 'debrief' after the recorder was switched off, in which the researcher asked how participants had found the interview and could answer any further questions they might have about the research process.

4.6.7 Transcription

As soon as possible after each interview, some preliminary reflections were handwritten in a 'field notebook'. These notes could later be transferred to typed memos as part of the initial analysis (see next section) and helped the researcher to reflect on his own experiences of and reactions to the research process. Interviews were then transcribed verbatim, including the researcher's own part in the dialogue. A notation system was used in line with the principles set out by O'Connell and Kowal (1994). They argue that there cannot be a standard transcription system for research purposes; instead the 'ideal transcription is the one that best serves the purposes - however

modest - of the researcher' (1994: 104). In other words, researchers should limit what is transcribed to what is going to be analysed. In an IPA analysis the emphasis is on the participant's description of experience, while in CDA it is the use of language that is of interest. Neither method demands a complicated notation system detailing the interaction between interviewer and interviewee, as in conversation analysis (Willig, 2008). However, for both IPA and CDA it is worth recording non-verbal contributions, e.g. emphasised words, laughter or gestures denoting 'quotation marks' around certain phrases. The simple notation system used for transcription in this study is shown below in Table 4c:

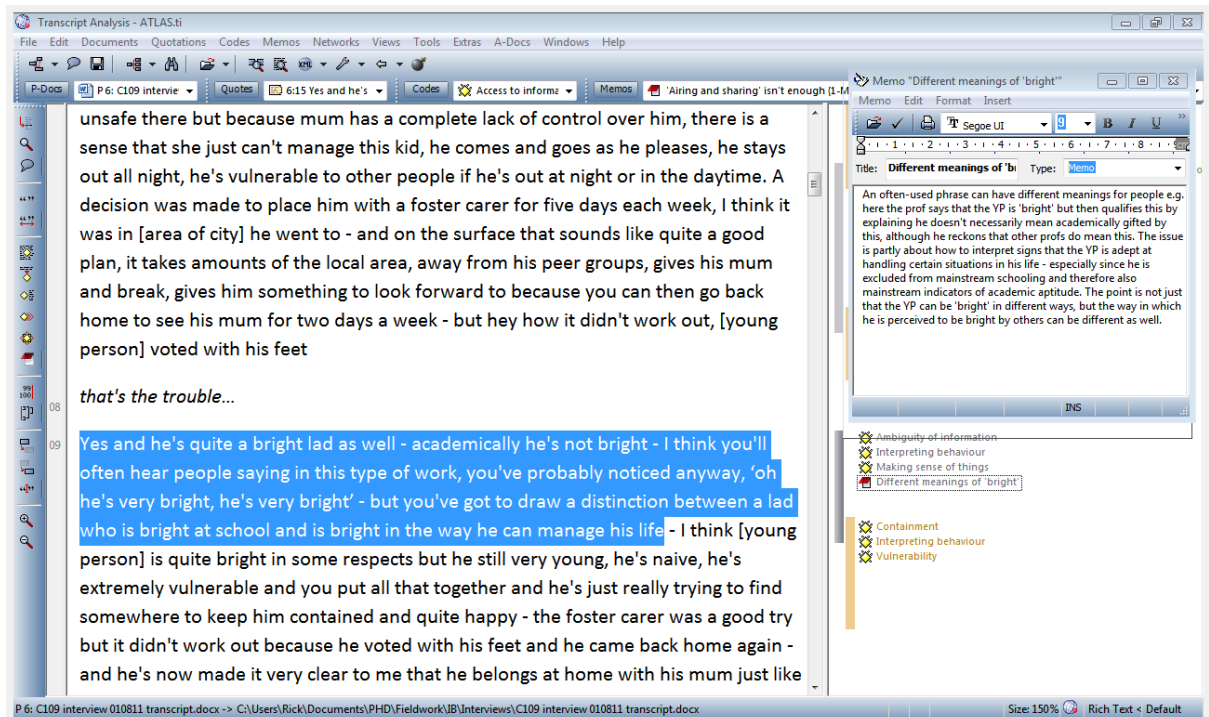
Table 4c. Notation of transcripts

Notation	Meaning
...	Pause
–	Sentence interrupted
<i>Italics</i>	Emphasis
[unclear]	Indecipherable speech
[laughs]	Laughs
[points to picture]	Gesture or action

4.6.8 IPA analysis

The general method of carrying out IPA has already been described in Section 4.4.3, following Smith et al. (2009). It is a mainly inductive approach that works from a detailed transcript analysis towards general themes and categories. It is also idiographic, particularly in the initial stages, meaning that transcripts are analysed on an individual basis, with comparisons between interviews only being made at a later stage. For this study, the procedure described by Smith et al. (2009) was adapted so that analysis could be undertaken using ATLAS.ti (Scientific Software Development, 2011), a qualitative data management tool. After a thorough reading and re-reading of each transcript, an intensive line-by-line analysis was undertaken using the software. This process is illustrated below in Figure 4c, which shows a screenshot from ATLAS.ti.

Figure 4c. Interpretative phenomenological analysis in ATLAS.ti



In the screenshot, one of the transcripts is shown on the left-hand side, while the researcher's own interpretations are shown on the right. Using the software, 'memos' were created to capture the researcher's reflections and notes on the transcript. One of these memos is illustrated on the top right, concerning the meaning of the word 'bright' for the participant. The memos represent the stage of IPA that is about trying to interrogate the data in different ways. The aim is to interpret the semantic content of what is said but also to draw out more implicit meanings, suggested perhaps by the use of imagery and metaphor. In the highlighted extract above, for example, the participant comments on the intelligence and awareness demonstrated by Martin's social presentation, but also on how the terms employed by practitioners – even straightforward-sounding ones such as 'bright' – offer scope for ambiguity and misunderstanding. The central image of brightness therefore relates not just to a characteristic of the young person but also to how practitioners understand certain behavioural signals. These concerns are captured in the emerging themes listed beneath the memo, such as 'ambiguity of information' and 'interpreting behaviour', which are linked to sections of transcript as marked by the coloured lines. This interpretative process of memo-writing and theme-generation, maintaining a rigorous link with quotations in the transcript, aims to connect the 'phenomenological core' of the participant's account to the researcher's own interpretation (Larkin et al., 2006).

After the stages detailed above had been completed for each transcript, each emerging theme was reviewed and refined by examining the quotations linked to it across all of the interviews. One advantage of doing the analysis in ATLAS.ti was the ease of performing such procedures, since it was possible to revise themes while retaining the link to the original quotations. After this a table was created showing which themes had appeared how many times in which interviews. At this stage, certain themes were discarded as being relatively unimportant to participants as well as to the research question. Some themes could be combined with others, but care was taken to check that any new categories were consistent with the quotations from which they derived. The next stage was to cluster themes together in order to generate superordinate themes that were relevant for all or most of the interviews. Here the concern was to capture what was shared but also what was divergent in the way people make sense of their experiences, so that themes were not discarded once they had been grouped together. The aim of creating superordinate themes was to group themes around clusters of related meaning, while also ensuring representativeness throughout the body of transcripts. An example of how this was done is given in Figure 4d, which shows a screenshot of an Excel table:

Figure 4d. IPA themes in Excel table

	B	C	D	E	F	G	H	I	J	K	L	M	N	O	
26	P 1: C101	P 2: C104	P 3: C105	P 4: C107	P 5: C108	P 6: C109	P 7: C110	P 8: C111	Total 1st Rnd	P 9: C101	P10: C113 inte	P11: C112	P21: C11	Total 2nd Rnd	
27	Critical periods and events	14	5	1	1	1	7	14	2	45	3	0	3	1	7
28	Multiple factors	2	1	0	0	8	2	5	5	23	0	0	7	1	8
29	Surface and depth	2	2	0	0	1	1	3	0	9	1	5	0	1	7
30	Exploration of cause and effect	18	8	1	1	10	10	22	7	77	4	5	10	3	22
31															
32		P12: C201	P13: C203	P14: C204	P15: C205	P16: C206	P17: C208	Totals	P18: C201	P19: C203 inte	P20: C207	Totals Rnd 2	CASE 2		
33	Critical periods and events	4	0	1	1	2	4	12	3	1	1	5	17		
34	Multiple factors	2	0	0	0	0	0	2	6	3	0	9	11		
35	Surface and depth	5	5	2	1	1	0	14	3	4	0	7	21		
36	Exploration of cause and effect	11	5	3	2	3	4	28	12	8	1	21	49		
37															
38															

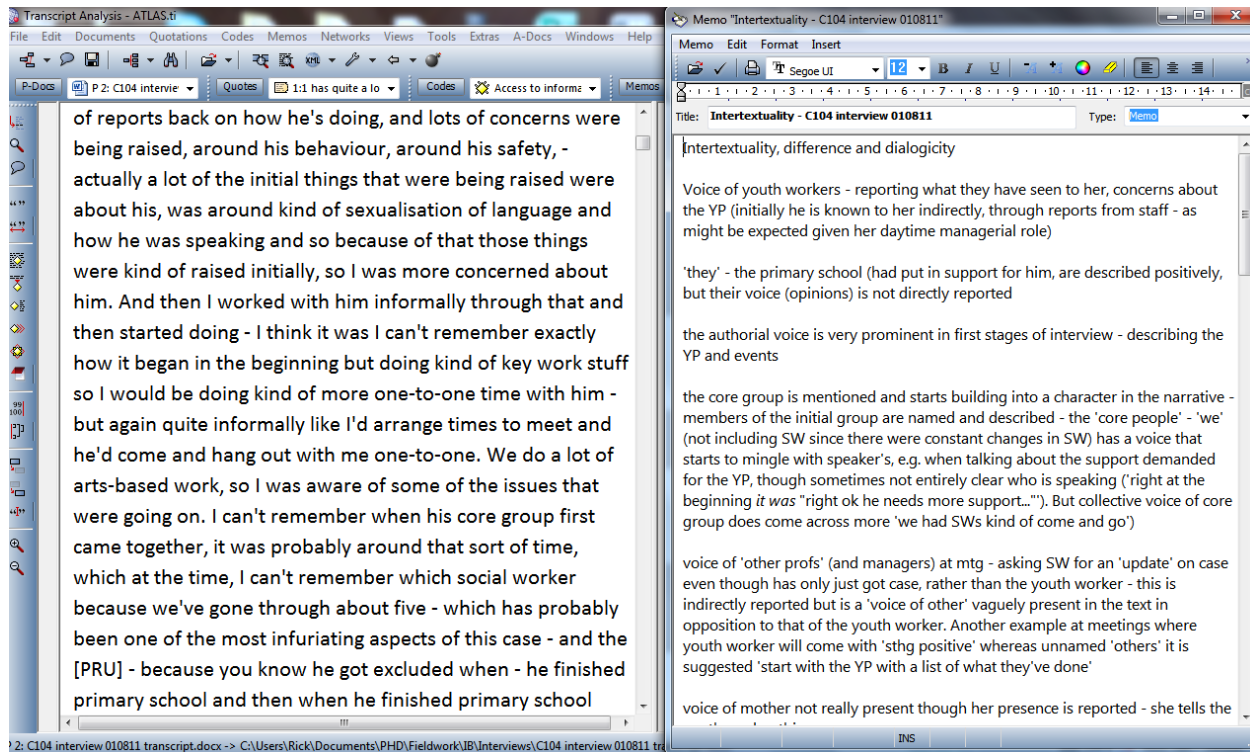
The table shows three different sub-themes that were grouped under the superordinate theme of ‘exploration of cause and effect’. The upper half shows the transcripts for interviews with practitioners working on Case 1, and the bottom half for interviews on Case 2. The numbers are taken from a summary table generated by ATLAS.ti, and show how many quotations were associated with each theme in each transcript. These frequencies are not statistically valid in any

way, but serve as a rough indication of which themes were found in which transcripts. For example, it can be seen that 'exploration of cause and effect', the superordinate theme in bold script, contained a number of sub-themes that were emphasised to different degrees by participants in the two cases. For example, 'critical periods and events' were often mentioned by C101 (social worker) and C110 (school nurse) in the first case, particularly in the first round of interviews. 'Surface and depth', on the other hand, was a consistent theme for C201 (headteacher) and C203 (fire prevention officer) in the second case. In other words, while the superordinate themes sought to explore commonalities in how participants made sense of complexity, the sub-themes reflected the finer grain of differing emphasis and distinction. As a final step, designed more to help structure the findings than as an analytical stage, the superordinate themes were themselves grouped under broad categories suggested by the research question (see Chapter 5).

4.6.9 CDA analysis

CDA analysis was carried out using a methodological approach adapted from Fairclough (2003), as outlined in Section 4.5.3. The sample of texts was the same as for the IPA, i.e. every interview transcript was analysed. Unlike IPA, the analytical categories were set out in advance (genre, intertextuality, and so on) and explored for each transcript in turn. Nevertheless, within this general framework there was still scope for findings to emerge inductively from a detailed reading and re-interpretation of the text. In addition, it was helpful to have the framework as a way of looking afresh at texts that had already been exhaustively examined from another perspective. The bulk of the analysis was again done in ATLAS.ti, although here the emphasis was on carrying out a socio-linguistic analysis through detailed memos accompanying each text. This process is illustrated below in Figure 4e, which shows a screenshot from ATLAS.ti:

Figure 4e. Critical discourse analysis in ATLAS.ti



The screenshot shows the usual arrangement in ATLAS.ti with the transcript from C104 (youth worker) on the left-hand side and an analytical memo about 'intertextuality' on the right. Here the emphasis is on how the 'speaker' (although see Section 4.7.1 on the co-authorship of interview transcripts) draws on different perspectives, including other speakers and texts, in order to construct her account. The memo comments on a number of aspects of intertextuality, including the juxtaposition of the authorial voice with others present in the text. These include the collective voice of the 'core group', which itself is a combination of the points of view of different practitioners, and then represented here by the speaker. Such concerns relate to Bakhtin's ideas on the 'dialogic' nature of texts (Bakhtin, 1981), and the extent to which the dialogue with other texts (or points of view) is carried out, e.g. whether differences are highlighted, obscured or resolved (Smith, 2003). A similar procedure was then carried out for all the analytical categories for each transcript, eventually generating a body of memos for comparison. In the next stage, memos for each category were grouped together in a table in order to identify common and divergent elements in the analysis for that category. For example, under intertextuality it proved interesting to explore whether and how the collective voice of the core group was referred to across different transcripts and cases.

At this stage, it was sometimes useful to supplement findings from the line-by-line analysis with some word lists or concordance searches using Wordsmith (Scott, 2008). The software can help to identify patterns in large bodies of texts, or corpora, a task that would require a great deal of time to do manually. To enable some degree of comparison, the sample texts were arranged into three corpora: all transcripts, Case 1 transcripts, and Case 2 transcripts. An example of how Wordsmith was used to generate data on a particular corpus is shown below in Figure 4f:

Figure 4f. Word list for Case 1 interviews, using Wordsmith

N	Word	Freq.	%	Texts	% Lemmas	Set
1	THE	1,985	3.65	12	100.00	
2	AND	1,786	3.29	12	100.00	
3	TO	1,704	3.13	12	100.00	
4	OF	1,324	2.44	12	100.00	
5	THAT	1,296	2.38	12	100.00	
6	I	1,225	2.25	12	100.00	
7	A	1,134	2.09	12	100.00	
8	HE	941	1.73	12	100.00	
9	WAS	833	1.53	12	100.00	
10	IT	717	1.32	12	100.00	
11	IN	690	1.27	12	100.00	
12	SO	640	1.18	12	100.00	
13	IS	622	1.14	12	100.00	
14	WITH	588	1.08	12	100.00	
15	YOU	558	1.03	12	100.00	
16	HIM	533	0.98	12	100.00	
17	FOR	477	0.88	12	100.00	
18	BUT	471	0.87	12	100.00	
19	BECAUSE	427	0.79	12	100.00	
20	HIS	416	0.77	12	100.00	

The screenshot displays a word list for the corpus of transcripts from Case 1 interviews, showing the twenty most frequently appearing words in those texts. The frequencies of particular words could be compared to the corpus of Case 2 interviews, for example, and this was in fact done in relation to pronoun usage as part of the analysis of intertextuality (see Chapter 6, Section 6.3). Another function of Wordsmith was to generate concordance tables showing how particular terms appeared in context across the whole corpus of texts, and these tables could be used to verify the issues emerging from the analytical memos. The contribution of Wordsmith was therefore in line with what Mautner (2009) calls ‘checks and balances’ to support interpretation within a CDA framework, by helping to make sure that findings were grounded in the actual texts.

The final stage of the analysis was to draw connections and contrasts between the findings from the analytical categories. The aim here was to link the different ways in which accounts were constructed to wider social practices relevant to the research topic. As with IPA, this final stage was the most interpretative part of the process, and therefore most dependent on the researcher (see below). An important reference point here was the critique of technocratic ‘expert systems’, and the place of practitioners within those systems, which had emerged from the literature review. As noted in Section 4.5.2, such critiques generally form part of the rationale for choosing CDA over other methodological approaches, and provide a focus for the detailed textual analysis that ensues. Different discursive practices arising from the analytical categories were therefore linked together under the umbrella of three different ‘orders of discourse’, which were seen as significant in shaping the account participants gave of their work on these complex cases. The characteristics of these orders of discourse are discussed in the conclusion to Chapter 6.

4.7 Quality in qualitative research

This final section will consider how the aim of producing ‘good’ qualitative research was addressed in this study. The starting point might be seen as the ethical principles described earlier in Section 4.6.1. Various authors have provided guidelines for qualitative research, often in the form of a list of criteria (e.g. Leiniger, 1994, Yardley, 2000, Elliot et al., 1999). It could be argued that no single framework can fit the variety of epistemological and ontological concerns addressed by different research methods, particularly in pluralist study designs such as this one. However, there do seem to be some common concerns in addressing questions of quality, and these will be addressed below under the headings of reflexivity, credibility and transferability.

4.7.1 Reflexivity

Willig (2008: 10) describes reflexivity in the research context as involving ‘an awareness of the researcher’s own contribution to the construction of meanings throughout the research process’, and so acknowledging ‘the impossibility of remaining “outside of” one’s subject matter while conducting research’. Similar definitions can be found in other discussions, e.g. Etherington (2004: 32). Willig goes on to distinguish between ‘personal’ and ‘epistemological’ reflexivity. Personal reflexivity requires researchers to consider their involvement in their own research as people with

particular interests, values and preconceptions, some of which may themselves be changed in the process. Epistemological reflexivity has to do with how the research process itself helps to shape the knowledge that is produced, e.g. through the framing of research questions, or the design of a study. Both types of reflexivity will be considered here.

4.7.1.1 Personal reflexivity

Researchers impose their own ideas at every stage of the research process, from formulating the initial research question to writing up the final report. This contribution is acknowledged in the critical realist paradigm, which emphasises the 'double hermeneutic' involved as researchers try to make sense of how other people make sense of reality (Danermark et al., 2002). Reference to the double hermeneutic is also widespread in the IPA literature (e.g. Smith et al., 2009; Smith and Osborn, 2003), while CDA openly adopts a stance of critique, for example in focusing on 'a social wrong in its semiotic aspect' (Fairclough, 2009: 174). It is therefore advisable for qualitative researchers to practise in a reflective manner and openly acknowledge their influence on the results of their research. In this study, reflections on various aspects of 'doing a PhD' were made as handwritten notes in a dedicated notebook and as 'free memos' (i.e. not linked to transcripts) in ATLAS.ti.

Speaking now as the researcher, a major personal influence on this piece of research has been my previous experience as a social worker. This certainly played a part in the choice of topic, since 'complex cases' were those with which I was most preoccupied as a practitioner. However, it also fed through into every other stage of the research. When it came to approaching agencies and practitioners, for instance, I would often identify myself as a social worker as well as a researcher, in the belief that this would make people more receptive to taking part, i.e. I would be seen as a 'fellow professional' as opposed to an intrusive academic. This may indeed have helped in terms of gaining access to research sites, but when it came to the participants I was concerned that such a perception might actually inhibit them from talking about their casework and allowing it to be 'exposed' to another practitioner. I therefore became conscious about foregrounding my formal role within the research process. Yet the importance of creating rapport in interviews meant this was a difficult balance to strike, and some participants did refer to my professional background in their interviews (e.g. 'as a social worker you'll know this...'), suggesting that their knowledge about me might also have influenced the 'data' they were inclined to give me. When it came to

interpreting the transcripts, I was also aware of the temptation to analyse the cases themselves, rather than what practitioners were saying about the cases, and often spent time reviewing memos and themes to try and disentangle the two. And equally, the reverse was also true, since what other participants said about working together on these cases also made me reflect on my own practice and gave me new insights into past experiences.

4.7.1.2 Epistemological reflexivity

Epistemological reflexivity is inherent in the 'double hermeneutic' of qualitative research, if one accepts that producing knowledge about society is itself a social process (Danermark et al., 2002). In this study, boundaries of interpretation and explanation were established in the acts of defining a research topic, formulating a theoretical framework, and deciding on a study design. Although the IPA part of the study aimed for an 'insider's perspective' on complexity, as experienced and perceived by participants, interpretation was ultimately guided by the preferences and characteristics of the researcher. Equally, while the CDA part of the study aimed to explore how complexity was constructed in texts attributed to participants, those texts had actually been generated by the research process. Whereas most of a given interview would consist of the participant speaking, it was the interviewer who had control over the overall line of questioning, turn-taking, what questions were asked, what areas were followed up, and so on. In effect, the researcher was the hidden 'co-author' of the text, however minimal or open-ended he might try to make his own contribution. By way of illustration, an extract from an interview is given below:

I: 'He has some complex issues in that he is diagnosed as having ADHD and also has been possibly diagnosed as having Asperger's but on the lower spectrum and it wasn't 100% clear and there seems to be a little bit more investigation is being done as to what his true diagnosis was.'

Q: 'So there is still a bit of uncertainty about the diagnosis?'

I: 'Yes to some degree. I mean generally speaking, I think it's generally accepted that there is a bit of ADHD linked with a little bit of Asperger's syndrome, albeit at the higher functioning level.'

[C105, mentor]

Here the interviewee (I) is referring to one aspect of the complexity of the case, which is the possible impact on the young person's behaviour of two different medical conditions. The questioner (Q) picks up on the lack of clarity about diagnosis, and rephrases it as a question about 'uncertainty'. The interviewee qualifies his initial response by observing that the core group has in practice 'generally accepted' a composite diagnosis that seems to reflect the young person's multiple needs. The interviewer has therefore influenced what is said in this extract in two ways: firstly by prompting a further reflection on diagnosis, and secondly by inviting the speaker to consider the issue of uncertainty. Similar processes would doubtless be observable in other parts of the interview, and indeed throughout the whole chain of knowledge production. The next sections will therefore look at how credible and transferable such knowledge can be said to be.

4.7.2 Credibility

The term 'credibility' is here understood as referring to the dependability, authenticity and trustworthiness of the information presented and the knowledge claims made in a study (Morris, 2006, Guba and Lincoln, 2005, Neuman, 2006). In this respect, some of the authors just cited differentiate between the concepts of 'reliability', meaning the consistency of techniques used to make observations, and 'validity', meaning the accuracy of the observations that are made. Arguably, this is a distinction that derives from quantitative methodology, with its emphasis on operationalising concepts as empirical measures, and is therefore somewhat problematic for qualitative research. While qualitative researchers aim to be as consistent as possible in how they observe and interpret social reality, the relationship between themselves and their data is an evolving and interactive one, subject to a unique mix of circumstance, context and interpretation. It is also important not to overlook the diversity of subjective viewpoints that make up the essence of a social phenomenon. Furthermore, a critical realist ontology and epistemology leads away from the kind of study design that relies on positivist/quantitative notions of validity. Nonetheless, issues of authenticity and fairness are crucial for any study concerned with the experiential aspect of human life, as is the question of trustworthiness for research adopting a critical perspective. In this study, following the discussion in Smith et al. (2009: 179-185), credibility is argued to derive from three attributes: conformance with general principles of research practice, independent audit, and triangulation. They are discussed in turn below.

4.7.2.1 Principles of good research practice

Yardley (2000) outlines four broad principles for evaluating research practice: sensitivity to context, commitment and rigour, transparency and coherence, impact and importance. These deal not only with reliability and validity, but also with how research is carried out and what is done with the resulting data. In this study, sensitivity to context was demonstrated by gaining an in-depth understanding of the research topic, fully explaining the research to potential participants and their agency managers, as well as preparing thoroughly for interviews and conducting them with tact, empathy, and skill. Care was taken to ground analytic claims in the raw data, and include verbatim extracts in order to give participants a voice in the completed study. Secondly, commitment to the study was demonstrated by the researcher's personal investment of three years of time and energy. The study was carried out in a rigorous manner, which meant carefully preparing for interviews, carrying them out to a high standard, and completing the analysis for all the data collected. Thirdly, the final thesis has aimed to set out an overall argument and presentation of themes in a transparent and coherent manner, with ambiguous or contradictory results highlighted and dealt with consistently. Finally, an effort has been made to disseminate and discuss findings with the participating agencies and the wider academic and professional community, through research summaries, conference presentations and journal articles. The real test of any kind of research is whether its findings and conclusions are considered interesting, important or useful, although this is something that will only become evident over time.

4.7.2.2 Independent audit

Yin (2009) suggests researchers set up a 'case study database' as a means of filing all the information relating to a study in a way that can be easily accessed and retrieved. This enhances the credibility of research by providing a 'chain of evidence' that can be followed and verified by others. In this study, almost all the information pertaining to the study was organised in folders on a password-protected computer, and linked to the ATLAS.ti analytical software. This made it easy to construct a virtual 'paper trail', linking conclusions and findings to analytical notes and observations, then to empirical data such as documents and interview transcripts, the methods adopted to elicit those data, and ultimately to initial hypotheses and research questions. For the researcher, this had the benefit of facilitating analysis and encouraging a disciplined approach. It also allowed his academic supervisors not only to inspect the overall progress of the research but

also to view the methodological approach first-hand. Smith et al. (2009: 183-84) refer to such checks as an 'independent audit' of the research. But as they point out, knowledge claims in qualitative research are more about plausibility than proximity to exact truth – there may be a number of possible claims but the credibility of particular claims may be judged according to 'how systematically and transparently' they have been produced.

4.7.2.3 Triangulation

Triangulation in research methodology is a metaphorical term based on 'the idea that looking at something from multiple points of view improves accuracy' (Neuman, 2006: 149). In qualitative research, triangulation is usually associated with using a combination of methods, observers or theoretical approaches to gain an 'in-depth understanding of the phenomenon in question' (Guba and Lincoln, 2005: 5). In this study, a dual form of triangulation was built into the research design due to there being two cases as well as two main research methods. The perspectives of IPA and CDA enable participants' personal lived experiences to be complemented with an exploration of how those experiences are constructed, bringing a more diverse interpretative lens to bear on the research question. At the same time, studying professional networks in two different cases allowed for a comparative element to feed into the generation of theoretical ideas.

4.7.3 Transferability

It was observed in Section 4.3.1 that while social research within a critical realist paradigm does aim to make generalising claims that go beyond the idiographic account, it acknowledges the impossibility of establishing universal social laws (Byrne, 2009a). In other words, explanations of social phenomena arrived at in one study *may* be applicable to other settings, a characteristic that has been described as 'transferability' (Morris, 2006: 198). Indeed one of the points of good research practice as described above is to create the conditions for transferability by providing the reader of a research report with sufficient contextual information, including a detailed description of methodological procedures. Other aspects of the study design might also be seen as enhancing transferability, such as the triangulation of research methods and the sampling of two cases to provide a comparative basis for the findings. Transferability may also be viewed as part of the

impact of a study. As such it is decided by the reader first and foremost, who must evaluate its contribution to the knowledge base on a given topic.

4.8 Summary

This chapter has set out the aims of the study and the methodological approach for addressing the research question. A pluralist qualitative approach was described, employing two complementary research methods, interpretative phenomenological analysis (IPA) and critical discourse analysis (CDA), within a case-based study design. The research process was described, including ethical considerations, the sampling of cases and data collection using semi-structured interviews. The process of analysis was described for both methods, using examples to illustrate how findings were generated from transcripts. Finally, issues of quality in research of this nature were considered, focusing on reflexivity, credibility and transferability. The next two chapters will proceed to set out the findings from the study, looking first at the interpretative phenomenological analysis of interviews with practitioners.

5. Interpretative phenomenological analysis

5.1 Introduction

This chapter will present the findings of an interpretative phenomenological analysis (IPA) of interview transcripts. Here the question to be explored is how the participants experienced complexity, and made sense of that experience, in the context of working together on the two cases sampled for the study. The chapter is divided into five main sections: causality, relationships, assessment, intervention and risk. Superordinate themes from the IPA are grouped within these categories, which serve to connect the thematic analysis to the literature review and theoretical framework that were set out in earlier chapters. The categories admittedly owe something to the study's design, since it would be hard to imagine practitioners not touching on any of these topics when invited to talk about complexity in an ongoing case. Nonetheless, the idiographic sensibility of IPA is intended to draw out both what is shared and what is divergent in the way people make sense of a phenomenon, here 'complexity'. Each superordinate theme, which describes a degree of commonality in the way participants made sense of complexity, therefore retains its original sub-themes, a finer grain of differing emphasis and distinction that enables a comparison of accounts between cases, and between practitioners at different stages of the case. The result is an interpretative narrative of findings, which sets out general patterns of shared experience without losing sight of individual perspectives.

For reference purposes, since the findings will frequently compare experience across cases, the characteristics of the two cases sampled for the study are reproduced below in Table 5a:

Table 5a. Overview of cases

	Case 1	Case 2
<i>Family make-up</i>	Mother, son	Mother, father, 3 sons, one daughter
<i>Ethnicity</i>	Black British Caribbean	White British
<i>Subject of child protection plan</i>	14-year-old boy, 'Martin'	7-year-old boy, 'David'
<i>Duration of plan</i>	18 months	2 months
<i>Main issues</i>	Out of parental control Out of education Involvement in criminal offences Vulnerability to abuse (in community)	Neglect and lack of supervision Fire-setting in the home (risk to siblings) Aggressive and sometimes violent behaviour towards family members
<i>Participating practitioners in core group</i>	Social worker (C101) Youth worker (C104) Mentor (C105) YOT mentor (C107) CAMHS psychiatrist (C108) YOT case worker (C109) School nurse (C110) FIP worker (C111) YOT case worker (C112) School keyworker (C113)	Primary school head (C201) Fire prevention officer (C203) CAMHS specialty doctor (C204) Family support worker (C205) Young carers (manager) (C206) Social worker (C207) Family support worker (C208)

Quotations will be attributed using the participant code given in brackets (e.g. 'C107'), as well as the practitioner's background (e.g. 'YOT mentor'), and whether it was the first or second round of interviews (i.e. '1' or '2'). A quotation from the first round of interviews with the YOT mentor working in Case 1, would therefore be attributed as: [C107, YOT mentor (1)]. The next section will begin the account of IPA findings, looking first at superordinate themes relating to causality.

5.2 Causality

It was seen in Chapter 3 that propositions about cause and effect lie at the heart of theoretical accounts of complexity. Concepts such as non-linearity and self-organisation describe the causal dynamics of open adaptive systems, as part of an effort to explain (if not exactly predict) the 'behaviour' of such systems. Though they might use different terminology, practitioners involved in complex cases are also concerned with causal processes. Their job requires them to assess problems, devise a strategy to resolve those problems, and intervene in people's lives to try and bring about change. All of these tasks involve an understanding of cause and effect – or at least a set of assumptions about it. In that sense, issues of causality might be said to permeate most functions of casework, most evidently in matters of assessment or diagnosis. Nevertheless, the themes explored in this section point to a particular aspect of the experience of complex cases, which is the way 'causality' becomes a problematic area in itself. The discussion of causality will comprise two superordinate themes, beginning with the exploration of cause and effect in participants' accounts, before considering their perceived lack of control over events in these complex cases.

5.2.1 Exploration of cause and effect

Exploration of cause and effect incorporated three main sub-themes: 'multiple factors', 'chain of events', and 'critical periods and events'. The first of these is familiar from the literature (see Chapter 2, Section 2.2.7), since core groups in complex child protection cases can generally expect to deal with multiple problems. The interrelationship between multiple needs makes it difficult either to identify one 'main' problem, or alternatively to tackle those needs on a piecemeal basis. The theme of multiple factors was particularly significant in the first case, and was often mentioned by practitioners with responsibility for assessment, such as the CAMHS psychiatrist (C108), and for coordinating interventions, such as the social worker (C101). Practitioners referred to the difficulty of resolving multiplicity of need into a clear cause for the young person's troubled behaviour:

'There's probably not a neat straightforward answer, I think it's a combination of his family life, his home background, his own special needs he's got - if you put all that together and sort of stir it up a little bit you've got Martin.'

[C109, YOT worker (1)].

The lack of a 'straightforward answer' to the young man and his problems brings the case into the realm of 'wicked problems' described by Rittel and Webber (1973). On the other hand, the practitioners were taking one step towards defining the problem, in that such observations tended to focus on the young person himself. In other words, he was perceived as the embodiment of all the different interacting factors. As another practitioner observed during a second round interview, 'the main issue with Martin is Martin, you know!' [C101, social worker, (2)]. The practitioners in Case 1 therefore saw much of their activity as geared towards understanding and influencing the young person's behaviour, which then was attributed to an array of complex interacting factors. In the sense described by Nybell (2001), the young person had come to be seen as a 'complex system' in his own right.

There was a rather different emphasis in Case 2. Multiple factors were mentioned by practitioners who were in close contact with the parents, such as the headteacher (C201) and the fire prevention officer (C203). This seemed to reflect the perception that the problematic behaviour of the youngest child, David, was part of a broader context of family dynamics as well as the interactions between parents and practitioners. Characteristics of the parents as well as siblings were seen as key to the multiplicity of need:

'You've got the disability of the father that adds another dimension. And actually you've got mum herself who has issues, so actually it's not just one child, two children, or even the three children that are here, I'm concerned ... but about the two adults involved as well.'

[C201, headteacher (1)].

Factors such as age and family context meant that practitioners in this case were reluctant to locate causality in the person of the child, at least to the same extent as in Case 1. David's needs, in contrast, were seen as inextricably bound up with those of his parents and siblings. At the same time, the search for a single, plausible reason for the difficulties experienced by the family led to competing explanations for what is wrong. While the parents preferred to present their son's behaviour as symptoms of a medical condition, such as ADHD, practitioners saw the fundamental issue as a lack of consistent parenting in the home. As will be seen in later sections, conflict between these positions drove much of the dynamics in Case 2.

The second sub-theme around cause and effect was the idea of a 'chain of events', often associated with an account of the case history or chronology. What might be considered 'background information' to the case tended also to convey a narrative about causality, i.e. what had happened to lead to the current state of affairs. In Case 1, most of the participants referred to a series of events starting around the time of Martin's transition from primary to secondary school. The common elements in their accounts posited a causal chain that may be summarised as follows: Martin's inappropriate behaviour in school, possibly linked to learning disabilities as well as to aspects of his upbringing and childhood experiences, led to him being excluded from mainstream education aged 11, whereupon a failure to provide necessary support and resources meant that he remained excluded for a lengthy period, during which time his behaviour, influenced by peers, escalated into anti-social and criminal activities. Most of those interviewed, other than the CAMHS psychiatrist (C108) and the educational keyworker (C113), reproduced some version of that sequence of events – for reasons that might have to do with the dynamics of the core group (see Section 5.3.1).

In Case 2 there was less emphasis on a linear chain of events when describing the context to the case, but rather on a cyclical pattern of engagement and disengagement, which had recently been disrupted by the intervention of child protection services in respect of the youngest child. Since causality was seen as tied up in the multiplicity of need within the household as a whole, it was hard for practitioners to provide a sequential narrative, other than to point out how the locus of concern in the family had shifted historically from one family member, child or adult, to another. Unlike in Case 1, the contextual picture emerged through successive practitioner's accounts, rather than being consistently represented throughout. For example, the practitioner from the young carers service (C205) recalled that when she first met the parents, it was not David but rather his oldest brother, whom they had wanted to be referred to CAMHS. The family support worker (C208), on the other hand, remembered concerns about the emotional wellbeing of the 'middle' brother. Towards the end of the second stage of interviews, there were signs that the next shift might be occurring, with attention now moving away from David's behavioural difficulties and towards his sister's learning needs in school.

The third sub-theme was 'critical periods and events', which were experienced as significant for causality in two respects. Firstly, such events would emerge suddenly from a host of contributory factors; and secondly, they would then trigger off other (often adverse) consequences. The sense

of 'lurching from crisis to crisis' [C110, school nurse (1)] was conveyed by several of the practitioners in Case 1, particularly the social worker (C101), youth worker (C109) and FIP worker (C111). As well as these one-off incidents, which were usually precipitated by the young person's own actions, participants also recalled critical periods in which the potential for trouble seemed to escalate. The transition from primary to secondary school, along with the intervening summer holiday, was widely perceived as a critical time when things 'went wrong' for Martin. Practitioners who had developed a close relationship with Martin, such as his mentor (C105) and social worker (C101), referred to an incident during the summer holidays, before starting secondary school, in which Martin had sustained a serious injury while associating with older peers in the community. Since it was unclear what had actually happened, it was difficult to say how much the incident had contributed to his subsequent behaviour, but it was generally felt that Martin's propensity to associate with older peers made him vulnerable to being exploited, e.g. by being drawn into criminal activities.

For practitioners in Case 2, there was an overall sense that critical events were emerging periodically out of the troubled dynamics of the family. The summer holidays were also seen as a 'telling time' [C201, headteacher (1)], when there was a particular need for services to support families who were under stress. In contrast to Case 1, crisis situations were confined to the home and were often brought to the practitioners' attention by the parents themselves. The most frequently cited example was an incident when David injured his sister during an argument, which was considered serious enough to warrant the involvement of child protection services. However, it was the fact that this incident occurred against a backdrop of other worrying events and behaviour, such as fire setting in the home, that tended to confirm the sense of a family in crisis:

'I think that's the thing, you can have a critical incident but that's almost like a one-off, because there's nothing else there, whereas you can have, you know, several critical incidents and then that's more of a risk to a child than maybe just a one-off.'

[C206, social worker (1)].

The social worker here expresses the idea that a succession of incidents may serve as a warning sign about risk to children's safety. In complexity terms, a series of worrying but apparently isolated events could be interpreted as a cumulative indicator of the system approaching a tipping point, and this would logically feed through into a heightened perception of risk. In this respect, it

was interesting to note that most of the participants referred to a professionals meeting, held a few weeks before the actual child protection conference, as a turning point in the case. Of course, this was by no means the first network meeting to be held about the family, but appears to have been the first in which a number of key issues were openly voiced and shared. The reasons for this will be explored in later sections, but in terms of causality this meeting was felt to be significant because it triggered a number of changes in the way the case was perceived.

5.2.2 Lack of control over events

The second superordinate theme around causality related to practitioners' perception that they lacked control over events, which in turn encompassed the sub-themes of 'volatility', 'surface and depth', and 'unwanted consequences'. Volatility was a significant theme for almost all the participants, and was attributed to a range of phenomena, including behaviour, relationships, or the overall course of events. In both cases, observations about volatility threw up some suggestive parallels between identity and behaviour, i.e. between what people 'are', as opposed to what their actions 'mean' for others:

'He's such a potential volcano. Because you don't know whether he's going to go completely off the rails again or whether he will actually be really chuffed with himself'

[C203, fire prevention officer (2)].

'For us it was incredibly frustrating when those moments of crisis arose... they boiled up into this kind of volcano-type eruption and then nothing occurred, nothing changed – and so it kind of then receded and just carried on again bubbling under the surface until we hit crisis point again'

[C110, school nurse (1)].

Both practitioners here draw on the same image of the volcano, in the first example to describe the characteristics, or nature of a person, and in the second to describe the pattern of events characterised by a person's behaviour. Causality on a number of levels thus becomes associated with powerful, unpredictable and uncontrollable natural forces. One striking result of this, already evident in the above quotations, was a prevalent notion of the 'unstable' child, who is temperamentally explosive and therefore defies some of the conventional expectations of adults, e.g. that children should be malleable, controllable – or at the very least knowable. In contrast, the

children at the centre of these cases were seen by most practitioners as exceptionally volatile; for example, their behaviour could switch quite quickly, e.g. between likeability and aggression, depending on context or behavioural ‘triggers’.

Unsurprisingly, this type of observation tended to be made by practitioners who had a lot of direct contact with the child, and so was particularly a feature of Case 1, in which most of the practitioners interviewed had spent time doing one-to-one work with Martin. This could certainly be challenging, since Martin tended to react badly to authority or to being told ‘no’. However, just as importantly, he could also be very rewarding to work with. Far from being the stereotypical delinquent teenager, Martin was described as unusually bright and responsive for an adolescent in his situation. By the time the second round of interviews took place, he had started to attend a residential day school located well outside his home area, returning home at the weekends. The stark contrast between his regimented routine at school and a more freewheeling existence at home, led his school keyworker to observe that Martin appeared to be leading ‘two different lives’ [C113, school keyworker (2)]. A further interpretative step might be to view this as an insight into how *volatility* – of the case and of the young person – comes to be perceived in terms of a ‘Jekyll and Hyde’ struggle, not only between different personal qualities – but also between positive and negative outcomes.

In Case 2 the focus of practitioners tended to be less on the individual child and more on the volatility of family dynamics and the interactions of parents with practitioners. Exceptions to this were the two practitioners, the fire prevention officer (C203) and the first family support worker (C208), who had undertaken most of the direct work with the youngest child, David. They both commented on how he had become a powerful figure within the family, able through his extreme behaviour to ‘push’ his parents as well as bully his older siblings. An interesting aspect of Case 2 was how communication between practitioners became necessary to establish a multi-faceted view of David, for example in revealing that he displayed different behaviour in different contexts. This observation proved significant in terms of allowing practitioners collectively to challenge the parents’ view that David’s difficulties were caused by ADHD. Because of the history of parental disagreements with services, practitioners felt they needed to reduce the cycle of conflict in order to refocus attention on the children within the family system. This contrasts with the situation in Case 1, in which the parent seemed acquiescent to professional involvement but her son was seen as beyond parental control. In that case, while efforts were made to improve the relationship

between mother and son, interventions ended up focusing more on the young person and trying to exert influence on his decisions and actions.

A second sub-theme around lack of control concerned the idea of 'surface and depth', recalling the discussion in Chapter 3 in relation to semi-submerged causal tendencies (see Section 3.3.2). This theme was also implicit in the 'volcano' imagery mentioned above. In Case 1 two practitioners spoke similarly of events 'bubbling up' and 'bubbling under the surface' [C104, youth worker and C110, school nurse, (1)]. Particularly during critical periods or times of transition, troubling issues would start to force their way to the surface until they became known to practitioners. Participants in both cases commented on the importance of 'underlying' problems, and described situations when hitherto unknown information was 'revealed' or 'disclosed'. Even in the second round of interviews, when some of the practitioners did feel able to acknowledge that their work had resulted in progress, there was also a sense of foreboding about what might still be to come:

'But the thing is we are all just holding our breath because this has only been a very short amount of time. This stability has only really been since the very end of August, start of September, was when it sort of settled into how it is now and there's only been a couple of blips, but we are all still waiting to see how long he can maintain it for'
[C101, social worker (2)].

In other words, practitioners remained uneasily aware of the potential for plans to go awry, or for relationships that appeared to have stabilised to suddenly be thrown into disarray by unforeseen events. This connected to the third sub-theme, that of 'unplanned consequences'. In complexity terms, services were hoping for planned systemic change, a new and stable configuration that was self-sustaining – unlike the previous pattern in both cases, which demanded regular professional intervention because periods of relative calm would be punctuated by unpredictable crises. Unfortunately, without the benefit of hindsight it is hard to distinguish whether such a shift has occurred. It was therefore understandable that the social worker quoted above was wary about reading too much into the 'stability' that has followed such a long period of chaos. Other practitioners in Case 2 express hope that the recent turbulence in the family, and the concomitant impact of child protection plans, might be the critical period that yields a change for the better. But at the same time they cannot help but worry that it might not:

'Q: At this stage in this case what do you think are the main uncertainties?

I: I think sustainability, sustainability... But I think it's also because they are growing at the same time. Because actually, if you think about it, they are still very young, as young adults. [...]I think they are trying to get themselves out of any cycle but they find that quite difficult'

[C201, headteacher (2)].

The practitioner (I) here alludes to the potential for the parents to develop and change, something that provokes both optimism and doubt. She goes on to observe that although the children's mother is making a great effort to address her children's needs, in doing so she still has a tendency to ignore her own. The results of intervening in complex systems may be far-reaching but not as intended, and practitioners therefore face an unenviable task in trying both to set in motion and then control the type of critical periods that lead to wholesale change. Even limited interventions may provoke unwanted consequences, as some of the practitioners in Case 1 found when arranging home education for Martin; designed as a stop-gap measure, this ended up being the only educational provision he received for a number of months, exacerbating tensions with his mother as well as encouraging him to abscond and associate with other marginalised young people in the community. On the other hand, interventions that appear to work out badly may have an unexpectedly positive effect. Martin's brief and unsuccessful stint in foster care may have been an example of this, according to his social worker – since following his return home he managed to stay out of trouble for most of the summer.

5.2.3 Summary

The way practitioners explored cause and effect in their accounts provided some interesting links to theoretical ideas about complex systems behaviour (see Chapter 3. Section 3.2). These cases presented practitioners with 'wicked problems', since the interaction of multiple needs made it difficult to pin down cause and effect. Nevertheless, most participants had a view on the chain of events that had led to the present situation. In Case 1, practitioners presented a consistent story, a linear sequence based mainly on the behaviour and activities of the young person. In Case 2, a cyclical pattern of events emerged from a combination of perspectives, based mainly around family dynamics. This finding appeared to be linked to the way practitioners interpreted the 'site' of causality, or the system to be targeted. In Case 1, the focus was on the young person as a complex system in his own right, whereas in Case 2, the focus was on the family system. In both

systems, there was a perceived tendency for critical periods to build up towards periodic crises, usually manifested as an escalation in individual behaviour (Case 1) or in familial conflict and confrontation with services (Case 2). While their interventions were often designed to try and nudge these systems towards stability, the potential for unwanted consequences was a troubling issue for some.

A second major theme was a lack of control over events. Practitioners felt that aspects of the case had gotten 'out of control', so that finding ways to shape the course of events became a paramount consideration. This was made difficult by the uncertain dynamics of cause and effect but also the volatility associated with change in complex systems, and often associated with the crisis situations and critical periods discussed above. The experience of volatility was likened to uncontrollable natural phenomena such as the volcano, with submerged forces felt to be 'bubbling' underneath the surface. Practitioners whose role involved a lot of one-to-one work, such as mentors and family support workers, often drew attention to the child or young person as challenging and unpredictable. Particularly in Case 1, practitioners would sometimes see-saw between positive and negative evaluations, both of the young person and his situation, in a way that brought to mind the 'Jekyll and Hyde' metaphor of duality and ambivalence, but also reflected the uncertainty of possible outcomes. In Case 2, on the other hand, there was an effort to shift emphasis away from the idea of reducing volatile behaviour in the individual and towards implementing systemic change in the family as a whole.

5.3 Relationships

The foregoing analysis showed how the way that participants experienced certain aspects of causality reflected some characteristic dynamics of change in complex systems. But this is not to suggest that they were somehow at the mercy of the impersonal 'forces' of complexity. As noted in Chapter 3, social systems are uniquely human in their workings, and the dynamics of cause and effect are largely down to the interactions and affiliations between people (see Section 3.2.3). The discussion will therefore shift now to a consideration of relationships, as experienced by the practitioners working together on these cases. This was an important topic, since most participants found building and maintaining constructive relationships with families, professionals, managers and others, to be a prerequisite for anything else they wished to achieve. Three superordinate themes will be explored under this general heading. Firstly there were a number of

issues relating to acceptance and rejection, with their parallels in a shifting pattern of alliances and fault-lines between different stakeholders in the case. Secondly, there was the experience of managing a variety of relationships in each case, and maintaining a balance between them. Thirdly, there was perception of areas of conflict and disagreement, between professionals as well as with service users.

5.3.1 Dynamics of acceptance and rejection

The experience of relationships in these cases reflected the tendency for patterns of affiliation in the respective core groups to be affected by the variable response of families to practitioners and their interventions. The superordinate theme around dynamics of acceptance and rejection covered related sub-themes of 'hostility and acceptance', 'isolation' and 'togetherness'. In other words, practitioners talked about their involvement being accepted or rejected by family members, about belonging to a group of collaborating professionals, or conversely about working in a relatively isolated way.

In Case 1, one of the key drivers of relationships was the sense of common purpose and identity forged by an inner core of practitioners within the professional network. This has already been touched on above in the section on causality, where it was observed that despite all the uncertainty and unpredictability surrounding cause and effect, most of the practitioners were pretty consistent when it came to the case history. For those involved in the case from an early stage, a common perception was that social care services had failed to act promptly or effectively. This was a potential source of difficulty for the social worker (C101), who had taken over the case after eighteen months of little or no progress, and therefore had to try and alleviate the accumulated scepticism and frustration of her fellow professionals. Indeed, the social worker was the only practitioner in Case 1 to talk about hostility, either from other practitioners or service users, other than the school nurse (C110). Fortunately she already had an 'ally' in the core group, having previously worked successfully with the school nurse on a few other cases:

'At least there was one person in the core group that already knew me as a professional, and was therefore not feeling hostile towards me coming into the core group . She knew that I would come in and try and make sense of it and then try and get going with the work as soon as possible.'

[C101, social worker (1)].

The social worker therefore had the benefit of having someone 'on the inside' to help convince the core group that they should give her a chance to demonstrate her commitment and competence. There were other signs that the core group, having formed a cohesive view of what had happened, as well as what needed to happen, tended to take a dim view of outsiders who did not share their collective view. For instance, the long process of getting approval and funding for resources was presented in terms of obstructive and bureaucratic 'red tape' [C111, FIP worker (1)]. Three participants [C101, social worker, C104, youth worker, and C111, school nurse] complained of the resistance they encountered in getting CAMHS to reassess Martin's mental health needs, which was seen less as a difference of opinion and more as symptomatic of a lack of respect on the part of that service for their own expertise and experience. Whether this was a fair comment is hard to say, but it seemed to contribute to a shared view that practitioners were fighting against the odds to obtain the right services for the young person.

A dynamic of inclusion and exclusion might be seen as integral to any group, particularly one that develops a sense of mutual solidarity in the face of intractable problems. The participants who were involved in the early stages of Case 1, such as the school nurse and the youth worker, started off as isolated practitioners attempting to deal with the fallout from Martin's exclusion from school. Later, as the core group took shape, practitioners such as youth justice workers and mentors came on board and became part of the group, while other agencies such as CAMHS and (to begin with) social care remained on the periphery. Meanwhile, at the centre of all this activity, Martin himself was also subjected to conflicting pulls of acceptance and rejection – having been cut off from mainstream education, he was increasingly drawn into the orbit of inappropriate peer groups, but was also able to engage positively with a variety of professionals seeking to 'reintegrate' him. The accounts of these relationships portray a dynamic tension between isolation and belonging, between togetherness and separateness, that is never fully resolved.

Some of the same dynamics were apparent in Case 2, although with rather a different emphasis. Unlike in Case 1, the family itself seemed to play a significant role in determining the density, and to some extent the composition, of the professional network. A key issue was whether certain services or approaches were accepted or rejected by the parents. Many of the participants commented that the mother could be quite aggressive and even verbally abusive at times. Hostility and lack of cooperation would therefore cause some agencies to retreat, while the

parents might also take action themselves, e.g. they had previously changed their children's school due to a disagreement with staff. To the extent that the network could be said to have developed an inner core, this reflected at least an element of parental choice. In other words, the 'core' consisted of those practitioners who had been able to remain on good terms with the parents long enough to form a working relationship with them:

'So [family support worker], [fire prevention officer] - I like to think me as well - have been instrumental in bringing about what's needed to her. And I'm not going to discount the social worker, but it's those things that have actually made a difference - because those, the three of us specifically, and I can add [social worker] in, have actually had the time to speak to mum and have the conversation with her.'

[C201, headteacher (2)].

Here the headteacher singles out the contribution of a trio of practitioners at the heart of the case, including herself, who she feels have managed to sustain a constructive dialogue with the children's mother. Similar sentiments were expressed by the fire prevention officer [C203 (2)]. However, it is worth pointing out a parallel development in the case that is partially obscured by these comments. The family support worker to whom both these practitioners were referring actually stopped working with the family after the first round of interviews, when his agency decided to close the case. By the time the second round of interviews took place, the family had been referred for parenting support to a different agency, a family centre, who had in turn allocated another support worker. Yet the involvement of the latter was barely mentioned by the other two practitioners in their second interviews. Indeed, the experiences of the two family support workers make for a telling contrast, as the following quotations demonstrate:

'The parents are actually working with me whereas before I think, to be honest, criticising other agencies was how they were... Literally I would go in there and "the social worker is this, that", "they said this, that"... But now I think they are taking it on board and now I am seeing change in the parents and they are putting things in place for the young people.'

[C208, family support worker (1)].

'I have written letters, have made appointments, have been ringing. And they know where we are. So I don't know why... unless things have progressed. The family might feel they are managing and his behaviour is quite calm, so they don't need the intervention'.

[C207, family support worker, (2)].

Whereas the first worker appears to have regular access to the family and has succeeded in being accepted by them, the second worker in contrast presents a rather isolated picture, her intervention has barely got off the ground. Almost as striking is the difference in knowledge of what is going on – the first family support worker places himself at the heart of the case ('I am seeing change') whereas the second places herself on the outer margin ('I don't know why'). The differences between these two accounts are a reminder of how this service, like most, ultimately depends on the quality of relationships, between practitioners and clients, as well as between practitioners. Equally it is a truism of any relationship that there will be some 'ups and downs' along the way; the manager of the young carers service wryly observes at one point, 'they fall in and out of love with us' [C205, young carers service, (1)], citing sporadic disagreements with the parents over which of their children are eligible for the service. Flux within a particular relationship might therefore also influence who will become part of the 'inner' core group at a given time, or who will assume a more peripheral role. Another service treading the path from centre to periphery was CAMHS. Their involvement had been welcomed by the other practitioners, since their assessment had been able to resolve the question of an ADHD diagnosis. However, since their assessment was vehemently disputed by the parents, who stopped cooperating with the service, CAMHS felt unable to offer further support and closed the case. As we shall see in Section 5.3.3, this withdrawal had repercussions for the network. For practitioners who remained in the network, maintaining all these different relationships entailed a lot of effort in itself, as will be discussed below.

5.3.2 Managing the relationship

Managing relationships was a key concern for practitioners, who discussed the careful balancing act of working with each other and with families in often fraught and sensitive circumstances. The interrelated sub-themes in this respect were 'trust', 'openness' and 'rapport'. In Case 1, there was a particular emphasis on issues of trust and rapport, while in Case 2, there was more of a focus on openness. In Case 1, most of the practitioners set great store by establishing a good relationship

with the young person. For some this meant striking a balance between formality and informality, finding an approach that was appropriate for the interactional style of a young adolescent. For example the YOT worker (C109) and FIP worker (C111) would often take Martin out rather than sit in the office to have a 'meeting' with him. The youth work manager (C104) considered that the informality and voluntary nature of Martin's contact with her enabled him to trust the service and accept support. As more practitioners became involved, it was sometimes difficult for 'new' members of the core group to establish the same rapport. The FIP worker, for example, found that Martin's mother was wary of speaking to a male practitioner and tended to feel more comfortable talking to his female colleagues. Since it was ostensibly his remit to work with the mother, this had repercussions for his contribution to the network, since he would feel embarrassed if it transpired she had disclosed information to them that he did not know. The issue of expectations could be a source of tension, as will be further explored below (Section 5.3.3).

In both cases, it was considered important to know family members on their own terms, which in time might encourage them to talk honestly and openly about what is going on in their lives. The trusting relationship was therefore not an end in itself, but a means to obtaining the kind of feedback that might allow the core group to intervene effectively. Practitioners such as mentors and family support workers linked their activities to what the network as a whole was trying to achieve, albeit in slightly different ways. Whereas the mentor in Case 1 (C105), for example, saw himself as reporting back to the 'wider group', passing on disclosures made by the young person so that other practitioners might understand him better and in this way facilitate their assessments and decisions, the family support worker in Case 2 (C208), made a further point about differentiation:

'I think when we go in we have to build a relationship first and be clear, "we're not social workers, we're here to prevent this situation escalating", and sort of get in close and try and work with them on their level to sort of say "look we want to help you turn things around, make things easier."'
[C208, family support worker(1), Case 2(1)].

The family support worker here positions himself within the family as a contrasting (though not oppositional) figure to the social worker. The aim was not to be seen as somehow more benign or less threatening than the social worker – although the family might well take this view. Instead, the nature of his role, working alongside the family, made the distinction a helpful one. We will

return to the theme of roles in a later section, but in the present context it is worth noting that gaining the trust of families was perceived to be a vital part of assessment and intervention. Nonetheless, the truism is that trust – like respect – has to be earned, and so the steps that practitioners take in order to retain that trust may have unintended consequences for other relationships within the network. The social worker in Case 2 made some interesting observations in this regard:

'But then once the parent comes in then you know I become the 'ogre', I have to deliver the bad news. "Oh you tell her that you're going to go down child protection". And it's like "well yes" I'm happy to do that because then it's obviously my decision. But you also need to say "actually we do agree with this" [...] It's like I have to be the bearer of bad news and they can be the bearer of good news - it doesn't work that way.'

[C206, social worker (1)].

Clearly for the social worker it was frustrating to find other practitioners differentiating themselves along these lines, although she was also keen to acknowledge their efforts to help the family. For frontline practitioners, having painstakingly built a good relationship with parents, there might be some pitfalls around reporting concerns about children's welfare. The social worker, to some extent drawing on her experience of other cases as well as this one, observed a tendency for practitioners sometimes to report things to her without first telling the family they were going to do so, or to verbally pass on concerns that were then omitted in their written reports to case conferences. Since the sources of referrals and information might come to light at a later stage, such actions might then even lead to a loss of trust on the part of the family – and in the social worker's view this could be avoided if concerns were discussed openly in the first place. Indeed it was evident from the accounts of other practitioners in Case 2 that the particular brand of diplomacy required for maintaining a constructive relationship with the parents created difficulties when it came to being 'open' about their concerns. Two practitioners, the fire prevention officer (C203) and the CAMHS specialty doctor (C204), both noted that the corollary of feeling wary of giving messages that might be perceived as negative or unhelpful was a default setting of encouragement and positivity. In turn, this could be frustrating if it inhibited discussion of the 'real' issues:

'I think that makes it quite difficult to - for professionals to be - to absolutely say actually what - what they're thinking - you have to say everything in a way that is helpful to a family without being, necessarily, blaming or negative - you have to be very careful that everything that you say comes out in a way that is going to be positive and helpful'.

[C206, CAMHS specialty doctor (1)].

The CAMHS doctor here makes the connection between her experience of this case with a more general expectation about how practitioners should communicate with service users. Several participants commented on how early network meetings in this case seemed get caught up in the parents' heated defence against inferred criticisms and inaccuracies. In view of this, and with the family beset by mounting problems, the solution eventually arrived at was to hold a professionals meeting in two parts: firstly without the parents, so that practitioners could talk 'openly' to each other and form a consensus on the main issues, then 'bringing in' the parents in order to feed back what had been discussed. This kind of format is nowadays unusual in a social care setting, since family members would normally participate fully in meetings – and therefore links back to the expectations around openness highlighted by the CAMHS doctor. In this instance, however, the practitioners were prepared to sacrifice openness to some extent, in order to get to the heart of the matter without alienating the parents. Nonetheless, we know that the social worker's view was that delivering the 'bad news' was largely left to her – and that as soon as the parents entered the room, other practitioners would lapse back into making encouraging and positive-sounding remarks. It could be surmised from this that the 'united front' presented by the practitioners was underwritten in some ways by the statutory authority brought (or represented) by the social worker.

Openness seemed to be less of an issue in Case 1, where practitioners appeared to have reached a consensus early on that Martin was 'beyond parental control' and this had helped to promote a less stigmatising narrative for the family than the formal category of 'neglect' associated with the child protection plan. Whereas in Case 2 practitioners sometimes found it hard to say what they really thought to service users, in Case 1 the problem was perceived to lie in the other direction. A shared concern seemed to be that Martin was experiencing some form of emotional or psychological distress, the reasons for which he was unwilling to disclose. Several participants, such as the education keyworker, thought it was important that he be encouraged to 'open up' through counselling or some other therapy. Other practitioners, such as the youth worker and

school nurse, attached significance to signs that he could work through emotional issues non-verbally, for example by drawing. Yet trust can be a double-edged sword; while practitioners valued what they saw as Martin's responsiveness to positive influences, they were equally worried about his susceptibility to negative ones, i.e. older peers involved in criminal activities. These considerations helped to shape the meanings attached to relationships within the network, but could sometimes lead to conflict as well as consensus.

5.3.3 Perceptions of conflict

Participants spoke about conflict via a number of sub-themes, exploring specific 'areas of disagreement', but also some of the underlying 'power dynamics' in the network. Linking the two in both cases was a third sub-theme around 'being heard'. However, specific areas of disagreement emerged in different ways. In Case 1 there was a tendency for an alliance between some practitioners in the core group to be accompanied by periodic conflict with certain other agencies. In Case 2, conflict often emerged in the relationship between practitioners and parents, with this then having consequences for how practitioners were able to work together. Common to both cases was the contested area of diagnosis and risk assessment. Case 2 saw a pattern of mutual disenchantment arising from two competing forms of explanation for the youngest child's behaviour. On the one hand, parents appeared to believe that practitioners were not hearing, or were dismissing, the extent to which their children were impacted by disability or disorder. On the other hand, practitioners made precisely the same complaint about the parents, who were seen as refusing to listen to advice about their parenting style. This mutual incomprehension would feed through into a mismatch between the kind of service the family expected or wished to receive and what the agency itself was 'willing' or able to provide:

'It was almost like I've already explained this to the family on more than one occasion - and it's just - but they didn't want to hear it - they want us to take all four kids off their hands. That's how it comes across.'

[C205, young carers manager, Case 2(1)].

While the parents did seek support from a variety of agencies, they were often dissatisfied with the service they received. As the above quote suggests, what was ostensibly an argument about need was often interpreted as being about responsibility. Other practitioners in Case 2, such as the

social worker (C206) and family support worker (C208), observed that the parents favoured a medical model of explanation. This meant they could adopt a preferred role as carers requiring professional support, as opposed to the practitioners' focus on 'parenting' and family dynamics. Practitioners also observed that parents would allude to the shortcomings of other agencies in an effort to gain their support. In one sense this might simply be regarded as 'divide and rule' tactics, but as the following quote demonstrates, the appeal to be 'listened to', when made by service users, can be quite a powerful one for practitioners.

'They are very upfront, so they were saying that they felt that they hadn't been heard by other professionals right from the beginning, so I - I guess I wanted them to feel that I was listening to them'.

[C204, CAMHS specialty doctor (1)].

The CAMHS doctor here acknowledges the understandable urge on the part of practitioners to convey to families that their views are being heard and taken seriously. Practitioners naturally tried to respond to what the parents were saying, and this could sometimes lead to misunderstandings or misconceptions about the work which other agencies had undertaken. For some participants, these discrepancies were only really resolved at the professionals meeting, as discussed earlier, when all the different agencies had a chance to share information openly with each other.

In Case 1, the question of whose voice was heard loudest was linked by some participants to issues of power and status. This was most evident in the accounts of practitioners from universal services, such as the youth worker and school nurse, who felt that their efforts to bring concerns to the attention of specialist services such as child protection and CAMHS had been largely ignored. After a new lead professional, the social worker, managed to allay these concerns, emphasis then shifted to the struggle between the core group itself and resource gatekeepers/managers – 'the people who have powers regarding those areas' [C111, FIP worker (1)]. This was a key issue particularly for the social worker, who had assumed responsibility for obtaining specialist provision for the young person and also for pursuing the issue of an appropriate diagnosis with CAMHS. The frustration experienced by a number of practitioners therefore revolved around the way their views were treated by another service or some higher level of management, who were perceived as more powerful than, and in some ways detached

from, the rest of the group. On the other hand, the perspective of CAMHS was that they had already completed an assessment and that a re-referral was unnecessary:

'I thought I'd made it - I thought my letters had explained what I felt were some of the reasons possible - but then we have had a re-referral because some people think - I think they felt that they weren't absolutely sure about it'.

[C108, CAMHS psychiatrist (1)].

The psychiatrist here acknowledges that some of the referring agencies have queried the earlier assessment, although he presents this as a question of uncertainty rather than a difference of opinion. The distinction is an important one, given that the psychiatrist goes on to maintain that the original assessment was clear enough and in fact did incorporate some of the issues around social functioning that the other practitioners have raised. It also sets to one side the tricky issue of power over diagnosis, i.e. to what extent medical or non-medical practitioners who are not doctors or psychiatrists feel able to suggest (or contradict) a diagnosis that officially can only be made by a doctor or psychiatrist. It was evident in both cases that frontline practitioners, while acknowledging that they were not qualified to diagnose a condition, considered themselves able on the basis of their experience and direct work with children to comment on whether a diagnosis might be appropriate or not. An additional source of tension lay in the fact that diagnosis had a significant bearing on what resources were made available, e.g. the type of specialist residential school that could be applied for. In Case 1, this meant that the power to diagnose was not held by the core group, but by an agency perceived as external – or even as aloof and inaccessible. Meanwhile, in Case 2 the withdrawal of CAMHS from the core group was also experienced as problematic – not because of the need to clarify diagnosis, for this had been satisfactorily resolved from the practitioners' point of view – but because the family was seen as in need of expert therapeutic support.

Of course, conflict is not necessarily a negative thing and may ultimately have some productive consequences. In Case 1, persistent appeals for greater assistance from children's services, combined with the fallout from the young person's own activities, eventually brought the case to the attention of senior managers. The case had become 'high profile', in the words of one participant [C109, YOT worker (1)] and as such was monitored more closely than others.

Reallocation to a new social worker was one result, as perhaps was the eventual authorisation of

expensive resources such as a residential school placement. At the same time, the core group had built up a sense of solidarity and mutual respect, which enabled its members to question and challenge each other's views in a constructive way. Some of these tendencies were also evident in Case 2, in which the escalation of conflict within the family eventually led to a referral to statutory child protection services. This raised 'profile' arguably resulted in a more cohesive approach on the part of practitioners, after they had the opportunity to share their knowledge and views about the case. However, the fault-lines between service users and practitioners appeared to be far more divisive than in Case 1. Even those practitioners who were on good terms with the parents were conscious of the potential for disagreements to flare up. Other services, such as CAMHS and the second family support agency, thought it likely that the parents would resist whatever was offered to them. For practitioners such as the headteacher, who felt she had no choice but to manage the relationship with parents as best she could, this was experienced as frustrating:

'And the whole issue about falling out, professionals falling out with them, or her falling out with professionals... I think it should be down to the professionals to manage that. I'm not saying I'm perfect - I'm not - but I think I manage that.'

[C201, headteacher (2)].

The headteacher's comments raise the question of who – if anyone – should assume responsibility for managing the conflicts between service users and practitioners. In both cases it seemed that establishing a core group around a child protection plan had given practitioners a strong mandate for managing conflict – but in each case different kinds of conflict were being managed. In Case 2, where both causes and solutions were seen as located within the family system, the challenge was to integrate the parents *into* the core group whilst avoiding the defensive infighting this might entail. In Case 1, the core group had largely avoided confrontations with the parent, but were focusing on keeping the young person out of harm's way (and from harming others) while arranging alternative care and education for him. This did not mean that interventions to try and reduce conflict within the family home had not been tried – they had – but they were not currently the main priority. In other words, perceptions of conflict were linked to what the core groups respectively saw as their main tasks. This issue will be returned to later in the chapter.

5.3.4 Summary

Participants discussed a range of issues in connection with relationships, which recall some of the ideas on group dynamics outlined in Chapter 2 (see Section 2.5.5). The findings coalesced into three superordinate themes. Firstly, dynamics of acceptance and rejection were significant in shaping collaboration in both cases. In Case 1, the core group developed a cohesive identity over time, and this could inspire a sense of solidarity and togetherness for those in the group, as well as a pressure on new workers to prove their worth. In Case 2, there was also an 'inner core' of practitioners, based in part on which services the parents were willing to engage with. Some members of the network had been working in quite an isolated fashion until the escalation of child protection concerns resulted in a series of professionals meetings. The second major theme concerned the management of relationships in the network. In Case 2, it was difficult for practitioners to be open with parents about their concerns because the ensuing defensiveness and hostility might lead to a breakdown in relations. The social worker felt that this caused other members of the network to rely on her to deliver 'bad news'. In Case 1, the difficulty lay in the other direction, with several practitioners feeling the young person should be encouraged to 'open up' to therapeutic support. Consequently, there was a great emphasis on one-to-one work with this young person, with the relationship seen as a vital resource for assessment and intervention.

The third major theme was about perceptions of conflict. In both cases, development of an 'inner' core group sometimes led to criticism of the more peripheral parts of the network, who might be seen as aloof and unhelpful. This was a more prominent feature of Case 1, in which the fault-line was initially between universal and specialist agencies, and later between the core group and various management bodies and resource panels. In Case 2 the issue was more around how practitioners manoeuvred around the potential for conflict with parents. Some practitioners felt that they were left doing the hard job by other agencies, who would either withdraw on the basis that the family was not cooperating, or make life easier for themselves by only relaying positive messages to the parents. Status issues arose in relation to the power to assess and diagnose, which was seen as fundamental to intervening effectively in this sort of case. Some practitioners were frustrated that their views had not been taken seriously by others in higher status professions. The appropriate use of medical terminology also proved to be a source of disagreement in both cases.

5.4 Assessment

Having considered practitioners' experiences of causality and relationships, we move now to the general category of assessment. Assessment is here understood in a broad sense to mean how participants experienced the process of acquiring and interpreting information relevant to a case in order to arrive at some form of explanation or judgement (Rose, 2009). This links to the issues around professional judgement discussed in Chapter 2 (see Section 2.4.4.) and is a critical function of interprofessional networks (see Chapter 7, Section 7.5). The findings presented here showed assessment to be as much a cyclical process as a linear one; while the formal narrative of an assessment might assume a progressive movement, e.g. from description to analysis to conclusion, the actual experience of assessment involved a constant iteration between these stages. Furthermore, the dynamics of relationships, both between practitioners and with service users, affected what information was available at different stages, and how it was interpreted. The participants therefore had to question what was relevant or accurate, and combine their different perspectives in order to understand the situation. For the most part, they did arrive at some explanations and conclusions, although these were often tentative and contingent on events.

5.4.1 The significance of information

Participants' reflections on the subject of information gave rise to a superordinate theme around the 'significance of information', in the dual sense of importance *and* meaning. Four interrelated sub-themes contributed to this area of experience: 'access to information', 'context and history', 'ambiguity of information', and 'information sharing'. Information was in some respects seen as the factual glue holding the case together, with 'old' information providing the basis for assessment and intervention, and 'new' information being produced by those processes. Yet this apparently straightforward concept could also be undermined by the blurring of fact and opinion, since all information necessarily involves an element of interpretation, and assessments could be a source of dispute as well as clarification. Both cases had a history of professional involvement, in which successive workers could draw on the material contained in a chronology or history, or on what was verbally communicated by other practitioners. Information had multiple sources and was unevenly distributed around the professional network, putting a premium on information sharing. Yet at times there were even doubts about what could be 'known' about a case, as new information came to light or a previously trusted source proved to be unreliable in some way.

Access to information seemed to be more of a problematic issue for practitioners who did not have a coordinating role, or who found themselves isolated from the core group. In Case 1, this

applied to the mentor (C105), youth worker (C104), and education keyworker (C113), and in Case 2 to the fire prevention officer (C203) and young carers manager (C205). For these practitioners, various pieces of information were either disclosed or became apparent in the process of building a relationship with members of the family. This might lead them to flag up concerns to other agencies, especially CAMHS or children's social care, although such agencies might not attach the same significance to this information. For these practitioners there was also the possibility, particularly in the initial stages of involvement, that they did not have access to sources of information that some other agencies did. Most did not feel they had all the information they needed, including which other agencies were also involved in the case, until they had attended some sort of professionals meeting as part of the child protection process. Others, such as YOT workers or social workers, did have access to a full case history and chronology at the point of taking over the case:

'Part of me likes to read files to get an understanding of what's happening, but another part of me doesn't like doing that because then you've got this preconceived notion of what this young person is like. So I have read some of the information and it is very alarming some of the stuff that I have read, and it is very concerning. And then, as I said, I haven't actually done any specific work with the young person yet, because I'm just still getting to know him and building that relationship'.
[C112, YOT worker (2)].

For the YOT worker, the case history forms a useful starting point for approaching the case. However, she feels that her knowledge of the young person is not complete until she has had a chance to interact with him a bit more and make her own judgements. As in the hermeneutic circle (see Section 4.4.1) there is a necessary connection between discrete 'pieces' of information, such as observations or records of meetings, and the more comprehensive picture that can be assembled from *all* the available information. Indeed, the metaphor of a picture was a recurrent one, being used at some point by around half of the participants in both cases. The common idea was that bringing together different perspectives, in the form of written or verbal testimonies from a range of sources, helps to provide a 'wider', 'fuller' or 'holistic' picture – not just of the 'case' but of the people involved.

Of course, cases with a large professional network may end up with a number of different pictures in circulation. For this reason, practitioners often placed emphasis on meetings as a venue for

'exchanging stories', and on the prompt circulation of updates via email or phone calls. Some participants felt that the 'airing and sharing' of information was not enough, since it did not always lead to progress being made or even a plan being formulated. Even problems that were recognised by the core group as a whole might be seen as so intractable that they were simply accepted as part of the picture. An example in Case 1 was the mother's lack of parental control over her son. In other words, information was only really useful to the extent that it allowed meaningful action to be taken. Another problem was the ambiguous nature of some of the information that was shared. In Case 2 most of the practitioners recalled points at which they had to question what they were being told by family members, or what they thought they knew about the case. Practitioners had to take into account the possibility that family members might be selecting or even distorting the information that went into their assessment. There were also instances when such ambiguities became an area of knowledge to be contested between practitioners. One such issue was whether the youngest child had a tendency to be cruel towards animals:

'I think there has been some misinformation possibly about tormenting animals, because - and then I think it gets said and it gets repeated and then it gets written down – and there's no verifying of the truth because on one of the reports it said that he kicked the school cat and I asked [head of school] "has he kicked the cat?" and she said well she's seen him chasing the cat but she hasn't seen him kicking the cat. And so then, you know, who has seen him kicking the cat? I would want to be very clear.'

[C204, CAMHS specialty doctor (1)].

The problem described here is not just about checking whether a given piece of information is true or not, but also about verifying the factual basis for judgements about a child's character or disposition. The CAMHS doctor has misgivings that certain aspects of the child's behaviour have led some practitioners to speculate on the possible existence of a conduct disorder. While such hypothesising is an inevitable part of assessment, the risk is that opinions assume an increasingly 'factual' guise through being repeated, written down and disseminated. Indeed, the two practitioners who were interviewed twice in Case 2, the headteacher and fire prevention officer, considered the issue of (mis)information to be more rather than less problematic by the time it came to the second round of interviews. This was despite the progress made on many parts of the child protection plan. In the meantime there had been a change in emphasis. In the first round of interviews, the main issue had been around fragmented or conflicting information. This had been

largely resolved by a series of meetings among practitioners, which had provided clarity about the ADHD diagnosis and cleared up other misunderstandings between members of the network. Having acquired a more complete 'picture' of the family, however, there was increasing wariness on the part of practitioners about the reliability of new or even existing information, for example about health issues:

'I: Nobody knew about the heart condition that one of the children has.

'Q: The sister?

'I: Yes. So there was a big question mark over that. And there seems to be an awful lot of question marks over the different diagnoses which have been thrown around in that family, and why that's happening, and where that's all coming from, and the impact that that is having on the family'.

[C203, fire prevention officer (2)].

For this practitioner (1), an uneasy sense of self-perpetuating crisis in the family, fuelled by their preoccupation with diagnosable conditions, serves to undermine her confidence in the sustainability of recent improvements. Some of these reflections are echoed in the experience of practitioners in Case 1, who also found themselves questioning the accuracy or verifiability of information provided to them. This included disclosures made by the young person, who for example would make claims about activities such as drug use that would concern the practitioners even as they wondered how much of it was true. Concerns about the sticking power of diagnostic labels were also to do with the powerful influence this kind of 'information' could have on the provision of support and interpretation of behaviour. Already it was apparent in Case 1 that while the social worker continued to press for a reassessment by CAMHS, the appropriateness of diagnosis was given less prominence by newer members of the core group. They simply acknowledged that the young person was believed to have elements of different types of condition, which affected his behaviour in certain ways. A given item of information could therefore mean different things to practitioners, depending on how it fitted into their particular assessment of need.

5.4.2 Emotional resonance of the case

It has been pointed out that people should not be seen merely as 'information processors' in a purely rational sense, since emotional responses play an important and underestimated role in

how we make decisions and judgements (Haidt, 2001, Kahneman, 2003). Nevertheless, emotions have traditionally been viewed almost in opposition to ‘reason’, not only as providing an unreliable guide to situations but potentially as distorting people’s judgements. As noted in Chapter 2, practitioners in the field of child protection are often exposed to anxiety and stress during the course of their work, and psychological coping mechanisms to deal with such responses can derail collaborative endeavours (see Section 2.5.5). Given this context, it was therefore interesting to explore the emotional resonance these cases evoked for practitioners, discussion of which emerged in the form of three main sub-themes: ‘concern’, ‘frustration’, and ‘empathy’. Of these, concern was by far the most commonly referred to by participants in both cases, almost always in the sense of being worried about a child’s welfare, or the welfare of those affected by the child’s behaviour, e.g. family members or peers. Some practitioners used the term ‘worry’ as well, but usually concern and its derivatives (lemmas) were employed to signify a heightened awareness of risk:

‘When I did meet the family for my first session, it raised some alarm bells and concerns. Because I was working with the elder two, but the parents were very sort of concerning themselves about David, the younger sibling.’

[C208, family support worker (1)].

Here the family support worker describes his experience of concern as an alarmed reaction to information about a case. Visiting and speaking to the family, or hearing reports of a child’s behaviour in school, was similarly compared by other practitioners in terms of ‘danger’ [C203, fire prevention officer], or ‘warning signs’ [C104, youth worker (1)]. These images are instructive because they suggest that what practitioners learned during such episodes was significant enough to trigger an immediate and internal response. More generally, concern was perceived not only as a signal of need and risk, but also as a signal of severity or intensity, associated with adjectives such as ‘significant’, ‘big’, ‘grave’ and ‘main’. In other words, concerns represented problems that were considered to be most urgently in need of support and intervention. This points to another meaning of ‘concern’, as in the sort of issues one is concerned ‘with’ rather than ‘about’. Clearly there was a distinction, as well as a connection, between *feeling* concerned, and the *concerns* that practitioners had about a case – i.e. being worried about something as a separate matter from what it is that one is worried about, or why one is worried about it. As a further interpretative step, it might be considered that the particular constellation of meaning held by the concept of

'concern' enabled participants to link together these different facets of their work, e.g. for their communications with other agencies to express an acceptable degree of emotional content. An observation made by the psychiatrist in Case 1 was interesting in this respect:

'I think it's more complicated when you get people concerned about sexual imagery, sexual behaviours, that "alarm bells" always tend to sort of... I think it makes professionals more anxious at the mention of "sexual" behaviour.'

[C108, CAMHS psychiatrist, Case 1(1)]

Here the psychiatrist comments on the effect of a certain type of issue, i.e. sexualised behaviour in a child, which may provoke anxiety in practitioners as well as heighten their perception of risk. Again the image of 'alarm bells' is used, conveying the sense of urgency associated with such matters. While the psychiatrist mentions 'anxiety' here, this is not a term used by any of the other practitioners, who instead talk about being concerned or worried. Of course, one action that a worried practitioner might take is to ring up a specialist to discuss their concerns. However, from the perspective of the psychiatrist, phone calls 'out of the blue' were seen as unwelcome because they presented information in a way that did not necessarily set out its context or significance. Far more preferable was a written referral or letter, which would do so. In other words, CAMHS wished to receive information as part of a structured assessment process, so that a considered response could be in due course. Whether this would meet the needs of the practitioner finding it necessary to ring up for advice or support is another matter. Feelings of frustration about the lack of input from another specialist service, i.e. children's social care, were also expressed, often in strong terms, by some of the practitioners in Case 1:

'A: The core group itself was quite vocal, they are quite, you know, "We need this, and we need it now, for God's sake!"

'I: Were they quite demanding of your agency?

'A: Yeah and it needed to be allocated to someone that's equally vocal, which I am, to be able to sort of manage them and bring it down and say "Right OK, hold on a second, there are limits to what we can do", and be clear about what we can and can't do.'

[C101, social worker, Case 1(1)].

What this quote illustrates is the way that escalating need and risk, or the perception of same, sometimes led to an emotionally charged dynamic between practitioners from universal and specialist services. In Case 1, practitioners such as the school nurse (C110) and youth worker (C104) often described the frustration they felt in trying constantly, and in vain, to alert specialist services to a progressively worsening situation. For the social worker, on the other hand, coming to core group meetings was initially a daunting prospect, since it meant having to manage this pent-up frustration, or a series of 'vocal' demands for immediate action. While none of the participants talked explicitly about feeling stressed or anxious, there were frequent references to being frustrated by all the obstacles to progress (see also Section 5.4.3). In Case 1, over half of the practitioners criticised bureaucratic delays in securing funding and authorisation for specialist resources. Turnover of staff, and particularly of social workers, was also seen as holding back the core group, since people 'got up to speed' with the case only to leave their post soon afterwards. Partly as a consequence, critical interventions were now happening too late. Two practitioners, the school nurse (C110) and the social worker (C101), referred to their experience of dealing with the managerial system of decision-making in education and social care as being like 'hitting my head against a brick wall'. Others such as the FIP worker (C111) referred to the pressure on their workload and having insufficient time to devote to the case.

In Case 2, practitioners described feeling frustrated by the lack of a specialist service that could work with the family to improve parenting in the home, and by the relationship between practitioners and service users. But many also referred to the stress and pressure experienced by family members. This came across as an empathetic mode of understanding the family's situation, i.e. a compassionate 'feeling for' people as well as the more dispassionate 'analysis' of their needs and capabilities. For some practitioners, such as the headteacher (C201) and family support worker (C208), there was sensitivity to the potential stigma of the child protection process, something that was also mentioned by the YOT practitioners in Case 1 (C107, C109 and C112). Of course, this empathetic understanding was also necessary to develop a constructive relationship with family members. For the practitioners involved directly in working with the family or young person, such as the mentors in Case 1 (C105 and C107) or the family support worker in Case 2 (C208), this was an important aspect of their work. In Case 2, practitioners had to acknowledge the parents' own worries and concerns while at the same time trying to focus their intervention in line with their role and field of expertise. This was a delicate balancing act, and sometimes led practitioners to perceive that they were being diverted from their principal remit. In Case 1,

practitioners' contact with the young person gave them cause for both optimism and pessimism. They considered him to be likeable and bright, and admired the fact that despite missing so much school he continued to place value on his education. These characteristics gave them hope that their efforts might bear fruit – he gave them 'something to work with' [C109, YOT worker (1)]. On the other hand, they were also acutely aware of his vulnerability, which made them worry about his future. Such feelings ebbed and flowed over time, feeding into the processes of understanding and explanation, which will be described in what follows.

5.4.3 Processes of understanding and explanation

Stafford et al. (2012) observe that assessment is essentially about identifying a child's needs, and consists of two related tasks: gathering information about what *is* happening (for the child, in the family etc.), and analysing that information to understand and explain *why* it is happening (2012: 140). It is therefore not information as such, but the interpretation of that information, which forms the basis for subsequent action and intervention (Seden, 2007). Practitioners in this study adduced various pieces of information as a means of reaching and revising their judgements about the case. Assessment was experienced as an iterative process, which was compared earlier to the interpretative interplay of part and whole described by the 'hermeneutic circle', or to the construction of a complete picture from a range of individual perspectives. Within practitioners' accounts, this process was characterised by four sub-themes: 'interpreting behaviour', 'immersion', the 'search for diagnosis', and 'boundaries'.

Beginning with the first of these, interpreting behaviour was an important concern for practitioners in both cases. The behaviour to be interpreted was generally that of children and young people but also of parents and other family members. Often behaviour was interpreted in a symptomatic way, as being evidence for or against the diagnosis of medical conditions such as ADHD. Some practitioners were struck by behaviour that was inconsistent, or appeared to contradict their expectations, which initially at least made it more difficult to understand. In Case 2, for example, most of the practitioners observed that the child behaved very differently at home, with his parents, than he did when he was at school or alone with practitioners. This inconsistency of behaviour between contexts was seen as important for understanding the child, particularly in relation to whether he had a medical condition such as ADHD. In Case 1, practitioners who were relatively new to the case, such as the YOT workers (C109 and C112), found aspects of the young

person's social presentation to be surprising, in a positive sense, in that his relative approachability did not entirely conform to what one might expect from a young person with his history of offences. Others made similar observations, building a picture of a young person who was 'bright' and 'likeable', as well as 'challenging' or occasionally aggressive.

Practitioners in both cases often regarded an initial period of 'getting to know' the family to be essential for understanding the case. This came across particularly strongly in Case 1, where exposure to the family dynamics between Martin and his mother was seen as a formative experience. For example, the YOT mentor (C107) described how witnessing the pattern of escalation in an argument between Martin and his mother had helped him to understand and manage the young person's behaviour when they were out together in the community. More generally, the social worker (C101) observed that taking over the case during a period of crisis meant she had to involve herself on an intensive level with the family's circumstances:

'And quite a lot of crises happened in quite a small space of time, which meant that I was round that house a couple of times a week. If you immerse yourself that quickly in the case you are going to get a handle on it quite quickly.'

[C101, social worker (1)].

The social worker uses the metaphor of 'immersion' to convey the idea of a rapid learning process, in which repeated exposure to new information and stimuli accelerates understanding, or 'getting a handle on it' (similar ideas form the basis for 'immersive' approaches to language learning, for example). But the metaphor is interesting in other ways, for example connecting with the concept of 'surface and depth' in the earlier discussion of causality (see Section 5.2.1). Being immersed in this sense might imply an exploration of underlying causes rather than a superficial knowledge of events or behaviour. An additional connotation is that of an experience that is not altogether comfortable, alluded to in another 'liquid' metaphor when the social worker elsewhere described her initial struggle to get to grips with the case as being 'like swimming in treacle'. Even at a later stage in the case, when things appear to have stabilised, uncertainty about what will happen is likened to 'a feeling of holding my breath' [C101, social worker (1)].

While other participants did not use this terminology, the metaphor of immersion does seem to capture some of the contrasting aspects of their experience of trying to 'understand' these cases.

For instance, while most practitioners in Case 1 placed great emphasis on getting to know the young person, this contact also brought with it the potential difficulties of managing his behaviour, as well as the nagging sense that certain events and disclosures were somehow still hidden and waiting to emerge. In Case 2 it was the revelations that arose from closer involvement with the family that led ultimately to child protection inquiries, but also to the problem of verifying some of that information. Different practitioners might have that intensive involvement with the family at different stages in the case, raising the issue of managing that relationship at the same time as feeding information back to the wider core group. In Case 1, practitioners from universal services who had been intensively engaged in the case at an early stage, i.e. the youth worker (C104) and school nurse (C110), felt that specialist agencies, i.e. children's social care and CAMHS, were too detached from the situation, and furthermore did not respect their knowledge and experience as professionals. From the perspective of CAMHS, on the other hand, there was little possibility of 'immersion' in the sense conveyed by these practitioners, since their contact with service users was infrequent and tended to be in a clinical setting.

Most participants acknowledged that it was difficult to identify a single, overriding problem in these cases, or a single underlying cause for a variety of problems. Accordingly they drew on a range of explanatory accounts to summarise key issues in the case. Explanatory accounts of behaviour could even become perceived as problematic in their own right. For example, in Case 1 it was considered by some that Martin might well have an autistic spectrum disorder (ASD), but that he did *not* have an attention deficit disorder (ADHD). Particularly in the view of the social worker (C101), school nurse (C110) and youth worker (C104), the fact that ADHD had been diagnosed and not ASD had significant repercussions. For not only was ASD affecting Martin's behaviour as an innate 'condition', but the failure of services to pick this up and provide appropriate support had led to environmental deficits that were exacerbating his difficulties. Conversely, while ADHD might not be affecting his behaviour directly, i.e. from 'within', the diagnosis itself could nonetheless have an impact on the way others perceived him, i.e. through a misleading or inappropriate 'label'.

The importance of medical explanations also raises the question of authority over diagnosis, especially in an interprofessional context. It has already been noted that some of the practitioners in Case 1 felt that their knowledge and experience was being overlooked by the specialist agency responsible for diagnosis, i.e. CAMHS, while in Case 2 it was CAMHS who expressed misgivings

about the recurrence of diagnostic labels which they had not approved. In both cases it was apparent that some practitioners were inclined to search for a medical diagnosis of their own, while possibly also questioning the diagnoses made by others. In Case 2, the capacity of the parents to diagnose conditions such as ADHD for their children was consistently challenged by practitioners, i.e. services users were not seen as able to diagnose. But what about non-medical practitioners? As in Case 1, an abundance of other actual or potential medical conditions were mentioned at various points, relating not only to the child but to the rest of the family as well. Broadly speaking, a tendency in Case 2 as a whole was for uncertainty to resolve itself into an oppositional dialogue around diagnosis. Even the term 'parenting' started to resemble a quasi-diagnostic term (e.g. 'it comes down to parenting' [C208, FSW (1)]), employed by practitioners to shift the focus of assessment and intervention away from the individual child, and to counter the inappropriate 'disorders' emphasised by the parents. Tensions around the search for a diagnosis were particularly marked in the practitioner-parent relationship, but also spilled over into interprofessional dynamics in the network, as observed earlier in relation to the debate about conduct disorder (Section 5.4.1).

In contrast to the disputed area of diagnosis, the concept of 'boundaries' provided a kind of unifying principle for practitioners' explanations in both cases. Boundaries most obviously referred to ideas about how, and to what extent, appropriate limits were placed on a child's behaviour. Particularly in Case 2, a number of concerns in relation to parenting capacity and family dynamics were accordingly summarised as a 'lack of boundaries', with the concomitant task for parents and practitioners being to 'put in boundaries'. There was a close association between boundaries in this sense, and the view that 'structures', 'routines', and 'rules' in a child or young person's environment were necessary for their healthy development. In this respect, the involvement of the family support worker (C108) was highlighted by others in the core group, such as the social worker (C206) and fire prevention officer (C203), who thought that he had been able to help the parents see this for themselves. Meanwhile, the child protection process had helped to resolve parental resistance to having a family support worker in the first place::

'The social worker's putting some boundaries in place and sort of outcomes from the child protection plan and things like that, and I'm doing a lot of explaining: why that was put in place, and breaking it down and how it can impact, how it can, in the future – "if you don't follow these..." – what the outcomes would be.'

[C208, family support worker (1)].

The FSW points out that his job has been made easier because the family's relationship with services has been reconfigured around implementation of the child protection plan. The core group is establishing boundaries *for* the family as well as *within* the family, in order to ensure that risks to the children are addressed. It is a distinction that might be reformulated as the combination of care and control, as will be explored further elsewhere. In Case 1, practitioners also understood that Martin's behaviour owed much to a lack of parental boundaries at home, but were more concerned with what he was getting up to when he was not at home. This progressively led the core group to consider ways of moving the young person to a context in which it would be easier to establish boundaries, such as a respite foster placement, or a residential school specialising in pupils with difficult behaviour. The idea of boundaries therefore helped practitioners to argue for specific resources on the basis of their assessment of need. Moreover, the generally held view that Martin had some form of autistic spectrum disorder was taken to mean that he would derive particular benefit from structure and routine, i.e. that he might need 'more' boundaries than most children.

Nonetheless, it would be misleading to present boundaries simply as a metaphor for the imposition of rules or some form of discipline. In Case 1, practitioners observed that Martin would 'challenge' them and try to 'push boundaries', but rather than just exert their authority over him, they would try and use these experiences to test out their understanding of his needs. This is apparent in the way in which practitioners undertaking direct work with him, such as the YOT mentor (C107) and youth worker (C104) reflected on their efforts to set boundaries in a positive and beneficial way. This was done by counteracting the young person's aggressive attitude with a calm and authoritative manner, without allowing the situation to head towards mutual confrontation. Sometimes this had an almost therapeutic connotation, a belief that practitioners could aid the young person's psycho-social development through their dealings with him:

'Because he knows me very well, he knows that I won't respond in a negative way, he kind of has - I don't allow it, I give him boundaries - but he knows that it doesn't really affect my relationship with him - so it's kind of a safe, for him I guess it's kind of a safe way to kind of challenge but then also find where his boundaries are.'

[C104, youth worker (1)].

The practitioner here suggests that the young person's challenging behaviour towards professionals can be seen in terms of internal psychological processes – they represent a 'safe way' for him to find his boundaries, in contrast to the social difficulties that he experiences in other contexts. Taking a further interpretative step, the relationship with a carer (or 'caring' adult) may be viewed from the perspective of attachment theory as a 'safe place', allowing the child to probe and test the boundaries between themselves and their environment. The child's interactions with significant others are a vital part of identity formation and psychological integration. While these ideas are not explicitly stated, they do provide texture to the meaning of what is said. In summary, what emerges from practitioners' accounts is a conceptualisation of boundaries that emphasises connection to others, rather than separation or confinement. In systemic terms, as Byrne (2009b) points out, boundaries not only constitute what is bounded, but also serve to link systems to their environments (Cilliers, 2001). This layer of meaning might also indicate why so many participants were attracted to the idea of boundaries, given their aim of promoting long-term stability in the systems identified for intervention and change.

5.4.5 Summary

Assessment was experienced as a cyclical, iterative process. Practitioners constantly had to adjust their judgements in light of new information, while certain narratives of explanation became influential over time. The significance of information lay not only in what was known and shared by professionals, but how it was interpreted. Frontline practitioners tended to have access to first-hand information through their involvement with families, but sometimes lacked contextual information until a meeting was convened. Practitioners combined different types of information in order to get a more complete 'picture' of the case, and for some practitioners this was an empathetic as well as analytical process. Some information was seen as inconsistent or ambiguous, leading to efforts to validate or reconsider its relevance. This might cause tension and disagreement, for example if medical diagnoses were being challenged or hypothesised by non-medical practitioners. The emotional resonance of these cases led practitioners to feel worried about the welfare of children and parents, and to become frustrated at obstacles to progress. Frontline practitioners often referred to CAMHS and children's social care when problems exceeded their own expertise, but were not always satisfied that their concerns were being heeded.

Practitioners were often required to interpret the behaviour of children and family members. In Case 1, direct work with the young person was seen as fundamental to making sense of the case and getting an insight into underlying issues. The metaphor of immersion used by the social worker in this case seemed to sum up this experience, in that the process of understanding was accelerated by repeated exposure, but this could also be challenging and time-consuming. Core groups in both cases tried to collate and make sense of all the different viewpoints held by their members, in order to present a consistent message to service users. This was effective in some respects, such as the view on ADHD in Case 2, and unsuccessful in others, such as the view on ADHD in Case 1. An oppositional dialogue around diagnosis was evident in both cases, with CAMHS' withdrawal making it difficult to fully resolve the issue of competing hypotheses within the network. However, a unifying theme for practitioners in both cases was the concept of boundaries. This not only encompassed common-sense notions of parenting or behavioural modelling, but also drew on the wish to connect children to their families, and in turn to their communities, and put an end to successive cycles of exclusion and conflict.

5.5 Intervention

Intervention refers broadly speaking to the strategies that practitioners employ in order to resolve the problems identified in their assessment. In complexity terms, practitioners intervene in order to bring about change in the 'target' system, or to shape and control the changes that are taking place (see Chapter 2, Section 2.4.1). Complexity also implies that the relationship between intervention and assessment is non-linear, since it reflects causality. In other words, intervention is bound up with assessment in a constant feedback process, as practitioners test out their hypotheses and adapt their understanding of the situation in the course of their work. Although practitioners may hope to conduct their assessment before starting any intervention, this is not always feasible. In complex cases, specialist services join proceedings at various stages, and over time the turnover of staff brings an imperative to get new workers up to speed as quickly as possible. It has already been seen that a range of assessments were circulating in the professional network in these cases, and this was at times a source of tension and conflict. The same tension between collective and individual purpose applies to the work carried out by services. While in principle the core group may be implementing an agreed care plan, in reality this consists of

multiple interventions conducted to the specifications of autonomously managed agencies. Practitioners reflected on these issues in a number of themes, which are discussed below.

5.5.1 Balancing care and control

Balancing care and control has always been a key issue within child protection work. Safeguarding the welfare of children may require agencies to act in a more or less coercive fashion, while at the same time trying to address the needs of vulnerable people, respect the rights of children and families, and work in partnership with them. In these cases, issues around care and control emerged in relation to three sub-themes: 'engagement and compliance', 'containment', and 'dependency'. Awareness of vulnerability, which was associated with a need for support from services, was balanced by the awareness of risk, associated with a demand for cooperation with services. There were some parallels here with the theme of 'boundaries' explored earlier, in that practitioners were seeking to connect with services users as well as impose certain constraints on their freedom of action.

Looking first at the question of engagement and compliance, there were various perspectives on this. Some participants acknowledged that service users could be hard to 'engage' but saw this as an area of expertise required of the professional. The mentors and youth justice practitioners in Case 1, for example, tried to adapt their practice to make their meetings with the young person as productive as possible, e.g. by taking him out of the office. Others took the view that engagement with services was ultimately down to the families themselves. CAMHS, for example, were unable to keep a case open if families did not turn up to appointments or refused to accept what was on offer. Some practitioners, in both cases, expressed disappointment about this, feeling that CAMHS expertise should not be withdrawn because parents or young people were challenging to work with. A similar problem was faced by the two family support workers in Case 2, both of whom had to overcome the history of parental resistance to practitioners giving them advice about their parenting:

'I just seem to have more agencies involved, that concrete barrier around, sort of watching and supervising and keeping an eye on you. It does put more pressure on people and it does help mum understand more, actually, if everyone is coming from the same angle and saying the same things.'
[C208, family support worker (1)].

'I have tried ringing them. Yesterday I went to visit and no one was in. I wrote a letter to tell them that I was coming but no one answered the door. Everything has been blocked because the family is not engaging. So I don't know. We've been down this line before.'

[C207, family support worker (2)]

The contrast between these two experiences is instructive, as it points to the significance of the wider network in shaping how (or whether) the family is able to engage with a specific service. The first FSW invokes the power of the core group as a way of circumscribing the parents' room for manoeuvre; they are no longer able to play one agency off against another because all the practitioners are giving them a consistent message. This then allows the FSW to position himself within the family as a potential catalyst for positive change. In contrast, the second FSW appears to be operating largely on her own initiative and is unsuccessful; she finds her efforts to work with the family to be 'blocked' by their unwillingness to meet with her. Indeed, her agency has encountered similar difficulties in the past with this particular family, hence her fatalistic comment about having 'been down this line before'. The balance between care and control is interpreted differently by these workers. Whereas the first FSW presents his involvement in terms of helping parents to comply with the child protection plan, the second FSW attempts to secure the same type of voluntary participation that eluded her predecessors. Of course, the involvement of statutory child protection agencies could also be interpreted as presenting a 'threat' to families, forcing them to cooperate with services they do not really want. While practitioners in Case 2 did acknowledge this element of coercion, they also perceived that getting the parents to engage, however reluctantly to begin with, had led to genuine insight and improvement.

In Case 1, the dynamics of care and control were slightly different in that the parent was seen as cooperative. At one stage, despairing of her ability to control her son's behaviour, she consented to have him received into temporary foster care. The burden of compliance shifted instead to the young person, who was seen as placing himself and others at risk through his activities.

Practitioners such as the social worker (C101) and YOT workers (C109 and C112) presented their involvement as a way of helping him to avoid the unwanted outcome of a custodial sentence. But in a more general sense, his compliance with the core group's plans was seen as promoting his welfare. This is demonstrated in the following description of a scene, in which the social worker persuades Martin to give his new foster placement a try:

'He's like face-down on the bed saying "I'm not going" [laughs]. And I'm like: "No – believe me you are going. This is not negotiable anymore!" And an hour and a half later, he did get in the car. And he was happy, he was joking away, he wasn't upset, or getting - it wasn't like we dragged him kicking and screaming into the car, he went of his own free will.'

[C201, social worker (1)]

As with the boundaries metaphor, we see the subtle co-mingling of restriction and connection in the social worker's belief that in being firm and authoritative she is also helping the young person to feel safe and cared-for. The speaker conveys a striking image, contrasting the teenager 'face-down on the bed' – the epitome of the non-engaging service user! – with the happy, joking figure who finally gets in the car. Her efforts to get the young person to go to the foster placement are not intended to curtail his liberty as such, but are conceived as a step on the way to overcoming his fears and anxieties. Nevertheless, the practitioners in this case were only too aware that the success of their interventions ultimately relied on Martin's own decisions. His willingness to attend a residential school, and the value he generally seemed to place on his education, were widely seen as grounds for optimism. On the other hand, he was not exactly compliant, absconding from his foster home during the summer and then putting his hard-won placement at school in jeopardy. His keyworker at school observed that the question of 'control' was a big issue for him:

'I've spoken to him about it and he agrees totally that he likes the control. So there is some realisation that he hasn't got the control but he'll still try and push the next day. He'll start, he'll accept, he will then play the victim. He is quite a complex guy, actually. He'll then apologise and he will do the same thing the following day. So it's a constant, ongoing thing with Martin, and it's a battle.'

[C113, school keyworker (2)]

The 'battle' for control depicted by the keyworker refers not only to asserting authority over a recalcitrant pupil, but also about gaining an insight into his emotional needs and how to address them. This practitioner notes a typically sequence of behaviour in which Martin will act up, then acknowledge his fault, but also make out he is being persecuted. Later on she notes that he can be very personable and 'as good as gold'. His complexity as an individual is therefore linked to the volatility of his behaviour, which challenges the ability of the system to hold and contain him.

Indeed, the theme of containment was often mentioned by practitioners in both cases. In Case 1,

most of those interviewed described efforts to provide a program of structured activities for the young person, particularly during the summer holidays, to keep him occupied and 'out of trouble'. While such arrangements were seen as effective, there were frequent descriptions of him 'breaking out' of provision: absconding, escaping, even jumping out of a window on one occasion. In Case 2, practitioners were seeking to re-establish parental control over David's 'volcano-like' behaviour (see Section 5.2.2.), while at the same time the professional network itself formed a protective 'barrier' around the family, preventing the parents from disengaging.

A final aspect of care and control was question of sustainability and avoiding longer-term dependency on professional services. The issue of dependency was explicitly raised by the social worker (C101) in Case 1 and the fire prevention officer (C203) in Case 2, who worried that once families had got used to the support of practitioners the challenge would become not so much about engagement but about restoring some sort of 'normalcy' to individual and family life. Other practitioners such as the school nurse (C110) and FIP worker (C111) in Case 1, and the headteacher (C201) in Case 2, were concerned about whether improvements could be sustained and the consequences of withdrawing services too soon. In Case 2, the concern was that the family dynamics would eventually result in another crisis, albeit perhaps revolving around a different member of the family. In Case 1, practitioners were uneasily aware that the young person's school placement might break down; in their view this would initiate another cycle of containment, escalation and crisis, in which the YP would move through different institutional settings, characterised by increasingly punitive constraints and socially excluded peer groups.

5.5.2 Negotiating one's contribution

The process of intervention in these cases was not only channelled through the relationship between practitioners and service users, but occurred in the wider context of organisational and managerial structures. The two sub-themes in this respect were 'roles and remits' and 'resources and gatekeeping'. Both involved a process of negotiation, between members of the core group, between practitioners and managers in their own agencies, and with resource panels and other decision-making bodies. In both cases it was possible to distinguish between formal negotiations that took place, for example, when specialist resources were deemed necessary by the core group, and more informal accommodations and compromises arrived at by practitioners and their agencies.

When it came to obtaining authorisation and funding for specialist resources, dealing with the lengthy bureaucracy and associated 'red tape' was a source of frustration for many of the practitioners in Case 1. The social worker (C101) felt this mostly keenly, since not only did her lead professional role give her the main responsibility in this regard, but she was conscious of having to make up for her predecessors' failure to have initiated such actions at an earlier stage. Other practitioners, such as the school nurse (C110), youth worker (C104), FIP worker (C111), and YOT worker (Y109), found that the delay in securing an appropriate educational placement meant that they struggled to address the young person's escalating problems. His needs as well as his age meant he could not easily be catered for in establishments such as the youth centre or pupil referral unit. The emphasis on one-to-one work with the young person created a high demand for the scarce resource of professional time, which practitioners had to reconcile with the rest of their workload. As more agencies were brought on board, there seemed to be a certain fluidity in role and remit as practitioners were deployed in different ways. The youth worker (C104) and YOT mentor (C107) thought that their contribution had gradually reduced over time as other services assumed greater responsibilities and their own contribution became less necessary. A certain mutability of role was also a feature of Case 2, in which several practitioners reflected on how their 'official' remits were stretched by the needs of the family. Developing a relationship with the parents sometimes made it difficult to compartmentalise their work, since practitioners became increasingly aware of all the factors that could affect the outcome of their particular intervention. The fire prevention officer (C203), for example, observed that it was not really her role to advise the family on parenting strategies, yet lack of supervision was a key factor in the fire-setting. The role of practitioners in the child protection process also changed after statutory services became involved, and practitioners reframed their involvement to reflect the change in dynamics:

'When we had the meeting and it was going down the child protection route I did sit mum and dad down and said "look, there will be a lot of people there". And actually I don't really have a problem with them not being at the meeting because I think she is better to have it told back to her than being where she has to defend her position when actually that's not what we need to do, necessarily, at a child protection conference.'

[C201, headteacher (1)].

The headteacher here presents herself as a kind of mediating figure and interlocutor for the parents, who are about to face the intimidating prospect of attending a case conference with all its implications and consequences. Since she knows the parents quite well, and has experience of the child protection process, she can try to prepare the parents for the meeting, or if they do not feel able to attend she can help to feed back the discussion and decisions in a way that does not alienate or antagonise them. For this practitioner, the parents' non-attendance might even be preferable if it avoids a breakdown in relations. The perspective of the social worker was somewhat different. For her, it was important for practitioners to take advantage of the meeting in order to present a consensus of opinion to the parents. Otherwise there would be scope for misunderstanding and conflict further down the line. As we have already seen, the social worker (C206) in Case 2 did not think that being the lead professional necessarily made her the authority figure in the core group, whose job was to 'deliver the bad news' to parents (see Section 5.3.2), although she reflected that other members of the network might seek to put her in that role, because it would allow them to present more 'positive' views and remain on good terms with the family. In contrast, the family support worker believed that the core group as a whole, and the social worker in particular, were there to set out a clear framework for intervention, without which the family would not cooperate with him. He was then able to work 'alongside' the parents, backed up by the fact that other agencies were monitoring the situation.

These experiences show how people's contributions were shaped by the dynamics of collaboration and the specific demands of the case. However, this negotiability meant that roles could become blurred, however clearly they were set out in referral criteria or care plans. This was a particular concern for the family support worker in Case 2, whose remit was to work with the oldest two children but who invariably found himself dealing with issues relating to the youngest child:

'But I think what's tricky for me, all this sort of spillage, where a lot of the time the parents try and push the focus onto the younger one, and I think that's happening an awful lot, even at home, where they are focusing all their energy on the younger ones, and I think I'm, I'm trying to take a really sort of strong role of not being drawn into that.'

[C208, family support worker (1)]

The FSW observes that his job, which should be focusing on the older siblings, is made difficult by the pressing need for someone to work with the parents specifically around David and his behaviour. Not only does his agency have age criteria, which prevent him from working with David, but he believes that the older children require a dedicated worker if they are to get any support. He uses the metaphor of 'spillage', not only to evoke how the youngest child's needs influence everything else that happens in the family, but also to convey the effect this has on his own role. Just as the child's needs cannot be contained or managed within the family, he struggles to keep his own involvement within the boundaries of a defined piece of work. The result was a discussion with other agencies about what additional resources could be put in place. However, other members of the core group had a different perspective on his contribution. In their view, this FSW had succeeded where others could not, i.e. in gaining the respect and cooperation of the parents, and so regardless of age criteria he was probably in the best position to work with the family:

'I suppose I can see the logic on both sides, but it's... There's something... I don't know, it's almost as if there are rules for the sake of rules. Why is it that [the family support worker] isn't allowed to work with the full group? Because they don't fit in somebody's box? Because they are too young, so they can't? And I know you've got to have cut off points, but in the end who are we doing this for?' [C201, headteacher (2)].

The headteacher here questions the relevance of gatekeeping criteria in this case, suggesting that an exception should have been made given the circumstances. On this point, she appears to share some of the same frustration with managerial decision-making and bureaucratic procedures that was expressed by participants in Case 1. It is also worth noting that the issue here was about the need for an additional worker rather than replacing one with another (although that is what eventually happened). While the idea of gatekeeping normally suggests controlling or restricting access to resources, some of the participants actually pointed to the opposite: a tendency for 'box-ticking' to result in a surfeit of interventions aimed at addressing particular needs. In Case 1, most of those interviewed commented on the large number of practitioners involved with the young person, which in turn raised issues about whether he was getting consistent messages or was even becoming habituated to an unusually high level of input. In Case 2, the key question was again not necessarily about putting in 'more' resources but about finding the right resource to undertake parenting work with the children, as well as using the statutory child protection process to

encourage greater cooperation from the parents. What practitioners considered to be their official remit was therefore not always aligned with their potential role in the core group or their actual contribution to the case – as illustrated by the FSW’s reluctance to take on the ‘whole family’ or the social worker’s annoyance at being cast as the ‘ogre’. In both cases, the formal processes of multiagency working were therefore underpinned by a more informal negotiation between practitioners and their agencies to determine what kind of contribution was necessary, or useful to the core group’s function.

5.5.3 Striving for progress

It was remarked by a number of participants that the whole point of professional intervention was to ‘change things’, yet historically the involvement of agencies had found it hard to make a sustainable improvement in these cases. Instead the core groups had found themselves battling against successive crises, marked by a worrying escalation in the problems they had been called on to address. The experience of striving for progress, trying to make headway in the face of multiple and seemingly intractable problems, incorporated the sub-themes of ‘movement and change’, ‘commitment’, and ‘trial and error’. Practitioners talked not only of the challenge of changing things but also of their determination to do so. The ebb and flow of optimistic and pessimistic prognoses, of alternating hope and frustration, was again noticeable. Some practitioners reported feeling ‘stuck’ at times, as in one person’s memorable image of ‘swimming through treacle’ (C101, social worker (2)). At other points in the case, there was a sense of movement and change:

‘I think from my point of view, the main thing around the case, and what’s going on, there’s a lot of communication but it doesn’t seem to be sort of going anywhere with the younger ones, in terms of the younger one and direction, to move forward.’

[C208, family support worker (1)].

‘There has been a really positive change in his behaviour, which I didn’t think... I thought his behaviour would be the same but there wouldn’t be any further fire setting, but his behaviour has changed. He really looks forward to seeing me, when he sees me he smiles, he talks about stuff that we’ve done in the past.’

[C203, fire prevention officer (2)].

These quotes, which are taken from interviews about three months apart, appear to show a clear progression in the work done by the core group in Case 2. The FSW's impression that nothing is changing for the younger children contrasts with the fire officer's sense of 'really positive change', which goes beyond the ostensible aim of preventing further fire-setting and adduces evidence of more profound shift in the child's demeanour and presentation. Yet the picture is more complicated than it appears. The FSW remarked elsewhere on the positive response he had begun to notice in the parents, who after initially resisting his involvement were beginning to take on board his advice about more consistent routines in the home. Yet his agency closed the case soon after this interview, ending his successful intervention, while the next family support worker was not able to re-engage with the parents. Equally, the encouraging feedback from the fire prevention officer about her work with the youngest child was counterbalanced to some extent by her doubts as to whether the parents were receiving enough support to sustain the improvement in the children's care, especially once her service and others pulled out. Similar uncertainties were apparent in Case 1, where real progress was made in terms of getting the young person back into full-time education, but the stability of his placement was increasingly undermined by his behaviour. Mindful of this, some of the practitioners advised making the most of 'small progresses' [C110, school nurse (1)] and tried to avoid setting unrealistic targets or expectations:

'I tend to go into work with an open mind, it's a new day, and obviously there might be things that you might want to work towards or targets that you might want to reach – yes it is that you are all working towards them but the expectation is not necessarily that you are going to meet those targets. You are aware that you might have an aim but you might have to change approaches to get there and it could take various different types of approaches or people or resources to achieve.' [C105, mentor, Case 1(1)].

Here the mentor points to the importance of keeping an open mind about what interventions might be feasible or effective in a given set of circumstances. This applies to the longer-term work of the core group as much as what a practitioner might hope to achieve during a particular visit or session. While the core group might share certain aims and objectives, achieving them might well involve a certain degree of 'trial and error', rather than simply expecting a specific intervention to have a specific outcome or effect. Several other participants made comments along the same lines, observing that if one approach didn't work it was necessary to move on and try something else, rather than become discouraged or withdraw from the fray. 'You just keep trying,' [C109, YOT

worker (1)] was the succinct appraisal of one practitioner in Case 1, reflecting on an unsuccessful attempt to keep the young person in respite foster care over the summer. For the headteacher in Case 2, the same pragmatic principle also meant making interventions as realistic as possible, so that the family was not set up to fail but was able to do what was expected of them in the child protection plan:

'I suppose what I'm saying is that professionals should be more sensitive to what's going to work for them and what isn't - and why it isn't, so let's look at something else. And I don't think that we as the wider group necessarily do that as well as we should do.'

[C201, headteacher (2)]

The sensitivity referred to by the headteacher is not only about the potential for a raft of micro-interventions to place an unnecessary burden of compliance on the family, but also puts the onus on the core group to find a way to achieve its aims. For some practitioners in Case 2, the attitude of agencies who cited parental resistance and non-engagement as a barrier to progress was questionable, especially when they perceived themselves to be persevering nonetheless. This emphasis on commitment and persistence was also a strong feature of the accounts in Case 1. Several practitioners referred to the demands on their time and the unusual extent of their involvement, for example, in one-to-one work or regular visits to the family home. The school keyworker even commented that the young person was 'a lucky boy' in that respect, since she had never come across a pupil with that level of professional support. The sense of past failures, as we have seen, also provided extra impetus to this sense of commitment, particularly for the social worker who had taken on the responsibility of lead professional after a period of turnover in previous workers. Even when matters seemed to take a turn for the worse, with the young person being arrested yet again as well as being temporarily excluded from school, practitioners did their best to overcome their frustration and keep on working for a positive outcome:

'At the end of the day, as much as we may feel the frustration we still have a duty to carry out our work with this young guy and the family. And I think we will because we've all worked so hard on this case we have some form of emotional tie to it, where in a sense we do want to see them progress in a more positive way and to kind of get things back on track.'

[C111, FIP worker (2)]

This reflection from the FIP worker encapsulates the determination of the practitioners in this case to build on their hard-won progress and fulfil their duty to help the young person and his family. What also comes across is a sense of how the core group has over time built a culture of solidarity and commitment among its members, which encourages them to carry on striving for progress. The idea of an emotional investment also ties in with the significance of relationships in both cases, and is recalled by the fire prevention officer's earlier description of how the child she works with has come to look forward to her visits. While all the stakeholders would no doubt have preferred a quick resolution to the problems faced by these families, the protracted process also served to underline the need for ever-closer collaboration among those agencies who remained involved.

5.5.4 Functioning of the network

While a professional network may be set up to deal with complex problems, it is also a complex social system in its own right, whose composition and characteristics will evolve over time (see Section 3.2.4). In turn, these changes are likely to affect how the network goes about addressing the needs of the family. In this study, a superordinate theme around network functioning emerged from a number of sub-themes to do with 'coordination', 'flexibility and adaptability', 'consistency' and 'withdrawal'. Turning first to the issue of coordination, practitioners in both cases highlighted the crucial role of the lead professional in such cases, pointing to the difference that one such individual could make to the collective endeavours of the group:

'Actually it made a huge difference when there was somebody kind of in the lead professional role, who shared every step of the plan, agreed the plan together with the team, the core group, and with the chair of the review conferences – and actually those started to feel like they were more productive and more effective because we were progressing things.'

[C111, school nurse, (1)].

It is interesting that the school nurse describes the lead professional's contribution not only in functional or practical terms, as in sending round emails or chairing planning meetings, but also in emotional and relational terms. The activity of the coordinator has helped to build consensus and a sense of collective purpose and progress, however incremental, which is important to the experience of collaboration in this case. The school nurse is referring here to the social worker, but

also acknowledges the possibility that another agency might provide the coordinating function. Indeed, there was evidence that the lead professional role could and did shift around depending on which services, and which particular practitioners, happened to be involved at the time. Another practitioner involved in Case 1 at an early stage, the youth worker (C104), commented on how the family intervention project (FIP) had previously pulled together the core group's activities. However, this was not exactly a formal arrangement, but the consequence of a relative lack of input from social care (at a time of high turnover of workers) being offset by the intervention of a committed FIP worker. The situation changed again when the FIP worker left and the core group gradually realigned itself around the new social worker. Moreover, with the social worker now taking an active role, the group was able to move beyond 'containment' of the young person through short-term packages of support, and take steps towards a more comprehensive solution to his needs, i.e. a residential school placement.

In Case 2, it was possible to get a picture of how collaboration was developing early on in the child protection process. Almost all of the practitioners pointed to a specific professionals meeting, taking place a few weeks before the initial child protection conference, as marking a step-change in the level of coordination. Up till then, agencies had been unaware or only vaguely aware of each other's involvement, each holding different pieces of information about the family and planning their interventions separately. Nonetheless, even before the referral to child protection services, a number of conversations between practitioners, such as the headteacher (C201), fire prevention officer (C203) and CAMHS (C204), had contributed to a growing sense that the family needed more specialist support. These concerns were passed on to a social worker linked to the younger children's school, who then convened the professionals meeting at the school. It was only at this point that an incident at home triggered the referral to statutory services. In other words, the network had begun to organise itself to some extent even before the core group was formally established:

'I felt that this one, the concerns were there but at a lower level and there was a support system being put into place to deal with – like the fire-setting, the Fire Brigade was dealing with that. With regards to behavioural issues - actually with regards to parenting there wasn't anybody addressing that – but in a way the professionals were already involved by the time it led to a Section 47.'
[C206, social worker (1)].

The social worker here acknowledges that support already existed for various additional needs before the 'Section 47' investigation led to a child protection conference. Nonetheless, her comment about there being nobody looking directly at how the children were being parented is pertinent because clearly this was at the heart of what practitioners considered to be the problem. Just as in Case 1, the absence of a key intervention, i.e. a practitioner who could engage successfully with the parents around this sensitive issue, had stymied the ability of the network to prevent an escalation in the needs of the children. The core group was therefore concerned to manage the risk by refocusing attention away from diagnosis and towards parenting, with practitioners maintaining a consistent message to parents and backing up the strategies adopted by the family support worker in the home. As we have seen, the core group operated quite effectively in this respect, even if the informal allocation of 'care and control' functions in the course of implementing the plan was a matter of contention for some (see Section 5.5.1).

Interestingly, practitioners assigned importance both to consistency and flexibility in the way core groups went about their work. Most obviously, there was a preference for practitioners, especially the lead professional, to remain consistently involved. New workers would need time to 'get up to speed' with the case and might not be able to contribute fully until they had got to know the family. Unfortunately, a regular turnover of workers was an inevitable consequence of long-running cases, and in Case 1 this had required the young person and his mother to repeat their stories to an inordinate number of practitioners. Even in Case 2, where the core group was only a few months old, a change in family support worker had significantly affected the level of intervention that was being carried out in the home. There was also the widely held perception that the core group should try as far as possible to provide families and young people with consistent messages, e.g. about what the concerns were and what was being recommended as a solution.

At the same time, practitioners described the need for flexibility and adaptability. This tended to be practitioners from universal services, or those who were working directly with families, i.e. the mentors (C105 and C107) and youth worker (C104) in Case 1, and the headteacher (C201) in Case 2. In Case 1, for example, these practitioners were often responsible for providing the young person with a range of interim educational provision and alternative activities during the holidays. In other words, flexibility was seen as a tactical necessity even if the network as a whole continued to look for a more consistent longer-term solution. Implementing such plans often demanded

extra commitment from practitioners, who found themselves operating outside of their normal remit. This led to frustration if specialist resources were not made available and stop-gap solutions allowed to drift on:

'It was just little bits here and there but it was constant, you know. We said ages ago he needs to go into residential school setting, like he needs... It's not just that he can't access school here, which he can't. The tutor thing was not working and he can't go to the PRU because of this, this and this...'

[C104, youth worker (1)].

This observation refers to an earlier stage in the case when the current social worker had not yet taken over the lead professional role. In their view, the feedback they were providing at that stage to specialist agencies was not being heeded, and as a result the overall strategy lost its coherence. In effect, the network had stopped adapting and therefore became incapable of fulfilling its function. Conversely, when the new social worker arrived and took on board the core group's assessment, there was a fundamental shift in strategy that eventually yielded positive results when new resources were put into place. A similar tension existed in the debate over the first family support worker's role in Case 2. On the one hand, this worker was proving to be very effective at helping to promote more consistent parenting in the home. On the other hand, this involved a blurring of his remit to work just with the older siblings. Eventually, he and his agency's wish to maintain consistent age criteria won out over the network's wish to retain his expertise, and the result was this worker's withdrawal from the case – though not before he had significantly improved the situation at home.

The withdrawal of services was an issue that came up for practitioners in both cases. Usually it was the timing rather than the fact of withdrawal that was experienced as problematic. Indeed, for non-universal services, withdrawal was seen ultimately as one of the goals of intervention, after families had been helped to a more stable situation in which additional support was no longer required. The concern that families might become dependent on services was balanced against the risk that problems might escalate again once services had pulled out. This was most vividly conveyed by the fire prevention officer in Case 2, who having successfully built a relationship with the youngest child, David, did not want him to revert back to fire-setting so that she might come back and visit him. Her intervention therefore comprised a carefully structured transition period

before case closure. Preference for a staged withdrawal was echoed by some of the other practitioners, particularly the social worker in Case 1, who was worried that a mass pull-out of services might leave the young person bereft of support just as his 'honeymoon period' at school began to wear off. While a given service might have 'seen out' its remit at a certain point, e.g. with the expiry of a YOT order, it was more difficult to know at what stage the network as a whole had fulfilled its function.

5.5.5 Summary

The work done by the core group could be seen both as an amalgam of independent interventions and a collective effort to which every practitioner contributed as and when needed. This was a source of creative tension, as practitioners sought to achieve a balance of care and control in different ways. In Case 1, individual interventions sought to establish connection as well as containment through an emphasis on one-to-one work. In Case 2, there was some functional differentiation within the network, so that the core group maintained a consensus around compliance, while individual practitioners tried to position themselves in less authoritative ways vis-à-vis the family. Both approaches had their merits but also faced challenges and inconsistencies. In Case 1, practitioners struggled within their own remit to cope with the young person's escalating needs, and he would regularly 'break out' of planned interventions. In Case 2, some practitioners were unhappy with the way their roles were being blurred or miscast in order to advance the core group's objectives. It was often hard for practitioners to compartmentalise their work given the complex needs of these families. Collaboration between members was often flexibly and informally negotiated, and roles would change over time as different services came and went. More formal interagency processes were invoked when the network as a whole felt additional resources were required. There was widespread frustration with bureaucratic 'red tape' and 'box-ticking', which was blamed not only for delays and withdrawals, but also for unnecessary duplication of services.

The experience of working with these cases sometimes led practitioners to feel 'stuck', unable to implement their plans, escape from a series of crisis situations, or create sustainable change. However, they were determined to keep striving for progress and if one intervention failed to try something else. This was particularly evident in Case 1, a long-running case in which the core group had developed a culture of commitment to the young person, partly fuelled by a sense that

he had been let down by services earlier on. In Case 2, it was observed that some agencies would persevere (in general) with trying to engage with families, while others would simply withdraw or stop trying if parents were uncooperative. There was also a tension between the organised and 'self-organising' aspects of network functioning. Frontline practitioners in Case 1 were able to organise themselves to contain the young person, but as his needs escalated they required a lead professional to coordinate a comprehensive solution to his needs. Similarly in Case 2, the network had begun to organise itself in response to mounting concerns, but the child protection process signalled a more coordinated approach that enabled the group to act more cohesively. Improvements in the situation led to some uncertainty about timing the withdrawal of services, since it was hard to tell if changes were sustainable or if events might start to build up towards a crisis again.

5.6 Risk

Much has been written about risk in the field of child protection and its links to the concept of complexity were discussed in Chapter 2 (see Section 2.4.3) and Chapter 3 (Section 3.3.3). Although this study was not specifically about risk, it was nevertheless an important reference point for participants' experiences. The high level of need associated with these cases was considered both in terms of short-term risks to children's welfare, such as fire-setting, as well as longer-term implications for social and developmental outcomes. Notions of risk were embedded in many of the ideas already discussed in this chapter, particularly around assessment and intervention. An example was the theme of 'concern', which was experienced both as an individual response to risk, as in 'feeling worried', and also as a way of communicating ideas about risk with others, i.e. passing on 'concerns'. In what follows, the way in which practitioners responded to risk will be explored more fully. Practitioners in these cases generally considered that the overall level of need was increasing, or had increased, to the point where the welfare of children might be seriously compromised. This led to a number of reflections around two main themes: judgements on the acuteness of need, and the struggle to regain control over a situation that was threatening to become unmanageable.

5.6.1 Acuteness of need

It will be recalled that models of integrated working usually envisage a spectrum of need in which increasing acuteness (or complexity) is matched to ever more specialised support (see Section 2.2.7). At the 'top' of the scale are cases of high-level need, in which the risk of harm to health and welfare are greatest, and which should be prioritised for support and intervention. The word 'scale' was not actually used by any of the participants, nor, with the exception of the YOT practitioners, was there any reference to actuarial methods of calculating risk. Nevertheless, practitioners did concern themselves with the idea of an overall level of need, via the sub-themes of 'vulnerability', 'dangerousness', and 'severity'.

Almost all of the participants talked about the vulnerability of children, but also of the parents. Vulnerability included harm resulting from one's own actions, as in Martin's risk-taking behaviour in Case 1. Vulnerability could be interpreted as 'risk-to-self', since the emphasis was on negative outcomes for the person who was vulnerable. A major concern in Case 1, particularly amongst the YOT practitioners and social worker, was the young person's susceptibility to being exploited by older peers who were actively criminal. Others, such as the youth worker (C104) and education keyworker (C113), pointed to his emotional vulnerability. This was evidenced by his case history, and had been exposed by service provision that was unsuited to his needs, such as the pupil referral unit, where he ended up being injured by other pupils. In Case 2, the family as a whole, including the parents, was considered to be vulnerable. The father, for example, had a disability and experience of adversity during his own childhood. The children were seen as vulnerable because over time the family dynamics had led to a lack of consistent parenting in the home:

'I do think that by putting more intense parenting skills and teaching the parents how to put boundaries in, these four children will do really well. Because there's no issues about substance abuse or neglect or anything like that. It's literally a lack of parenting. But it's also changing - you know, working with mum and dad and changing their perception of the child.'

[C206, social worker (1)].

The social worker here emphasises the importance of parental insight, or acknowledgement of the real source of their problems. This goes beyond giving the parents advice, e.g. about parenting strategies, but involves getting them to 'see' their children in a new light. Notably in her comment about the absence of substance abuse or neglect, the practitioner also rejects the idea that the parents are acting in a deliberately harmful way towards their children. For as well as vulnerability,

or risk-to-self, there is always another side to the risk equation, namely 'risk-to-others'. This might be expressed as 'dangerousness', although practitioners tended to use this term in an impersonal sense, e.g. 'the danger is...' [C203, fire prevention officer (2)]. Nevertheless, the question of whether vulnerable individuals might also pose a risk to the safety of others was a crucial one. While risk-to-self and risk-to-others are obviously interlinked, the different weights attached to them could have implications for how risk was interpreted overall, and therefore on what action was taken. An example in Case 1 was the young person's exclusion from mainstream school for his aggressive behaviour towards other pupils. In effect, the decision to exclude him, taken to ensure a safe environment for the other pupils, was seen by most of the currently involved practitioners as having overlooked Martin's own vulnerability and contributed to his subsequent trajectory towards offending behaviour. At the time the interviews were conducted, a widely held concern was that just one more arrest or conviction for Martin would lead to a custodial sentence, putting him further down the path towards adult criminality. On the other hand, while Martin's vulnerability might currently outweigh the perception of how 'dangerous' he was, this might not always remain the case:

'Potentially he could be a danger for the future - and potentially he could be a danger now - because obviously, as I'm sure you know, there's no such thing as no risk. But I think his risk of serious harm at the moment is quite low. Whether that translates into reality in another two or three years' time at the moment is probably anybody's guess.'

[C109, YOT worker (1)]

Here the YOT worker emphasises the contingency of all judgements about risk, which can be managed and possibly reduced but never eliminated. He also refers to the 'risk of serious harm', which is a formal category (ROSH) within the risk management process, or 'scaled approach', currently used within the youth justice system (Youth Justice Board, 2010). It is a reminder that the business of predicting and managing risk is central to the work carried out, not only by the professional network, but the agencies themselves. The YOT worker goes on to remark that this case has become very 'high profile', having been discussed at a strategic level by senior managers. This adds to the pressure on services to stabilise Martin at his current level of risk, since the case history suggests that the acuteness of his needs will escalate should they not manage to do so. A similar concern lies at the heart of attempts in Case 2 to get the parents to drop their

preoccupation with diagnosing their children and follow through with the parenting guidance they have been given:

'If the whole household goes back to that situation then David will revert back to that situation, possibly, and kick off. [...] I think the reason why all four kids, or the other three are on the child protection plan – the danger is, they're being protected because of David. And I think it would be even more frustrating for him because he's got so much, he's on such a good road at the moment and it's all positive and it's being kept there by the support of the professionals.'

[C203, fire prevention officer (2)]

The practitioner here is almost fearing the worst as she prepares to withdraw from working with the family, having observed a very positive change in the youngest child's behaviour but being less convinced about how profoundly the family's dynamics have changed. The image of David being on 'a good road' contrasts with this practitioner's concern in the first interview that he might be on the 'path' towards a conduct disorder. The idea of duality, both of destiny and of character, is here reminiscent of the views expressed in Case 1 about Martin. Indeed, there was at times a striking juxtaposition of vulnerability and dangerousness in how the youngest child was perceived in Case 2, particularly by this practitioner who had spent a lot of time working one-to-one with him. On the one hand, he was a 'little boy' whose behaviour was largely misunderstood by his parents and was 'crying out for help' [C203, fire prevention officer, Case 2(1)]. On the other hand, he was a little boy who was able to bully his parents as well as his older siblings at home, and who was reportedly cruel to animals. As with Martin in Case 1, the typically innocent and vulnerable child was contrasted with this more powerful and unpredictable figure, who could be destructive and violent at times, even towards adults. In both cases, the perception that the children were exhibiting unusual behaviour at quite a young age did much to augment the perceived severity of need:

'Because he was a little bit too young to be coming in first place, I wasn't – I was a little bit concerned that he was even coming to the youth club in the first place, and the way that he was behaving towards the other young people was putting him a little bit at risk sometimes.'

[C104, youth worker (1)]

The youth worker here reflects on a number of ways in which the young person's level of need became apparent. Apart from Martin's difficulty with social interactions, which was getting him into trouble with other young people at the youth club, there is also the question of why he should be wanting to attend a facility meant for older children. His vulnerability is exacerbated by the fact that he ends up accessing a service that is inappropriate for him – a recurrent problem in this case. Indeed, the fact that Martin was receiving so much professional support was seen by several practitioners as a double-edged sword, since it reinforced his deviation from the norm in some respects. This was another point in favour of his specialist school placement, since in one practitioner's words he would be 'nothing special' there [C101, social worker (2)], meaning he would not be singled out as a trouble-maker, whereas in a mainstream setting he would be perpetually transgressing the rules. In Case 2, on the other hand, practitioners were still unsure whether a resumption of 'normality' in the context of services withdrawing from this family would only lead to another crisis developing further down the line. These observations show that while practitioners had to apply certain normative assumptions in order to form their judgements and guide their interventions, their main concern was stability, at a certain level of need and with an appropriate level of support, rather than normality as such. The problem was knowing whether such stability had actually been established, as the next section will explore.

5.6.2 The struggle for control

It was observed above that practitioners were not just concerned about the scale or severity of need, but also about the direction of travel. In other words, was risk going up or coming down? This was a fundamental question for practitioners, whose interventions were as much about bringing about positive outcomes as about averting negative ones. The experience of trying to work towards greater stability and predictability in these cases mirrors the earlier discussion of causality, in which uncertainty about cause and effect was associated with a lack of control over events. The struggle to (re)gain control emerged via the sub-themes of 'escalation', 'projecting outcomes', and 'responsibility'.

The concept of escalation has already been encountered at other points in this chapter. In relation to causality, it was associated with volatility and with how a sudden spate of critical incidents might herald a transition towards a new (and possibly unwelcome) system state (see Section 5.2.2). In terms of relationships, there were observations of escalating conflict between family

members, or in the interactions of service users with practitioners (Section 5.3.3). Assessments identified an increase in the overall level of need and risk, which interventions subsequently sought to stabilise and reduce (Section 5.5.3). In this cyclical process, escalation became as much about the build-up of services as the occurrence of critical events. In Case 2, for example, practitioners such as the headteacher (C201) and family support worker (C208) described a collective push to get statutory child protection services involved, as the accumulating impact of concerns about the family slowly changed the dynamics of engagement:

'What I did was got my cluster social worker involved because I was concerned about various things and it then went into [referral and assessment team], which is then when it got hiked up because the social worker was made to feel very concerned about some of the things that mum was saying about the history.'

[C201, headteacher (1)].

The headteacher here describes how the overall perception of risk changes as existing members of the network react to new information and new members are brought in and start to form their own judgements. The headteacher's remarks show not only that she has been instrumental in getting initial concerns noticed by social services, but also that once the child protection process is underway she has a rather more limited say about what the social worker can be 'made to feel' concerned about. She draws attention to how risk is construed and discussed by the professional network. The family support worker in this case employed a similar idea in rather a different way, reflecting on his role as a conduit for information to the core group:

'I will keep the social worker up-to-date of ups-and-downs and positives. I'll take them to the core groups. I'll be clear with the family that "If you are putting things in place and working well and it's working, then that's something I can take and share. Obviously if it's not working then I have to share that too.'"

[C208, family support worker (1)].

While the family support worker is referring here mainly to his own intervention, his feedback has extra significance because of his privileged access to the family and the centrality of his work to the overall strategy of the core group, i.e. to improve parenting in the home. In effect, this practitioner can provide information that will be highly relevant to the core group's assessment of

risk. This also gives the parents an incentive to cooperate with him – since progress will be reported as well as any continuing concerns. By working alongside the family, the practitioner is trying to enable the parents to reduce the actual risks and keep their children healthy and safe, while also helping them to reduce the heightened risk perceptions that have led specialist agencies to take action. Reframed like this, the mutual goal is for the parents to gain enough insight into and control over their own affairs so that they no longer require professional scrutiny.

In Case 1, the theme of escalation was tied in other ways to the professional network's struggle for control. Several participants, particularly those involved in the case over a long period, attributed much of the escalation in his behaviour to a failure to put in place appropriate services at an early enough stage. In some respects, this was linked to the sequence of events that practitioners thought explained the young person's trajectory from difficulties in early childhood to his later exclusion from school, and by extrapolation from his increasing involvement in offending behaviour to the future world of adult criminality. The core group hoped that a specialist school placement, which was thought to address a range of his needs, would break this vicious circle of escalating risk and successive crisis. The core group had good reasons for believing this, for Martin had not been arrested over the summer and an initial trial period had gone well. Yet elsewhere the social worker speaks of 'holding her breath' and indeed it was not long before new doubts surfaced about Martin's ability to hold onto his placement. His behaviour at school took a turn for the worse and furthermore he was arrested for an incident in his local area. Having invested so much in supporting this particular intervention, some practitioners felt control slipping away again:

'Even before my time working with the case it's taken them two years just to get him into this - some form of EBD school. So you know, if it's taken that long, going through many different channels, different management committees, different panels... If he was to lose his place, how do we go about it the next time? What could we say that can be different, to persuade them to say "well we'll finance it" for another school?'

[C111, FIP worker (2)].

The FIP worker reflects on the challenges facing the core group, should the school placement fail. The case history suggests that securing further resources will be time-consuming and difficult, not least because of the negative precedent now established. In effect, the network had drawn on

their narrative of delayed support and escalating need not just to explain the current problem, but also to convince senior managers that they should approve an expensive resource, i.e. on the basis that it should both reduce the risk and provide an effective and positive alternative to custody. This sheds a new light on the social worker's earlier comments, for she had also used this argument as part of her struggle to obtain the necessary authorisation and funding. In both cases, communications about risk were therefore significant in their own right, often holding the key to whether a particular intervention was accepted, e.g. by the family or by agency managers. Of course, getting these messages wrong could also have consequences. While the core group members in Case 1 were determined not to give up on the young person, his failure to live up to some of their expectations meant their options (and his) were becoming increasingly limited.

The struggle to control or influence outcomes in these cases also intersected with the issue of responsibility. Neither core group could be described as a 'command and control' entity, even if its activities were being coordinated by a particular person. Participants referred to various lines of responsibility, both across and within agencies, which were invoked when events appeared to become unmanageable within a particular professional remit. While universal services tried their best initially to grapple with these problems, they would call on specialist agencies as their concerns mounted. Social workers accepted their responsibility for coordinating interventions in the field, but when it came to decision-making were embedded in their own supervisory and management structures, the 'higher powers', as one of them put it [C206, social worker (1)], who had the ultimate say about thresholds and resources. Looking at it another way, practitioners were also keen to uphold the responsibility of parents for their children. This was especially an issue for practitioners in Case 2, where there was a concerted effort to move the focus away from diagnosis and towards parenting. But even in Case 1, where the young person was largely acknowledged to be 'out of parental control', the social worker was keen to uphold the mother's responsibility for certain decisions, such as ending the respite foster placement. This was not just about legal responsibility (the placement being a voluntary arrangement under Section 20 of the Children Act). It was also about sharing the burden of obligation, i.e. not being 'cast as the bad guy' [C101, social worker (2)], since any sustainable change would require others to take their share of responsibility – especially the parents.

Control was therefore a contested issue in these cases. For if it is assumed that cause and effect *can* be controlled then the question may arise, with hindsight, as to whether it *could* have been

controlled. For example, practitioners in Case 1 were mostly convinced that more decisive intervention on the part of specialist services would have stabilised the young person in an educational setting much earlier. While the struggle referred to by practitioners was mainly about preventing outcomes from spiralling out of control, it was also about dealing with the consequences should services fail. In other words, collaboration was also about sharing the burden of responsibility for potentially insoluble problems.

5.6.3 Summary

As well as identifying the individual needs of children, practitioners tried to assess the overall acuteness of need in order to come to a view on risk. With the exception of YOT practitioners in Case 1, this appeared to be based more on intuitive judgement than on structured risk assessment tools. Risk was often associated with vulnerability, or risk-to-self. In Case 1 it was primarily the young person who was seen as vulnerable, while in Case 2 the family as a whole was seen as vulnerable, along with concerns about specific family members. In both cases, vulnerability was linked to the idea of 'dangerousness', in the sense of behaviour that posed risk to the welfare of others, such as fire-setting, aggressive behaviour, or inadequate parenting. The risk profile constructed by practitioners, in turn affected the services provided to the family, so that an escalation of need was accompanied by a steady build-up of services, and in particular the involvement of statutory agencies.

Practitioners were concerned to regain control of events in these cases, which meant trying to stabilise need and reduce the volatility of potential outcomes. Communication about risk was important in the joint approach taken by the core groups. For example, in Case 1 an argument around preventing an escalation in offending behaviour was used to press for specialist resources. In Case 2, the core group had to convince the parents of the likely negative outcomes if they did not take steps to change their parenting style. Collaboration also enabled practitioners and their agencies to share the burden of responsibility for managing risk. Various lines of accountability were invoked as risks increased beyond the purview of individual responsibility, passing not only up through hierarchies of managerial control but also crossing over from universal to specialist services, from practitioners to parents and even back to the children themselves.

5.7 Conclusion

The aim of this chapter has been to explore how practitioners experienced complexity while working together on these cases. Common elements in participants' experience were discussed in the form of superordinate themes emerging from a detailed analysis of interviews. These were then grouped into five sections relating to the overall context of collaborative casework. The findings are summarised below in Figure 5a.



Figure 5a. IPA findings: how professionals experienced complexity

Firstly, the implications of complex causality led participants to explore the operation of cause and effect, and was often experienced as a lack of control over events. Secondly, the importance of interactions in complex systems was reflected in a number of themes around relationships. Participants negotiated relationships with both service users and fellow practitioners, encountered

dynamics of acceptance and rejection arising from this social contact, and perceived various areas of disagreement and conflict. Thirdly, a cyclical process of assessment meant considering the significance of different pieces of information in the light of existing or emerging hypotheses about the case. There were both individual and collective processes of understanding and explanation, in which the emotional resonance of the case also played a part. Fourthly, intervention meant negotiating one's own contribution as the network came together to try and achieve the sustainable change that had eluded individual practitioners. Among other things, this involved a balancing act between care and control functions. Finally, heightened risk perceptions were associated with acute or escalating needs, and led practitioners into a struggle to reduce those needs or at least stabilise them at an acceptable level.

Moving on from this summary to try and pick out some common threads and key points for later discussion, there are some further conclusions to be drawn at this stage. Complexity in the sense of non-linear causality was certainly recognisable in many of the issues addressed by practitioners, such as volatility, escalation and unexpected consequences. The difficulty of predicting or controlling events was then exacerbated by the impact of the 'double hermeneutic', which placed a further interpretative burden on practitioners. These issues fed into the overall activity and functioning of the network itself. For example, relationships might be experienced as 'volatile', in the sense of becoming prone to breakdown or conflict. Practitioners often oscillated between positive and negative evaluations of character or circumstance, and tried to strike a balance between coercive and supportive modes of engagement. As well as trying to manage 'client systems', i.e. the primary sites of need and intervention, core groups also manifested their own complex behaviour. There was a certain amount of self-organisation, as collaborative arrangements and 'inner' and 'peripheral' structures developed within the network. At the same time, core groups were 'self-aware', in the sense of recognising and shaping their own behaviour. Characteristic of this self-awareness was the desire to have a strong professional lead, especially from social workers, to coordinate the group's activities.

Related to this last point was the question of what coordination actually meant. Were core groups carrying out a tactically coordinated amalgam of separate interventions, or a single 'strategic' intervention in which everyone played a part? The findings suggest this was a difficult issue to resolve, given the turnover in workers and affiliation of group members to their own agencies. A strategic approach might be more effective if it enabled the core group to tailor their intervention

to the problems at hand. However, it might also require practitioners to operate outside of their official remits or areas of expertise, raising concerns about blurring of roles and referral criteria. A similar discordance was evident in the assessment process, in which practitioners each contributed their perspective to an overall picture of the situation, but were also free to draw their own conclusions. Diagnosis was a particular problem in this regard, since the agency with authority to diagnose (CAMHS) tended to withdraw after completing their assessment, or if the family did not engage. As a result, a number of diagnostic hypotheses continued to circulate in the core group, which were not always derived from the original CAMHS assessment, and indeed sometimes were at odds with it entirely.

The findings also shed some light on the complexity of interprofessional communication, which served a variety of purposes, both explicit and implicit. The different layers of meaning around the term 'concern' was one illustration of how exchanges between practitioners shared more than just 'factual' information about families, but also conveyed messages about responsibility and risk. This is one of the areas that will be explored in the next chapter, which will look more closely at how such messages were constructed. Linked to this was a cluster of issues around status and hierarchy. Practitioners with a higher status in the core group were those from specialist agencies, with a remit to make assessments and diagnoses, to coordinate interventions, and make decisions about risk. Some practitioners, such as mentors and family support workers, understood their role more in terms of helping to implement plans and provide feedback to the group. Other practitioners saw themselves as equipped to comment on specialist matters, but were not always satisfied that their expertise was being acknowledged. CAMHS were perhaps the agency with the highest status, being a tertiary service headed by a medical practitioner, but were not always actively involved in the case. In general, there was an incomplete differentiation of roles and responsibilities in these core groups, exacerbated by a multitude of managerial lines of control. Overall this led to inconsistent expectations and dysfunction in certain areas, or at certain stages of the case.

In conclusion, practitioners experienced complexity as a myriad of issues stemming from their efforts to understand and influence behaviour in an unpredictable 'client' system, while also attending to their own dynamics as a network. Practitioners strived for long-term stability in their search for solutions to complex needs, but in practice this often meant battling to contain volatile outcomes while sharing the responsibility for risk. Depending on the degree of coordination, the

core group might function as a collection of separate interventions, as a self-organising network of ad-hoc collaborations, or as a collective enterprise. Practitioners had to cope with a considerable degree of uncertainty and ambiguity, which fed through into various dilemmas of judgement and practice. In response, they sought boundaries of involvement that aimed at connection as well as demarcation, and which emphasised relationships as perhaps the most important resource of all.

6. Critical discourse analysis

6.1 Introduction

This chapter will present the findings of a critical discourse analysis (CDA) of interview transcripts. The qualitative material is the same as in the previous chapter, but is explored through a different analytical lens. The interpretative phenomenological approach used the transcripts as a way of accessing the meanings attached by practitioners to their experience of complexity. From the perspective of CDA, their accounts are viewed as texts *about* complexity, which have been built up during the course of an interview (see Chapter 4, Section 4.5). CDA aims to deconstruct these texts, by looking at the ways in which their authors, or speakers, made certain choices about what to say and how to say it. This also means that what is 'outside' of the text is, or can be, relevant to what is expressed within the text. The textual analysis is situated in the context of 'discourse' in a broad sense, meaning influential ways of representing the world. For example, Fairclough (2003: 17) refers to an 'ill-defined penumbra' of other texts that help shape how particular phenomena are perceived and interpreted. This is not to say that experience is colonised or presupposed by discourse. The idea is that different discourses intersect and compete with each other, as well as being re-enacted and re-contextualised, as people (re)present their experiences from a particular viewpoint.

In contrast to the previous chapter, which examined how practitioners perceived and experienced complexity, the analysis in this chapter will show how they *constructed* complexity in their accounts – a somewhat technical usage that relates to the deconstructive aims described above. The CDA findings are discussed in six sections, which derive from the analytical structure set out in Chapter 4, Section 4.5.3. Firstly, there is a discussion of the 'genre' of the qualitative research interview, to which these texts arguably belong. Secondly, there is an exploration of intertextuality, or the treatment of different voices and points of view. Thirdly, some of the implicit assumptions underlying the meaning of texts are examined. The next two sections concern the representation of social events and then the question of 'styles', or how participants engaged with, and in some ways enacted, particular identities as practitioners. Finally, a discussion of interdiscursivity will show how a range of discourses contributed to, and emerged from, the construction of complexity in these texts. As in the previous chapter, the analysis will point to

common and divergent themes between cases and professional groups, and for ease of reference an overview of the two cases is reproduced below in Table 6a. The chapter concludes with an overall summary and some reflections on the critical implications of findings.

Table 6a. Overview of cases

	Case 1	Case 2
<i>Family make-up</i>	Mother, son	Mother, father, 3 sons, one daughter
<i>Ethnicity</i>	Black British Caribbean	White British
<i>Subject of child protection plan</i>	14 year old boy, 'Martin'	7 year old boy, 'David'
<i>Duration of plan</i>	18 months	2 months
<i>Main issues</i>	Out of parental control Out of education Involvement in criminal offences Vulnerability to abuse (in community)	Neglect and lack of supervision Fire-setting in the home (risk to siblings) Aggressive and sometimes violent behaviour towards family members
<i>Participating professionals in core group</i>	Social worker (C101) Youth worker (C104) Mentor (C105) YOT mentor (C107) CAMHS psychiatrist (C108) YOT case worker (C109) School nurse (C110) FIP worker (C111) YOT case worker (C112) School keyworker (C113)	Primary school head (C201) Fire prevention officer (C203) CAMHS specialty doctor (C204) Family support worker (C205) Young carers (manager) (C206) Social worker (C207) Family support worker (C208)

6.2 Genre

As noted in the discussion of CDA methodology (Chapter 4, Section 4.5.3), individual texts fall into genre categories by virtue of having developed from similar social practices. In a general sense, the texts examined in this chapter could be classified as 'interview transcripts', as they were all produced via a broadly similar interview process as part of a research study. On the other hand, the textual content of the transcripts may also have been influenced by other genres, such as supervision discussions or multiagency meetings. Practitioners often used medical terminology, referring to diagnostic criteria that might have initially appeared in a formal CAMHS assessment. In relation to ADHD, which was discussed by almost all of those interviewed, there was reference to the child 'tapping and walking around' [C203, fire prevention officer, (1)], and of the condition

being 'linked with a bit of Aspergers syndrome' [C105, mentor (1)]. Similarly, there was frequent recourse to terminology associated with the field of children's social care, such as 'support', 'concerns' and 'needs', all of which were identified as 'keywords' in relation to standard usage in the British National Corpus (see Section 4.5.3.7). One effect of this interpellation of professional terminology with more everyday language was to contribute a more formal 'tenor' to the interview (see Halliday and Matthiessen, 2004: 631), a tendency that may also have been linked to the desire to preserve confidentiality, or to limit the exposure of professional practice in an ongoing case:

I: 'If they had found a suitable school initially, and the necessary tests related to his learning abilities and mental health, they could have saved themselves a lot more money and things could have been a lot more improved.'

Q: 'So who could have made sure that happened?'

I: 'I just think the people who have powers regarding those areas, you know - so obviously this is taken to the highest level within the service and I think it's a matter of - like I say, I understand that they've got to distinguish which case deserves it, but I think with this one there was a lot of tell-tale signs where this case would be going.'

[C111, FIP worker, (1)].

This extract illustrates the choices available to the FIP worker (I) in speaking about a particular topic. He is advancing the view, which was shared by most of the core group, that this case has escalated from a relatively manageable level of need. The indefinite pronoun 'they' refers to those agencies, or people in positions of authority, who the speaker considers should have taken action at an earlier stage. Of course, while the FIP worker diplomatically avoids criticising partner agencies directly, he could also have chosen not to mention the issue at all. What this illustrates is how texts are inextricably linked to the social processes of which they are part. The explicit purpose of the interview, namely to elicit participants' views on a particular topic, will also incorporate more implicit or underlying concerns, e.g. on the part of practitioners to be careful about what is said 'on record', or on the part of the researcher to accumulate material that is relevant to his research question.

Analysing the purpose of a genre, or the purpose of the social practices involved in producing that genre, recalls Habermas' distinction between 'communicative' and 'strategic' action (Habermas,

1984). In the former, actors in a social process try to reach an understanding through cooperation and consensus. In the latter, the emphasis is on achieving particular goals, so that social interaction becomes 'instrumental' rather than communicative. Arguably research interviews could be viewed as a combination of both communicative and strategic action. Such interviews are conducted in a particular format for a specific purpose, but also involve a genuine effort on the part of both parties to reach an understanding. In the first extract given above, for example, the questioner (Q) follows up on a particular aspect of the interviewee's account, but does not have a desired response in mind. Indeed, Fairclough (2003) points out that we should be careful not to reduce such exchanges to purpose-driven strategies, as this ignores the multi-faceted nature of human communication.

A further issue is that of generic structure and differentiation *within* a given genre. The research interview is a defined form of face-to-face meeting, with conventions and expectations to do with the format as well as the subject of discussion. In this study, the topic itself was clearly defined, as was the experiential material on which participants were requested to draw, i.e. their involvement in a particular case. Nevertheless, that still allowed plenty of scope for variation, not only between the type of interview carried out here, and what might occur in other studies, but also between individual interviews in the sample. Interviews followed a loosely structured format, with areas of interest pursued in a conversational way rather than as a set list of questions. This enhanced flexibility and responsiveness, but meant that length, frequency and pattern of turn-taking varied from one interview to the next. Some interviewees gave long responses that covered several areas of interest, while others preferred to be prompted or to answer one question at a time. The interviews therefore facilitated a balance between variation and consistency, within the boundaries of a particular genre, and in accordance with the study design.

In summary, the genre of 'research interview' was influential as a form of social interaction that led to the production of texts for this study. While texts were very largely composed of what interviewees said, the researcher as co-author of transcripts also contributed to the direction and emphasis of discussion. Interactions involved a balance between strategic action, directed towards the purposes of researcher and participants, and communicative action in order to reach an understanding. Participants incorporated a variety of sub-genres into their accounts, often deriving from work contexts. The format of interviews was flexible enough to allow for variation in form and content within a loose generic structure.

6.3 Intertextuality

The analysis of intertextuality can point to the presence within a text of multiple voices and perspectives (see Chapter 4, Section 4.5.3). As such, intertextuality is linked to the way texts treat 'difference', not only differences of opinion between people but also people's awareness and acceptance of divergent or competing points of view. Among other things, the 'orientation to difference' of a text, or group of texts, might therefore give an insight into what social practices and discourses are seen as authoritative or conversely as subject to challenge. Some differences may be accentuated or even polemicised, while others are bracketed or suppressed. Recalling the foregoing analysis of genre, an example of 'bracketed' difference in this study would be any difference of opinion between the interviewer and interviewee, since the research process is designed to focus as much as possible on the views of the latter.

The interprofessional context of the case discussion in these interviews gave rise to a large variety of potential 'voices' and perspectives. Analysis of pronoun usage shed light on some broad tendencies in this regard. In addition to the authorial voice ('I'), participants were also inclined to adopt the collective 'we', referring either to their own agency or team, or to the professional network around the case. Individual practitioners were either mentioned directly, or referred to as part of a group – inclusively, e.g. as 'we', or separately, e.g. as 'they'. While parents and children were formally part of the core group, they were almost always mentioned separately rather than inclusively. Using concordancing software to examine the general patterns of pronoun usage across the two cases yields the following results:

Table 6b. Ten most frequently occurring pronouns (by case)

Case 1 transcripts			Case 2 transcripts		
Pronoun	Frequency (% of corpus)	Weighting (% of overall pronoun usage)	Pronoun	Frequency (% of corpus)	Weighting (% of overall pronoun usage)
<i>I</i>	2.25	26.3%	<i>I</i>	3.07	35.7%
<i>He</i>	1.73	20.3%	<i>They</i>	1.20	14.0%
<i>Him</i>	0.98	11.5%	<i>We</i>	0.97	11.3%
<i>His</i>	0.77	9.0%	<i>He</i>	0.76	8.8%
<i>We</i>	0.76	8.9%	<i>It</i>	0.72	8.4%
<i>They</i>	0.62	7.3%	<i>She</i>	0.55	6.4%
<i>She</i>	0.37	4.3%	<i>Them</i>	0.46	5.3%
<i>Me</i>	0.29	3.4%	<i>Her</i>	0.32	3.7%
<i>Her</i>	0.20	2.3%	<i>Me</i>	0.31	3.6%
<i>It</i>	0.57	6.7%	<i>Him</i>	0.24	2.8%

Even this basic statistical summary shown in Table 6b reveals some interesting differences between the two corpora (collections of texts). First person pronouns, e.g. ‘I’ and ‘we’, are more common in Case 2 texts than in Case 1. When it comes to third person pronouns there is an even more obvious split. ‘They’ occurs almost twice as frequently in Case 2 texts (and ‘them’ even more so), whereas the pronouns ‘he’, ‘him’ and ‘his’ are much more common in Case 1. Finally ‘she’ and ‘her’ occur more frequently in Case 2. Bearing in mind the findings of the previous chapter, it is possible to hypothesise even at this stage about whose voices are influential here. Most obviously, there is a greater focus on the young person in Case 1, while the mother’s voice is more prominent in Case 2. Less easy to explain is the greater usage of both ‘I’ and ‘we’ in Case 2, since there could be a number of reasons for this. For example, practitioners who emphasise the authorial voice might also tend to draw on arguments about which there is a consensus. On the other hand, it might be that certain aspects of the case have given rise to these choices. More specifically, one could hypothesise a link between the higher incidence of first person pronouns and the higher incidence of third person plural pronouns in Case 2, in that an ‘us’ and ‘them’ dynamic could reflect the exploration of antagonistic relations in the case. However, such an argument requires a closer analysis of the treatment of difference within the interviews, as illustrated by the two extracts below:

'These are professionals and none of us say anything to upset them or say anything too... for any other reason other than black and white: "This is what's happening, this is what our job is, to say 'this is a result of your parenting'". But they won't listen to it.'

[C203, fire prevention officer, Case 2(1)].

'Yes it was a professionals meeting initially but we called the family in as well because we wanted to discuss with them exactly what was going on and where we were at with things as well, to keep them up to date.'

[C208, family support worker, Case 2(1)].

Here both practitioners refer to the challenges of communicating with the parents about the impact of their parenting style on the children's welfare. We already know that the 'history' of the case has established an oppositional dialogue between the voice of the parents (particularly the mother), and that of the practitioners. In the first extract this is openly reproduced by the speaker, who represents the view of the network as a single voice ('we'). This voice is rational, concerned with establishing the 'black and white' facts of the situation, and authoritative, able to assert what 'is happening' with a high degree of certainty. In contrast, the parents ('they') do not offer a rational counter-argument, but react emotionally by getting 'upset' and refusing to listen. Although there is an acceptance of difference here, the protagonist-antagonist dynamic is clearly established via the (assumed) preference for rational insight into the family's problems. The dynamic develops further in the next extract, which briefly describes a professionals meeting at which parents were invited to participate at the end. Although the division between parents ('they') and practitioners ('we') is acknowledged, the former's voice is now absent as the latter concentrate on communicating their shared concerns. The voice of the network, which was distinctive in the other extract, here merges into the narrative as oppositional dialogue turns into a more instrumental process of discussion, i.e. about facts ('what is going on'). Instead of resisting what practitioners are saying to them, the parents can instead be kept 'up to date'. The differences that seemed so insuperable to the first practitioner have simply been bracketed as part of the emerging consensus achieved by the meeting.

What this analysis shows is that the presence and disappearance of different voices within a text, or collection of texts, can be linked to the relational dynamics discussed in the previous chapter. Efforts to resolve difference in Case 2 might eventually result in a merging of 'we' and 'they'

voices, for example, if parents came to hold the same view as the practitioners. On the other hand, the suppression of difference in meetings might not be sustainable when it came to implementing the plan, resulting in a resumption of adversarial interactions. Of course, the collective voice of the network will itself represent an amalgam of different views, which as we saw in the previous chapter might include disagreements about the right way to approach the family. Whatever is presented as a unified perspective will tend to accept the prominence of certain views over others. The resolution or bracketing of difference therefore forms part of the co-production of knowledge, which is later considered 'background information' in long-running cases. The acceptance of particular judgements about diagnosis and parenting capacity are an example of this process in both cases.

An important source of intertextuality was the 'case history' referred to by most of the participants (see Chapter 5, Section 5.4.1). The term suggests a semi-official corpus of documentary information that was available to practitioners, including but not limited to feedback from colleagues and service users. However, the origin of this information was only occasionally specified. In two interviews, participants referred to printouts of case notes and referral letters [C108, CAMHS psychiatrist, Case 1(1) and C207, family support worker(2), Case 2(2)]. This meant that part of their own account was either quoted or drew from existing documents, whose original authorship was unclear. The YOT workers and social workers, on the other hand, mentioned their access to case files as an important source of knowledge. Other than this, there was very little explanation of where particular pieces of information had come from, unless it was from family members. The main exceptions were the CAMHS assessments in both cases, by virtue of their significance for the contested issue of diagnosis.

I: On this occasion his diagnosis of ADHD has had a major implication on what we've managed to secure for Martin and on the interpretations of his behaviour.

Q: Have the resources that you were asking for relied on a particular diagnosis?

I: 'And we can't get anything. All of us think that he is on the autistic spectrum - or most of us think that he could be on the autistic spectrum - but we can't access any autistic spectrum directed resources because we don't have a diagnosis.'

[C101, social worker (2)]

In this extract, the collective view of the core group is reportedly at odds with the existing CAMHS assessment. The dispute is not only with a particular text, whose influence is felt to be detrimental to the implementation of the plan, but also with a Tier 3 medical service whose authority to diagnose is paramount. Intertextuality can be viewed here as serving a rhetorical function, in that the social worker invokes the group as a source of authority in order to counter the status of the CAMHS judgement. In the process, the official medical text is implicitly opposed to a number of other unspecified texts, which presumably stem from interprofessional discussion. Again it is worth noting that presenting a consensual view also means playing down various nuances of opinion that may exist among members of the network. For as we saw earlier, at least some of the practitioners involved in the case are prepared to assume a combination of ADHD and autism as a reasonable explanation of the young person's needs, and furthermore would not see it as their role to challenge the official diagnosis. The social worker therefore brackets some differences and accentuates others in order to construct her position as the protagonist in the argument. Other practitioners involved in Case 1 drew on the core group's collective viewpoint to express dissatisfaction with delays in service provision, which were then attributed to individuals or agencies with greater powers and responsibilities than individual practitioners.

Of course, difference did not always boil down to mutual antagonism or some form of consensus. The viewpoints of other individual practitioners were only occasionally mentioned. Practitioners also tried at times to explore different points of view without necessarily having to resolve or contradict them:

'And I think the other thing that they found very difficult is every time that one of these meetings happens, their past gets raked up. [...] And I can completely understand – well, you want to say "look that was done and dusted, it's gone, we've moved on, we're different people, we've grown up"'

[C201, headteacher (2)].

This practitioner presents the perspective of the parents in a sympathetic way, acknowledging their view that certain aspects of their personal history are no longer relevant to the current situation. This does not necessarily mean that she agrees with them, since from a professional point of view such information is part of the 'case history' and might have to be shared. It is this interweaving of voices that made some accounts seem more dialogical than others. While the

voice of the young person was often present in Case 1 interviews, it was usually filtered through what practitioners had observed and surmised about his behaviour. His mother's views were reported less often but tended not to be mediated as much. In Case 2, on the other hand, the perspective of the parents was influential but most often occurred as part of an oppositional dialogue with practitioners.

In summary, the analysis of intertextuality looked at the extent to which interview texts were dialogical, i.e. brought in different perspectives in addition to the authorial voice. This was then linked to the treatment of difference (e.g. disagreement, consensus) and the relational dynamics which had developed in the case. Patterns of pronoun usage suggested the significance of an antagonist-protagonist dynamic in Case 2, while in Case 1 the young person was constructed as the focal point (both subject and object) of professional involvement. The collective voice of the network was significant in both cases. In Case 2, an oppositional dialogue ('us' and 'them') pitted the rational, instrumental viewpoint of the network against the resistant and emotional response of the parents. In Case 1, the core group's combined weight of opinion was deployed by some practitioners to counter the medical authority of a disputed CAMHS assessment. Practitioners who adopted forms of collective identity necessarily suppressed differences that might exist within the group, e.g. varying degrees of acceptance of the diagnosis or of the client's viewpoint. Reducing dialogicality was therefore a feature of the co-production of knowledge, as a multiplicity of views coalesced into a consensus around certain key issues, e.g. parenting capacity. Over time, some of these originally contested meanings would blend into the background of documentary information about the case, which practitioners would refer to as its 'history'.

6.4 Assumptions

Fairclough (2003) identifies three types of assumption that may be analysed in texts: existential, propositional and value assumptions. Existential assumptions are about what is assumed to exist. Propositional assumptions assert that something is (or will be) the case. Value assumptions are about what is considered good or desirable. As noted in Chapter 4 (Section 4.5.3), assumptions tend to reduce the dialogical possibilities of a text by implicitly rendering particular viewpoints commonsensical and non-attributable. In the context of this study, a simple example might be the existential assumption that practitioners and service users exist independently of their

relationship to each other. Yet even this seemingly obvious assumption has certain implications, as the following extract illustrates:

'It's very telling that at the last meeting, one of the last meetings we had, Mum was very cross and said, basically said things about, "Well who's going to get the credit for doing all this? I bet it won't be us, and nobody has thanked us for doing this." And you want to say, "They're your children, it's your job, it's not..." So there is a complete mismatch of understanding about, about "Well you should be doing this, no actually they are still your children."'

[C201, headteacher (2)].

The speaker here refers to an episode during a core group meeting in which the mother reportedly suggested that professionals would unfairly claim 'credit' for implementing the approach set out by the child protection plan, rather than 'thanking' her for doing so. This strikes the headteacher as unjustifiable, since from her perspective the practitioners are helping the mother to do something that she should (and would) be doing anyway, i.e. enacting her role as a parent. However, the mother's words challenge the assumption that professionals exist in a neutral and objective space. Instead the relationship with their clients is presented as one of interdependence – for example they rely on parental cooperation to achieve the changes which their professional remit requires of them. Of course, such a stance ignores or downplays other assumptions, such as value judgements about parents being obliged to prioritise their children's welfare. In addition, working on child protection cases is not a core activity for the majority of practitioners, such as teachers. However, it is a measure of how significant for practitioners was their assumption that they were performing a 'helping' role that the mother's comments were seen as outlandish – not just by this practitioner but by another participant who mentioned the same incident [C203, fire prevention officer (2)]. From a more critical standpoint vis-à-vis the 'caring professions' (e.g. Illich et al, 2005), such views might have seemed contrarian but not incomprehensible.

The generally accepted notion that practitioners were (or should be) acting disinterestedly to promote the wellbeing of children and families was connected to a variety of other assumptions concerning the purpose and nature of intervention in these cases. These varied between practitioners and even within individual accounts. For example, in Case 1 most practitioners referred to the need to reduce the young person's offending behaviour and get him back into mainstream schooling. Interventions were aimed at encouraging him into socially acceptable

activities and away from anti-social or criminal ones. In other words, the welfare of this vulnerable young man was to be promoted by integrating him into the fabric of 'normal' society. This chimes with an assumption that welfare services are there to maintain that social fabric and with it the existing social order. At the same time, individuals have both the freedom and responsibility to make choices about their lives, including the decision to opt for a conventional lifestyle and stay out of trouble. These 'individualist-reformist' assumptions (Payne 2005) were complemented and to some extent modified by other perspectives:

'It's very easy for him to get stuck in a cycle of: "I want to achieve, how am I going to achieve? Society says I achieve by making money but I can't do that through getting a job because I haven't got any qualifications. So I want to be respected, I want people to think I'm worth something so I'll go and commit crime to get money." So even if he didn't want to do that it's like he feels pushed into it.'

[C107, YOT mentor, Case 1(1)]

'I think the boy needs to open up. And I think the in-house therapy that we have - professionals come into the school, so he doesn't have to travel, he'll be taken out of the school day, to just see if he can open up... I mean maybe he can't but I think it's something that we should offer him.'

[C113, school keyworker, Case 1(2)]

In the first extract, the YOT mentor presents an internal monologue, attributed to the young person, as a way of showing how social pressures might contribute to his actions and decisions. As well as the young person's peer group, whose respect is important to him, pressure is also exerted through the mismatch between conventional expectations, i.e. of material wealth and status, and his marginalised social position. The supposed train of thought posits the individual as a rational actor, who pursues reasonable goals but finds they are not easily achievable – not just because of personal deficits but also due to socially inscribed structures of disadvantage and opportunity. The pursuit of status, which might be more positively evaluated, e.g. as 'ambition', if carried out through conventional channels such as work or education, can accordingly become a driver of criminal activity. As a consequence, part of the aim of professional intervention must be to change the conditions that divert a person's life course away from constructive participation in society. Of course, this stops short of suggesting that society must be radically transformed in order to do so, but the responsibility for change is implicitly shared between society and the individual. Similar

assumptions underlay the emphasis placed by many of the practitioners in Case 1 on securing specialist resources for the young person, and their insistence that he had been let down by services in the past. It was also noted that as a young black male he belonged to a particularly disadvantaged section of society, and was as such perhaps more liable to be 'written off by the system' [C101, social worker, Case 1(1)].

The second extract, on the other hand, indicates a rather different set of assumptions about the nature of intervention and welfare. Here the keyworker states her view that the young person would benefit from some form of therapy or counselling. Her use of the term 'open up' suggests the value of gaining insight into feelings and subjective experiences, and a belief that people who are able to do so are better placed to overcome hardship and achieve personal fulfilment. The role of intervention is therefore to facilitate this process, through a cycle of interaction and understanding based on the therapeutic relationship between client and practitioner. In the long run, the individual may be sufficiently empowered to make improvements in his or her way of life, and in his or her relations with others. Of course, a focus on personal growth implies quite a lengthy period of intervention, and indeed the keyworker acknowledges this later in the interview. The young person would need to stay at the school for a number of years in order to benefit fully from what it had to offer him. A similar perspective was expressed by the youth worker, who emphasised the value of direct therapeutic work and a relationship characterised by informality and voluntary engagement. Other practitioners certainly acknowledged the need for such therapeutic work, but were also concerned to put in place measures to contain the young person and make sure his behaviour did not escalate out of control.

Assumptions about risk – particularly when risks were seen as increasing – were important in framing assumptions about the nature and purpose of intervention. This was also evident in Case 2, where the shared perception of escalating risk had eventually triggered a more coercive approach to intervention. Again the assumed basis for optimising welfare was consistent with a perpetuation of social norms. This could be seen in the emphasis on good-enough parenting in the home, as well as the notion that the youngest child might develop a 'conduct disorder' in the future (and that this should be prevented). The shift to child protection procedures also meant that the parents' attempts to challenge professional assumptions, for example about the validity of assessments or diagnoses, were dealt with more firmly than they had been before. CAMHS, it will be recalled, had previously carried out two assessments for ADHD on the youngest child,

largely on the parents' insistence. In contrast, the child protection plan sought explicitly to discourage the parents from requesting any further such assessments. At the same time, elements of a more therapeutic basis for understanding intervention were also evident in practitioners' accounts, for example in the fire prevention officer's descriptions of her direct work with the child, or in the headteacher's reflections on her relationship with the mother. Both practitioners continued to attach significance to the personal growth and ultimately the happiness of the individuals with whom they worked.

A crucial aspect of both cases was how to understand and manage behaviour. Practitioners invoked a range of different assumptions in this respect, which were often encapsulated in the debates about diagnosis. In one sense, the possibility of diagnosis was valued because it would enable a classification of behaviour in order to guide interventions, allowing support to be tailored to the child's needs. It also fitted in with a conceptualisation of professional practice as scientific, able to promote change on the basis of a rational understanding of human beings and their actions. On the other hand, the importance attached to diagnosis might also serve to divert attention away from equally (or more) important antecedents of behaviour:

'He could come here and sit for two or three hours and draw a picture or talk about art or do that for like two hours. And sometimes he couldn't but that's always based on his feelings, because of something that had just kicked off before he got here, just because of how he was feeling. It was emotionally based rather than a pure medical physical reaction to something.'

[C104, youth worker, Case 1(1)]

The quote from the youth worker criticises an assumed tendency on the part of some practitioners to medicalise the young person's behaviour, i.e. to see it as being generated by some underlying bio-medical mechanism. She suggests instead that behaviour will differ according to the individual's state of mind at a given time, highlighting the role of emotional responses to demanding or stressful situations. Her remark distinguishes between a medicalised discourse of behaviour as symptomatic – or as a 'cluster' of symptoms in psychiatric terms – and a more therapeutic discourse of behaviour as the contingent outcome of mental processes. What is left ambiguous is whether these mental processes are 'knowable'. From a strictly behaviourist point of view, it would not be possible to know what was 'going on' in someone's mind, but the practitioner implies that she does know the young person well enough to be able to interpret his

feelings. For her it is therefore not a case of substituting a correct diagnosis for an incorrect one, and adjusting the 'treatment' accordingly, but rather to move away from a medical model of understanding behaviour and towards a more therapeutic model. In contrast, other practitioners in Case 1, such as the social worker, continued to vouchsafe a diagnostic understanding of behaviour, even if some of them disputed the content of a specific CAMHS assessment. In Case 2, on the other hand, diagnosis was more widely seen as a problematic discourse, mainly because of its association with parental resistance to professional recommendations but also because of ethical concerns about wrongly labelling a young child with a psychiatric disorder.

Clearly most practitioners assumed that it was possible to change the behaviour of service users, even if they might disagree about the way to do it, e.g. through medication, counselling, or the application of social learning techniques. On the other hand, their reflections on people's character tended to assume a certain constancy or consistency, as in the characterisation of the young person in Case 1 as being 'bright' (i.e. regardless of his level of education), or of the youngest sibling in Case 2 as being predisposed to aggression (i.e. compared to his siblings). Both innate and environmental factors were therefore assumed to play a part in producing a given set of behaviours in the current context, as well as a likelihood of life outcomes in the longer term. This was linked to a further series of assumptions around individual autonomy and freedom of choice, as opposed to determinism and the absence of choice. In Case 1, the young person was held to be 'out of parental control' [C111, YOT worker (2)] and insofar as his mother was perceived as cooperative and doing her best to deal with him, she was not held to be at fault for his activities. As long as the young person remained excluded from school it was this structural deficit that was held chiefly to account. However, once he was back in school more emphasis was placed on whether he chose to comply with the rules and restrictions placed on him. In Case 2, the parents were mainly held responsible for their children's behaviour, although they were acknowledged to be coping with stressful circumstances. Crucially, they were in a position to accept or reject the support offered to them. Autonomy was associated with personal responsibility for outcomes, and therefore counterbalanced both the accountability of expert systems and the wider impact of social structures.

In summary, practitioners made a number of assumptions about what was knowable, possible and desirable. These were sometimes complementary and sometimes in conflict. Tensions were evident in Case 1, where a bio-medical understanding of behaviour co-existed with a more

therapeutic perspective that emphasised subjective experience and personal growth, or in Case 2 when parents considered practitioners to be unhelpful and indifferent to their views. Some assumptions were generally held by practitioners, for example that professional judgements could be neutral, or that the aim of interventions was to encourage pro-social behaviour and promote integration into mainstream institutions, e.g. education. Escalating risk was assumed to justify a more coercive form of intervention, with greater emphasis on individual reform and responsibility. Explanations of cause and effect were often bound up with value judgements about who bore responsibility for problems, as well as for outcomes. In both cases, the link between assumptions about fact and value may have contributed to the dynamics of collaboration, in Case 1 by shifting the focus of intervention onto the young person rather than the parent, and in Case 2 by fuelling an oppositional dialogue between parents and practitioners.

6.5 Representation of social events

While interview transcripts did not constitute a sustained narrative in the same way as a story or newspaper article, they were nevertheless texts about social events. These ranged from single events such as meetings and conversations, or processes such as assessment and intervention, or more abstract concepts to do with the development of relationships or engagement with bureaucratic procedures. Practitioners often drew on specific examples of their interactions with service users, and to a lesser extent with other practitioners. On the other hand, interactions with managers and administrators were rarely described concretely, instead being incorporated into overall processes of case management and resource allocation. However, when such interactions were mentioned, it showed that they were crucial to intervention and decision-making:

'I can take all the recommendations and the information that we have to give to my manager and to the safeguarding team with my recommendation of going to child protection conference. However it can also be rejected because they say "well there are a lot of professionals involved, there is a lot of support going in, it doesn't need to go to child protection". However in this case I think everybody, you know, higher powers as such did agree that there is a significant risk to these children.'

[C206, social worker (1)].

The practitioner here provides an insight into the managerial chain of command, referring to the process of deciding whether a child protection conference should be held. She presents her role almost as that of a petitioner, who 'can take' the views of frontline practitioners (including herself) to 'higher powers' for judgement. Although based within her own agency, this decision-making body is nonetheless presented as a separate unit, composed of various managers ('they'), who may or may not agree with the views held by the network ('we'). The depiction of managerial decision-making as a rather aloof function, remote from the business of everyday frontline work, was quite prevalent in practitioners' accounts in both cases. Implicit in this was the idea that shifting from universal to specialist services meant dispassionate bureaucratic systems started to impinge on the more relation-centred realm of professional practice. While the emphasis for practitioners was on getting services in place to deal with the family's assessed needs, they knew their managers would have to establish whether those needs met pre-ordained thresholds and gatekeeping criteria. The subordination of practice considerations to these managerial systems assumed an imbalance of power, which seemed to gain greater prominence when needs were perceived to be escalating. In such situations, needs became reformulated as 'concerns' and requests for resources were constructed as an appeal for help to a remote and potentially indifferent authority. Awareness of power dynamics also meant that practitioners could represent their efforts to challenge managerial decisions as a struggle against the system as a whole:

'They told me that the IFA was too expensive and I wasn't getting it any more – they told me this less than 24 hours before I was supposed to take him into the IFA – and I turned round to my management and said "I'm not telling Martin's mum that we've lost this placement so sort it out!" And eventually they did manage to get it sorted out so it was fine.'

C101, social worker (1)].

In contrast to the earlier extract, in which the social worker in Case 2 accepted her subordinate role within the managerial hierarchy, the social worker in Case 1 is seen here to challenge the higher powers within her own organisation, seeking to assert her own authority upwards, against the normal run of things. Her aim is to persuade her agency to reinstate funding for a foster placement with an independent fostering agency (IFA). The practitioner implicitly contrasts the integrity of her own relation-centred approach with the capricious and potentially callous nature of bureaucratic decision-making. A similar stance was adopted by two other practitioners in Case 1, the school nurse (C110) and youth worker (C104), who tried to exert pressure on the local

authority to step up social care involvement. However, this type of intervention required practitioners to go beyond their official remits and confront an amorphous but powerful 'management'. Indeed the social worker (C101) goes on to observe that in doing so she was 'taking a major risk with my job'. Thus while practitioners did see themselves as protagonists in securing specialist resources, this often required them to battle through a bewildering thicket of procedures, and occasionally pitted them against an intimidating managerial hierarchy.

Another distinguishing feature of professional discourse in these cases was the representation of interactions between practitioners and service users. While practitioners often referred to conversations and discussions they had had with family members, this usually involved re-contextualising the original event, or series of events, in order to provide evidence for a broader assessment of character or situation, or to illustrate the dynamics of a particular relationship:

'You're constantly throwing that at them and then they're throwing something else at you. Like: "But it's because of his behaviour." "Yes but that's because he doesn't have boundaries, so let's try this." "But it's because he has ADHD." "No but he doesn't have ADHD." "Well it's conduct disorder'. [laughs] "Tell him off now and then! Place some boundaries!"
[C203, fire prevention officer (2)].

The fire officer here describes an exchange between herself and the children's parents. While it might be a verbatim report of what was actually said, it seems more likely to have been reconstructed from various different conversations. The exchange is not situated in time or place, and is framed by general rather than specific pronouns, i.e. 'you' (one or more practitioners) and 'they' (parents). The main function of the 'quoted' part of the text is therefore to illustrate the adversarial metaphor ('throwing at') employed in the opening sentence, and therefore to represent the type of oppositional dialogue characteristic of discussions between practitioners and parents in this case. The exchanges are short and exclamatory, with a pattern of proposition ('has ADHD') followed by rebuttal ('he doesn't'). Communication is maintained but does not lead to a satisfactory resolution. The context suggests that practitioners are to be seen as the protagonists here, so that the exchange also illustrates the difficulty of overcoming parental resistance to a 'rational' (i.e. correct) assessment of the problem. On the other hand, the parents are also represented as active and assertive, capable of mounting a defence against the professional viewpoint.

The representation of social actors as active or passive connects with issues around choice and autonomy, which were discussed earlier, and have a bearing on the operation of power dynamics in the network. In Case 2, the agency of parents was often tied up with a choice of whether to comply with the interpretations and recommendations made by practitioners. In Case 1, the parental figure was much less prominent, and was often depicted as engaged in a struggle for control with her child. Indeed, several practitioners represented the interactions of mother and son as a similar sort of oppositional dialogue to the one quoted above, emphasising its escalating intensity and emotional impact. Of course, the depiction of parent and child as equally matched and hostile antagonists also serves as a vivid illustration of dysfunction. In contrast, when practitioners recounted their own interactions with Martin, they represented a more conventional adult-child dynamic in which they were able to regulate the young person's behaviour in a non-confrontational way. The expertise and calming influence of practitioners, or the impact of particular interventions, was therefore represented by a passivation (in grammatical terms) of the young person, whose behaviour could be 'managed' and 'contained' in appropriate settings. Of course, this did not always work out and at other times the young person was described in very active terms, often using verbs of motion that conveyed his 'breaking out' of the constraints imposed on him. A similar juxtaposition of active and passive agency was evident in representations of the youngest child in Case 2:

'He's a perfectly - yeah an active little boy - doesn't give us any problems at all, you know - as long as he knows where he stands - give him clear instructions, pull him back in line if he is out of line - he's fine so - that does surprise me that he's got into the fire-setting.'

[C205, young carers manager (1)].

Here the practitioner emphasises the manageability of the child's behaviour in the controlled and structured setting of the young carers service. The qualified description of the child as 'active' implicitly suggests his potential to break free of such controls, but in subsequent clauses he is presented as the object of effective containment strategies – being given instructions, brought into line, etc. The extract finishes with a reference to fire-setting, highlighting the negative (and unexpected) consequences of allowing the child's behaviour to go unchecked in the family home. As in Case 1, the child displays a degree of autonomy that is at odds with what is normally expected from parent-child interactions (and older-younger sibling interactions). He is even

presented by some practitioners as the dominant or 'driving' figure in the family system. This unusual degree of agency ('active-ness') is therefore associated with the more dangerous aspects of his behaviour. On the other hand, as the practitioner above notes, he is also an active *little boy*, vulnerable in his own right and in need of boundaries and consistent parenting. This is a common theme in both cases. Vulnerability was represented by passive constructions in which the child or young person was being (or needed to be) safely contained within professional and parental boundaries. When this did not occur, the unregulated activity of the child was seen as increasing the risk to self and others.

The description and interpretation of behaviour was integral to many of the events described by practitioners. Particularly in Case 2, with its focus on the systemic problems within the family, behaviour was seen as a manifestation of relationships within the family system and the wider support network. Parental behaviour was often described in terms of emotional responses, such as getting 'upset' at the problems they were experiencing, or 'annoyed' with the comments of practitioners. In contrast, practitioners were mainly characterised as disinterested (i.e. impartial) and concerned with 'facts'. As the main target of assessment and intervention, children were often represented through detailed observations of behaviour:

'He's a friendly lad but he can't sit still for very long, he gets agitated, he starts walking around the room. His eye contact is very sporadic. In a sense, he will spend more time looking around the room than he will looking at you. But you don't read anything into it, that's probably a symptom of his needs.'

[C109, YOT worker (1)].

I think that David's behaviour – things like the hurting of animals, things like fire setting, they are the things you read about [...] They show those sorts of tendencies at this age and that's where the alarm bells start ringing.

[C201, headteacher (2)].

These quotes show how children can be viewed through the lens of professional assessment. In the first extract, the YOT worker reports a list of behavioural characteristics observed during one or more meetings with the young person. They are seen as symptomatic of underlying and unspecified 'needs'. While the young person is ostensibly an active agent – he walks around, looks

around the room – his activity is here re-contextualised as the object of professional scrutiny, a dispassionate medical gaze that does not interpret lack of eye contact in interpersonal terms, e.g. as dislike or uncooperativeness, but as indicative of some sort of condition or dysfunction. In the second extract, the headteacher ascribes behavioural ‘tendencies’ to the child, adducing them as possible indications of a predisposition for harmful behaviour. Behaviour is nominalised, so that actions (‘he hurt the animal’) are transformed into general traits (‘the hurting of animals’), which can then be compared to formal knowledge (‘things you read about’) concerning particular conditions or disorders. What is omitted, or provisionally backgrounded, is what the child might have been thinking, feeling or experiencing in those contexts where particular behaviour was observed. Instead the child is viewed in terms of a bundle of needs, constituted as risk factors, in order to inform assessment and guide intervention. From a Foucauldian perspective, both children are therefore constructed as bodies of professional knowledge; they become a sort of ‘text’ themselves, via their behaviour, which can be ‘read’ by practitioners with the requisite training.

In summary, social events were represented in a number of ways. Episodes and incidents were recounted in order to characterise more general trends and developments. Interactions with management were de-personalised and represented as a process. For example, 'getting authorisation' was presented as an act of petitioning vis-à-vis an impersonal decision-making body, seen as aloof from frontline activity. Escalating need and the shift to specialist provision meant that bureaucratic systems asserted greater control over the more relation-centred world of practice. Interactions with service users were often represented through dialogues that were reconstructed from a series of actual discussions, in order to generalise about the nature of the relationship or intervention. In Case 2 this may have been an oppositional dialogue between parents and practitioners, for example, or in Case 1 a description of how the practitioner was able to manage the young person's behaviour. Service users were represented as active or passive social agents and this was linked to issues of autonomy and engagement with services. When children were represented as active agents this was often connected to resistance, aggression, and breaking free of social controls. Passivity, on the other hand, was more associated with compliance, vulnerability and containment within institutional settings. Practitioners also represented events through detailed observations of behaviour, helping to construct children as bodies of knowledge to be deciphered through professional knowledge and expertise.

6.6 Styles and identities

This section will focus on how participants constructed their identity as practitioners in their interviews, looking at the discursive aspects of style (see Chapter 4, Section 4.5.3). There are some links to the earlier discussion of intertextuality, in which it was noted that the interviews were dialogical in the sense of articulating or suppressing a range of different ‘voices’, representing different perspectives and therefore identities. The mutable content of pronouns such as ‘we’ and ‘they’, for example, could be seen as balancing different forms of socialised identity, for example as a member of a core group, as employee of an organisation, or as representing a professional culture. In some interviews this was even an explicit theme, as the demands of casework exerted pressure on different aspects of professional identity:

‘I think within youth work in general it's one of the biggest problems - is evaluation and monitoring in youth work because you can't increase it loads and formalise it too much - because then it has a huge effect on the type of work that you do.’

[C104, youth worker (1)].

Here the youth worker reflects on the increasing emphasis on recording information and monitoring standards of practice. Such bureaucratic processes are somewhat alien to youth work’s informal ethos, and so require new ways of working that might be challenging or unwelcome in some respects. In particular, too much ‘formalising’ of youth work might put a strain on some of its core values, reducing the time available to build relationships with young people and detracting from the accessibility of the service. The youth worker’s comments are also linked to her dual role of managing the youth club while continuing to work as a practitioner. She therefore uses the indefinite personal pronoun ‘you’ (rather than ‘we’ or ‘I’) to indicate that she is generalising about youth work from a more detached viewpoint. The advent of bureaucratic systems is represented by process nouns (‘evaluation and monitoring’) that evoke distant and impersonal relationships – it is unclear who is monitoring whom – rather than the specific interactions described elsewhere in the interview. This represents a more managerial perspective about which the youth worker is perhaps ambivalent; she does not say ‘I monitor’ or ‘we evaluate’, for instance. The analysis shows how a speaker’s style, or combination of styles, may be bound up with different aspects of identification, such as the intersecting of ‘manager’ and ‘practitioner’ identities in their work.

Practitioners often explored different facets of the 'expert' identity, as adopted in their discussions with service users or vis-à-vis their colleagues. One important aspect of this was the idea of 'clinical' expertise, which enabled a practitioner to categorise and explain certain types of behaviour:

'I think in this particular case I felt that he did have I think both ADHD and social communication difficulties – that they were contributing factors but not necessarily the only factors that would be relevant.'

[C108, CAMHS psychiatrist (1)].

'I might not be a psychiatrist - but I work with this child on a far more intense level than you do. So you've got the expertise about psychological conditions, I've got the expertise about this child, so how about we work together on that one? But I do get the feeling sometimes that it's a bit like: "Well you are a social worker, you don't know what you're talking about."'

[C101, social worker (2)]

These two extracts show claims to clinical expertise being made in different ways. The first quote, from the CAMHS psychiatrist, stresses both the probabilistic nature of diagnosis ('contributing', 'not necessarily') and its subjectivity ('I felt', 'I think'). The diagnosis is presented as the *clinician's view* on the key difficulties out of a range of possible causes (which are not eliminated and remain in the background). The emphasis is on a particular kind of medical-scientific knowledge, i.e. causal 'factors' that are known to potentially play a part in shaping behaviour. The clinician is the central figure, whose expertise is around weighing up the information received from family members and other practitioners in the light of medical knowledge. In contrast, the social worker in the second quote emphasises a more dialogical form of assessment, as well as the validity of different types of knowledge. She constructs a hypothetical discussion between herself and the psychiatrist, positing diagnosis as a collaborative process in which the social worker's 'expertise about the child' is placed on an equal footing with the clinical expertise of the psychiatrist. Her point, of course, is that in this case (and others) this has not happened, and instead she has experienced an unequal power dynamic in which her expertise is not respected.

In Case 2, the equivalence of clinical expertise with medical diagnosis was disputed not just by other practitioners (e.g. in relation to conduct disorder) but also by the parents. This raised

additional problems, because it undermined the construction of service users as the 'objects' of professional intervention.

'When I started in my usual way, asking about what happened in the family home and the way they parent, they presented as parents who felt that they didn't have problems with their parenting, that they immediately wanted to go back to querying whether a diagnosis was appropriate.'

[C204, CAMHS specialty doctor (1)]

The CAMHS doctor is here describing an initial meeting with the parents, after they had been referred for individual sessions to help them improve their parenting skills. However, the parents were unhappy that their child had not been diagnosed with ADHD and did not agree that their parenting skills needed improving. While the practitioner is clear about the nature of this disagreement, which made it difficult for her to carry out her allocated task, she is careful to adopt a neutral standpoint when recounting the parents' views. The formulation 'they presented as parents who felt' (rather than 'they felt' or 'they said') reduces both the dialogicality and the confrontational impact of the interaction; the speaker superimposes a detached, clinical gaze, which observes how people 'present' rather than being directly involved in a debate. Some of this style is even imputed to the parents themselves, who are not described as complaining or criticising but rather as 'querying whether a diagnosis was appropriate'. The practitioner therefore continues to enact an exploration of the parents' wishes and feelings but must do so in a context where they are challenging the service provided to them. This compares with a later stage in the case, when parents are seen (from a different practitioner's perspective) in a more cooperative context:

'So we had a plan that if they refuse to go up: "You need to go to your room". "No we're not, we're going to sit down here and watch TV". TV off, and Dad just to sit there, just quiet with them, and just remind them that they need to go up. They will probably try to engage in conversation, get in that banter, and I said: "Don't have any of that. You are just: bedtime now, end of!" So it's about me monitoring Dad really to see how he does that.'

[C208, family support worker (1)]

Here professional expertise is constructed in a more straightforward way, without being contested or having to be explicitly asserted. The style emphasises interaction and involvement rather than assessment or clinical observation. Short material clauses setting out the nature of the intervention ('we had a plan') are combined with an illustrative dialogue focused on implementing bedtime routines. The practitioner is represented as a source of practical expertise, whose recommendations to the children's father are couched in a directive but informal use of language. The latter's implicit cooperation, or at least receptivity, is reflected in the speaker's use of the imperative mood ('don't have any of that!'). The practitioner's style therefore encourages and models an assertive parenting style, as well as conveying the impression that practitioner and parent are working towards a shared objective, i.e. establishing parental boundaries in the home. Another key indication of the speaker's expertise lies in his level of commitment to what he is saying. In linguistic terms, analysing 'modality' can provide an indication of how highly speakers evaluate the likelihood or necessity of their judgements. For example, the family support worker assigns a high degree of 'deontic' (obligational) modality to his proposals to the parents, i.e. they 'should' follow his suggestions rather than 'could' or being 'allowed' to do so. At the same time, he assigns a medium degree of 'epistemic' (truth) modality to his prediction of how the children will behave, i.e. they will 'probably' try to engage their parents in conversation, rather than 'perhaps' or 'certainly'. The practitioner's style therefore demonstrates confidence in his understanding of the context and the effectiveness of his methods, while allowing room for trial and error in their implementation.

Attitudes towards knowledge and prediction were an interesting component of style, especially in view of the issues around ambiguity and volatility that emerged from the IPA findings. Of course, the context of interview genre is important here, since practitioners were not only making (or reporting) judgements in relation to each other and to service users, but as part of a specific interaction (with the researcher) in which their views were being recorded. The high incidence of subjective markers (e.g. 'I think', 'I feel') or hedging devices (e.g. 'you know', 'actually') could therefore have been a response to the interview process as much as to the case in question. Nonetheless, there were noteworthy shifts in modality during interviews, as well as differences between practitioners. Practitioners responsible for assessments, such as the social workers or CAMHS doctors, sought to weigh up hypotheses and express judgements about risk. Practitioners involved in one-to-one work, such as mentors and family support workers, focused on empirical

observations of behaviour and practical interventions. The style of expertise adopted by practitioners shaped how they went about constructing their knowledge of the case:

'So I think she started to see that it's started to change a little bit and I do think that by putting more intense parenting skills and teaching the parents how to put boundaries in, these four children will do really well.'

[C206, social worker (1)].

'But just I guess observing the relationship between mum and him, and how that's maybe not - from what I've seen - it hasn't been the most positive interaction - and I guess trying to - not address that because that's not what my role is - but then trying to I guess move forward with that.'

[C112, YOT worker (1)].

The difference in style in these two extracts revolves around the way modalisation is used to express degrees of probability and uncertainty. Both use subjective markers, but while the YOT worker uses the speculative sounding 'I guess', the social worker emphasises the weight of her argument with 'I do think' and 'really'. Both refer to the need to address the parent-child relationship, but while the YOT worker hesitantly envisages 'trying to move forward' with a hypothesised intervention that may not even have started yet, the social worker refers to a more concrete process that is currently underway and which conceivably has an end-point, i.e. the children 'doing well'. Significantly, this also represents an evaluation of risk, with the implicit proviso ('by') that parents continue to make the required changes. The social worker also comments on the mental processes of others, e.g. what the mother has now 'started to see' after a period of intensive professional input. The YOT worker, on the other hand, focuses on empirical observations of past incidents ('from what I've seen') rather than on interpreting intentions or motivations. At this stage in her involvement in the case, her focus is still on gathering information and forming tentative conclusions about the situation, whereas the social worker has completed her assessment and is hence able to speak more authoritatively.

In summary, a range of professional identities were enacted in these accounts of collaborative casework. The shifting identificational content of plural pronouns such as 'we' and 'they' reflected the interplay of socialised identities, in which practitioners belonged simultaneously to teams,

organisations, professions and networks. Balancing these different identities was not always straightforward and could lead to conflicting demands, for example between managerial and casework priorities. Participants also explored different aspects of their 'expert' identity. The idea of clinical expertise, based on theoretical and technical proficiency, was combined with the more interpersonal knowledge acquired through familiarity with a case. Knowledge of a person, for example, could mean having privileged insight into their intentions or state of mind. Clinical detachment might be enacted when describing difficult or confrontational situations, particularly by medical practitioners. Other practitioners identified with a more involved and interactive style of engagement, which emphasised partnership and shared objectives but also allowed practitioners to be authoritative and in control of the situation. Attitudes towards statements and predictions varied between practitioners, possibly reflecting differences in role or their degree of involvement in the case.

6.7 Interdiscursivity

The purpose of this chapter has been to explore some of the characteristics of professional discourse when focused on the topic of complexity. In this section, the emphasis will be on 'interdiscursivity', which means looking at how different discourses were textured and layered within the sample of texts. As noted in Chapter 4 (Section 4.5.3), discourse is understood here as a kind of socio-linguistic practice, a way of 'representing the world' that can be linked to an identifiable cluster of meanings, perspectives, and transformations (Fairclough, 2003). In turn, each discourse will draw on a number of other discourses, in the process reworking and re-contextualising them.

One interesting aspect of interdiscursivity in the current context is the crossover of discourses between professions. Perhaps the most obvious example to start with is the salience of medical discourse (Atkinson, 1995, Wilce, 2009) in the accounts of both medical and non-medical practitioners. In part, this reflects the importance assigned to diagnosis, for example in accounting for the role of mental health issues in individual behaviour and family functioning. Officially, this was the province of the tertiary service, CAMHS, who were (or had been) involved in both cases. As we have seen, some practitioners (in Case 1) and parents (in Case 2) attempted to challenge the exclusivity of medical control over diagnosis. However, once a diagnosis had been made, even if it was disputed, it rapidly acquired credibility through being recorded in reports and repeated in

discussions (e.g. ADHD in Case 1, or conduct disorder in Case 2). The same thing could happen even if a diagnosis had not been made but had been widely hypothesised within the professional network (autistic spectrum disorder in Case 1, or conduct disorder in Case 2). On an individual basis, practitioners sometimes incorporated medical concepts into their hypotheses without claiming expert knowledge. In Case 2, for example, three practitioners referred to 'attachment' [C203, fire prevention officer(2), C206, social worker(1), C208, family support worker(1)] in a way that suggested a clinical meaning (i.e. in relation to secure/insecure attachment patterns) but without venturing a clinical opinion. The significance of diagnosis, both as an explanatory narrative and as a means of obtaining specialist resources (e.g. a school placement), meant that the power to diagnose was contested between practitioners (Case 1) and with service users (Case 2). Nevertheless, the medical profession was still considered to be the ultimate arbiter in such disputes, as evidenced by the continued emphasis on CAMHS involvement and re-assessment.

Other features of medical discourse entered into what Anspach (1988) calls the 'case presentation' aspect of professional and interprofessional activity. He argues that medical practitioners talking about their cases will tend to 'separate biological processes from the person' (de-personalisation), 'omit the agent' (i.e. use passive constructions), treat 'medical technology' as the agent, and emphasise the subjectivity of patients' accounts. Some of these tendencies have already been discussed earlier in this chapter, and again were not just limited to the accounts of medical practitioners. For example, it was quite common to talk about psychological and social processes independently of the individuals concerned, as in the phrases 'down to parenting' (used by 3 practitioners in Case 2), or 'offending behaviour' (used by 7 practitioners in Case 1). It has been seen that omission or back-grounding of agency often represented the containment of unwanted or risky activities, for example in a specialist school setting or through parenting strategies. Similarly, passive constructions were sometimes employed when it was a matter of envisaging or encouraging compliance, e.g. with recommendations or plans. Finally, the notion of intervention as a 'technology', or as an agent of transformation and control, was implicit in the nominalisation of relational activities such as 'support' (i.e. back-grounding who was supporting whom and how), or the assumption that children's needs, or parental deficits, could be 'addressed' (i.e. rectified through professional input).

While such features might be considered characteristic of any professional discourse, medicine has historically been a key influence on how other professions have sought to develop a 'scientific'

modus operandi in field of health and social care (Halliday, 1987; Friedson, 2001; Macdonald, 2005). Aspects of medical discourse therefore fed into the adoption of a 'clinical' identity by practitioners. This is not to say that they wished to be seen as doctors, but that they wished to demonstrate affinity with the values and competencies associated with that high-status profession. Practitioners considered impartiality to be both desirable and achievable, for example, and demonstrated familiarity with medical terminology and diagnostic criteria (e.g. in relation to ADHD or conduct disorder). The analysis of 'need' was generally presented as a kind of aetiology of problematic behaviour. This meant objectively observing and classifying a set of disaggregated 'behaviours' [C104, youth worker(1)], which could be clustered together as 'symptoms' [C109, YOT worker (1)] of underlying need. Following on from assessment, interventions were conceived as a form of treatment that would directly target those needs. In the process, practitioners used modalisation markers in order to convey authoritativeness and the ability to predict and alter outcomes through their own particular area of expertise.

At the same time, practitioners also drew on a variety of non-medical discourses to present and characterise their practice. As opposed to the detached and impersonal 'medical gaze' (Foucault, 1994), with its privileging of medico-scientific authority, members of the 'caring professions' (Abbott and Wallace, 1990) have traditionally given preference to more humanistic values: a commitment to personalised care, a 'relation-centred' ethos emphasising the needs of clients, a vocational element to professional work, and a respect for the individual right to self-determination. Many of these values were evident in the accounts of participants. Particularly for practitioners involved in direct work with family members, the relationship with the client was seen as a crucial resource as well as a vehicle for change. Some practitioners, such as the youth worker in Case 1, or the fire officer in Case 2, saw a therapeutic value in the way that specific activities (e.g. art sessions, story-based exercises) and a sensitively managed relationship could contribute to the child's psycho-social development. This idea of the 'therapeutic relationship', with its suggestion of individual casework rooted in psychodynamic theory, was sometimes combined, especially in Case 1, with a sense of dedication to the case and commitment to the young person (see Chapter 5, Section 5.5.3).

Practitioners also drew on a combination of systemic and individualist discourses in order to clarify their understanding of the case. In Case 2, while the family system was seen as the principal site of assessment and intervention, significance was also attached to mental health issues, disabilities

and the state of mind of family members. In Case 1, on the other hand, the focus was mainly on the young person as an individual, but his behaviour was often interpreted in the context of his relationships with others, e.g. his mother, his peers, or his keyworkers. The YOT-based practitioners, for example, drew on a variety of criminological concepts in order to explain and tackle the young person's record of offending. These included structural factors, such as the social pressure to achieve status [YOT mentor(1)], environmental factors exacerbating his vulnerability to exploitation, such as his exclusion from school [YOT worker(1)], cultural factors, such as the criminal activity of his peer group [YOT worker (2)], and individual factors such as a lack of 'consequential thinking' (all three YOT practitioners used this phrase). Interventions were targeted in the same way, e.g. one-to-one sessions to promote cognitive and emotional development, or a residential school placement to move the young person into a secure and pro-social environment.

A discourse of individual reform and development was therefore maintained in tandem, and to some extent in tension, with a more systemic emphasis on self-regulating relationships and patterns of interaction. For the most part, practitioners referred mainly to the 'client' system, i.e. the family system or the individual in their social environment. At other times, another kind of system was evoked, namely the 'expert system' of practitioners and their organisations (see Chapter 2, Section 2.6.6). The purpose of the expert system was to contain and stabilise the client system, which was manifesting signs of distress and dysfunctionality, and seemed to be escalating towards an 'out of control' state (e.g. fire-setting in the home, or a spate of criminal offences). Rather than relationships, the discourse of the expert system emphasised functions and processes, e.g. coordination, information-sharing, strategy meetings and care planning. Individual practitioners were seen as implementing measures to target needs and manage behaviour. The expert system was ideally associated with strength and reliability, with 'robust plans' [C111, school nurse (1)] designed to impose order on a volatile situation, and strategies to be 'put in place' by practitioners [C208, family support worker(1)]. As a discourse, the expert system was rational and technocratic in its assumptions and values. One effect was that practitioners found themselves grappling with issues around gatekeeping and thresholds for action, alongside the consideration of need and personalised care. This became apparent in the second round of interviews for Case 1, in which practitioners such as the social worker (C101) and FIP worker (C111) acknowledged the need to justify the cost of diverting further resources to support the young person, given his continuing difficulties in specialist provision.

The effect of interdiscursivity in these texts was therefore to reduce the tendency for one discourse to predominate. Instead, aspects of collaborative casework were viewed from a variety of perspectives, which were combined and layered within individual accounts:

I just seem to have – to have more agencies involved, that concrete barrier around, sort of watching and supervising and keeping an eye on you, it does put more pressure on people and it does help mum understand more, actually, if everyone is coming from the same angle and saying the same things, is, I think, that is helpful for families – although it's – if you are the family it can be seen as quite a negative thing as everyone is sort of looking, picking on, watching us. On the other side of it, the way we sort of work with families is 'we're here to help, we're not here to criticise'.

[C208, family support worker, Case 2(1)].

Here the practitioner is discussing the significance of having a core group and child protection plan to 'back up' his work with the family. In effect, the FSW is conducting a systemic intervention, in that getting the parents to stick to consistent routines with their children will hopefully have a long-term effect on family dynamics. However, he also relies on the strict boundaries established by the 'expert system', which ensure cooperation as well as monitor the situation. From a Foucauldian perspective, there is an emphasis on surveillance here, not only in that the family is being watched but also in the way that institutions use their power to gather information in order to define people's social identity, e.g. as parents, as service users, as subjects of a child protection plan. The imputed objectivity of professional assessment (the 'clinical' viewpoint discussed earlier) is here given more explicitly normative overtones – when agencies are 'keeping an eye on you', it is usually to prescribe or proscribe certain types of behaviour. The family is therefore justified in feeling uncomfortable and even threatened ('picked on') in such circumstances – whereas in opposing clinical judgements they were more likely to be characterised as resistant or hostile. In presenting his viewpoint the practitioner also shifts to a more dialogical and interactive stance, subtly moving away from the unitary, process-oriented world of the surveillance state. In this way, he is able to position himself on the boundary between the expert system and the family system. On the one hand, he is part of the core group and an important contributor of information that will influence judgements about the family. On the other hand, he is available to help the family with their problems and to act as a mediating figure. This liminal positioning is encapsulated in the ambiguous meaning of 'work with' – with its apparent connotation of partnership and shared

objectives, but also suggestive (within professional discourse) of the professional-client relationship.

A final aspect of interdiscursivity was to allow certain influential discourses to underwrite a variety of meanings, both explicit and implicit, within these texts. For example, it was seen in the previous chapter that messages about risk frequently featured in interprofessional communication, e.g. with respect to sharing 'concerns' with colleagues, or arguing for resources with managers (see Chapter 5, Section 5.6.2). What critical discourse analysis can add to this picture is a closer look at the underlying meanings that turn 'concern', for example, into a kind of codified way of talking about risks to children. While not always immediately obvious, the implicit content of such messages were sometimes available elsewhere in the text:

'Every conversation that we have with another service is recorded, just as back-up, as our safety net, so that if we find out in five years' time that one of our children went on and did something really horrendous, with or without fire, we can go back five years' time, and it's logged that we put that concern on to whichever other agency and said "This has to be done, dealt with..."'

[C203, fire prevention officer (2)].

The fire officer here provides an insight into one of the purposes of risk management, in that keeping a record of information shared with other agencies is also a way of safeguarding the agency itself from the repercussions of exceptionally negative outcomes. Indeed, most agencies involved in child protection cases will try to ensure that their records can demonstrate, if necessary, that correct procedures were followed (Hood et al., 2000, Rothstein et al., 2006). While there is nothing new or surprising about this, it is worth noting that such a perspective will form part of the 'discourse prosody' (Stubbs, 2002) around sharing information about risks to children, whether it is acknowledged or not. This will be the case in an informal discussion between practitioners as much as a formal referral between agencies. In the above extract, for example, the practitioner presents the sharing of concerns as a process of delegation – 'we put that concern on to [other agencies]'. Information about the child or family is only part of the message, albeit the most important part. It is also a signal that the referring agency has discharged its duty to flag up such issues and the specialist agency now has some of the responsibility for 'dealing with' them. Another characteristic of risk discourse, which can be seen above, is the combination of a low to

medium 'truth' modality (what 'might' or 'is likely to' happen) with a high 'obligation' modality (what 'should' or 'must' be done). This points to the way that risk management, conceived within the 'expert system' as a probabilistic technology, fits somewhat uneasily into a practice context shaped by relational dynamics and anxiety-provoking situations.

In summary, interdiscursivity related to the interweaving of different discourses within individual texts and between professional groups. The influence of medical discourse was evident in a number of ways. Medical terminology was commonly used and the power to diagnose was sometimes a contested area. Other discursive practices drew on aspects of medical case presentation, such as de-personalisation of 'needs' and the use of passive constructions to represent the impact of interventions on service users and their behaviour. Practitioners adopted a clinical identity that laid claim to high-status professional virtues such as objectivity, specialised knowledge and authoritativeness. In addition, practitioners drew on non-medical discourses to characterise their practice, including the humanistic values of the 'caring professions' and, for some, a therapeutic emphasis on personal development and growth. Practitioners combined individualist and systemic understandings of the problems in each case, which involved different assumptions about autonomy and responsibility. Efforts to inculcate pro-social behaviour directly (e.g. through one-to-one sessions) were therefore accompanied by efforts to change relational dynamics (e.g. within the family) and to shape the social environment (e.g. residential school). The professional-client relationship was a key resource in this respect, as was the 'expert system', through which services endeavoured to monitor and contain the unpredictable 'client system'. The expert system was associated with a discourse of surveillance and an instrumentalist use of professional interventions to shape outcomes for service users. Practitioners often maintained a liminal position in relation to the expert system in order to facilitate the transfer of expertise and information, at times performing a mediative role vis-à-vis the family. The expert system was principally designed to manage risk as a predictive technology, via functional processes such as information-sharing and multiagency meetings. Such processes accordingly became a site for agencies and practitioners to play out communication strategies around risk, which in turn were invested with implicit messages about accountability in 'high profile' cases, and the obligation to 'do something' in the light of hypothetical (future) outcomes.

6.8 Conclusion

The aim of this chapter has been to examine how practitioners constructed complexity in their accounts of working together on these cases. A critical discourse analysis of interview transcripts sought to relate the use of language to different conceptualisations of professional practice in complex cases. Six different aspects of discourse were discussed. Firstly, the genre of research interview meant that texts were structured and co-authored in certain ways. Participants also drew on a variety of work-related sub-genres to construct their accounts. Secondly, intertextuality concerned the way in which different voices and perspectives were combined or otherwise treated within the text. Practitioners' accounts were dialogical in the sense of giving space to alternative voices, there was also a tendency either to suppress difference in the co-production of professional knowledge, or to accentuate it in the form of a protagonist-antagonist dynamic. Thirdly, there was an exploration of what was assumed in these cases and the implications of making such assumptions, which sometimes led to misunderstandings and even antagonism between members of the core group. Fourthly, the representation of social events saw impersonal bureaucratic systems assert influence over the relation-centred world of practice, as practitioners sought to contain volatile situations and shape outcomes for service users. Fifthly, discourses were also associated with processes of professional identification, such as the knowledgeable and objective 'clinical' practitioner, or the involved and empathetic 'relation-centred' practitioner. Finally, the discussion of interdiscursivity suggested that while some discourses, such as medical discourse and risk discourse, were more influential than others, none was predominant. Practitioners instead found both opportunities and challenges in the intersections between them.

This analysis provides the basis for some further reflections on the dialectical interplay between the different interpretative frameworks available to practitioners, with a focus on issues of power and difference. Building on the findings presented above, it is possible to discern three distinct perspectives, reminiscent of what Fairclough (2010) calls 'orders of discourse', each of which defines itself in relation to the others on the basis of distinctive assumptions, identities, and representations of the world. These perspectives are summarised below in Figure 6a.²

² The discussion which follows is not intended to provide a conclusive typology of professional 'orders of discourse', for there are undoubtedly many others. It is derived from the critical discourse analysis conducted in this chapter and so may have some explanatory value for the discourse of practitioners around 'complex cases'.

Figure 6a. CDA findings: Orders of discourse in the construction of complexity



Firstly, there was what might be described as a ‘clinical’ perspective. This had its roots in medical discourse and traditional assumptions about professional objectivity and authority, based on command of a specialised knowledge base and adherence to formal codes of practice. However, it was not exclusively tied to a bio-medical model of functioning, being equally concerned with social and environmental factors. The process of ‘assessment’ replicated the formal characteristics of diagnosis and treatment, in that empirical observations and other information were analysed for evidence of underlying needs, which could then be addressed by practitioners. This required a degree of de-personalisation, in that needs were separated from the person, and interventions became a kind of technology designed to address dysfunction or encourage pro-social behaviour. Power relations between practitioner and service user emphasised the agency (activity) of the practitioner, whose job was to obtain information about the specific situation and then impart their knowledge and guidance to the service user. Power relations between practitioners were characterised by an impersonal clinical hierarchy defined by specialism and linked by formal referral processes. Needs (and therefore service users) seen as lying outside one practitioner’s remit were ‘handed on’ to specialist practitioners in the appropriate field.

Secondly, there was what has already been described as the 'expert system' perspective. This had some connections with the 'clinical' order of discourse, for example in adopting a tiered approach when it came to matching expertise to areas of assessed need. However, power relations within the expert system were driven by the requirement to allocate resources efficiently in an organisational and interagency context. Certain characteristics of medical discourse were accentuated, such as objectivity, de-personalisation and passivation. However, instead of being the province of skilled practitioners, intervention was de-coupled from the practitioner-client relationship and organised according to rational-technical principles. Likewise, professional knowledge and expertise were transferred from the individual practitioner, who in a clinical setting exercised their discretion on a case-by-case basis, to a body of scientifically validated evidence that allowed interventions to be mandated and supervised by managerial systems. As observed in Chapter 3 (Section 3.3.2), complex needs were tackled by disaggregating them into separate problems that could be addressed by appropriate interventions. The relationship between practitioner and service user, as well as the relationship between practitioners, became equivalent to the operation of functions and roles within the expert system as it sought to meet the overall demand for services.

The third order of practitioner discourse was perhaps less clearly defined than the other two. It could be described as a 'relation-centred' perspective, which highlighted the value of individualised care and the potential for therapeutic benefits stemming from the relationship between practitioner and service user. Again there were connections to the clinical perspective, for example in the assumption that expert practice was based on specialised knowledge and appropriate conduct towards service users. However, there was more emphasis on interaction and involvement with the client, on support rather than intervention, and on the possibility of self-determination. The discourse of relation-centred practice allowed for dialogicality and the co-existence of alternative views, and represented social agents as actively pursuing their own goals. Power relations between practitioner and service user were less clearly defined, being ostensibly geared towards facilitating the latter's personal growth and development. The relationship between practitioners tended to be mediated via the mutual relationship with the client, rather than through referral processes or coordination by the expert system.

The analysis in this chapter has shown that practitioners did not approach the case through the restrictive parameters of a particular discourse, or even confine themselves to an order of

discourse as outlined above. Elements of all three perspectives were evident in the accounts of most practitioners, even if they displayed a preference for one or the other. However, what was also evident was the way complexity was constructed on the boundaries between these orders of discourse, due to the ability of these cases to confound efforts to interpret and resolve problems in the 'usual' way. In Case 1, for example, the young person had a combination of needs that demanded a multi-faceted approach. He needed clinical attention to address his learning difficulties, a relation-centred approach to help him think more consequentially about his actions, and possibly therapeutic input to help him 'open up' to distressing incidents in his childhood. The response was to establish an expert system to manage risk and coordinate interventions. However, difficulties arose in all of these areas: his actual diagnosis was disputed and unclear, there was a constant turnover of practitioners undertaking direct work, and the expert system did not function effectively until a committed lead professional was in place. Deprived of a unitary framework of explanation and action, practitioners were obliged to combine various modes of engagement, undertaking 'clinical' assessments of need as well as 'relation-centred' one-to-one sessions, while implementing statutory child protection plans under the aegis of the core group.

In Case 2, the problems of the family required a similarly flexible response. Clinical judgements were involved in refuting a medical explanation in favour of recommendations around parenting. Relation-centred approaches were important in establishing a positive working relationship with parents, and undertaking direct work with the children. An expert system was required to deal with risks to safety and ensure compliance with the recommendations of the child protection plan. Again there were difficulties across the board: parental resistance to the lack of a diagnosis and to the involvement of family support workers, the difficulty of isolating children's needs from the overall family system, and the withdrawal of services from the core group. And again these problems led to professional assumptions being undermined and put to the question. For example, the parents not only challenged the exclusivity of professional control over clinical decision-making, but also turned the discourse of relation-centred care against practitioners, whom they alleged were not listening to them. While hypotheses about medical issues continued to circulate in the core group, in the absence of clinical input from CAMHS they remained unresolved.

The intersection of different professional discourses also reflected the flux in power dynamics as cases became more complex. The relation-centred approach characteristic of support-oriented

interventions allowed scope for service users to present their own view of the situation and to accept or reject professional involvement. It also privileged the individual expertise and discretion of the practitioner in a helping or caring role, i.e. as a source of advice and guidance. However, as additional needs were identified, there was a greater focus on clinical assessment and intervention. This not only meant that professional judgement took precedence over the views of service users, but also sorted the practitioners themselves into a kind of clinical hierarchy, with medical practitioners at the top. The clinical perspective also involved a shift from the concrete and interpersonal to the abstract and processual, with an emphasis on specialist bodies of knowledge controlled by professional institutions. With the initiation of child protection procedures, practitioners and service users alike were corralled within an expert system designed to manage risk and contain volatile behaviour. This involved a further transfer of power from professional institutions to statutory mechanisms of surveillance and social control. Clinical procedures of assessment and intervention were then organised according to instrumentalist principles, with managerial oversight to monitor effectiveness and to control costs.

In conclusion, practitioners constructed complexity as a series of challenges to the conventional orders of discourse through which they conceptualised their professional practice. In trying to understand and address the problems of complex cases, practitioners often operated on the boundaries between these different perspectives, but without entirely managing to resolve the tensions and contradictions between them. Dynamics of power and control were in a transitional state, as different strategies were employed to address need and manage risk. Practitioners endeavoured to assert their clinical authority over service users, and also in respect to other practitioners, but came under pressure for their own roles and activities to be coordinated as an instrumental part of the expert system. None of these transformations was completely accomplished. Instead, it was the state of flux itself that lay at the heart of the dilemmas and challenges experienced as 'complexity' by practitioners.

7. Discussion

7.1 Introduction

The starting point for this thesis was to observe that interprofessional working (IPW) could be seen as a response to complexity, and therefore it was worth exploring complexity as a phenomenon in its own right. In Chapter 2, a review of policy and practice in the field of children's services examined IPW as a way of dealing with complex problems that overlap professional and institutional boundaries. This was followed by a conceptual exposition of complexity in Chapter 3, based on a discussion of relevant theoretical perspectives. Complexity was shown to be a multi-faceted concept that combined ideas about how causality operates in open systems with a reflexive-hermeneutic emphasis on the construction of knowledge and the dynamics of social interaction. Having established the context for the research, and the theoretical framework to be employed, a qualitative methodological approach was developed in Chapter 4, aiming to explore the phenomenon of complexity from the perspective of practitioners. The study was designed to find out how practitioners experienced complexity in two, ongoing child protection cases, and to examine how they constructed an account of complexity in the context of collaborative casework. Chapters 5 and 6 presented the findings from interviews carried out with members of the 'team around the child' in the two cases, employing two complementary methods of analysis: interpretative phenomenological analysis (IPA) and critical discourse analysis (CDA). The aim of this chapter is to build on the findings, drawing together key elements of the IPA and CDA analyses in order to explore their implications for interprofessional working in complex cases. Critical themes identified in the literature review will be revisited and discussed, and findings will be put in the context of other research as well as recent policy developments in the field of child protection.

The discussion will start with an overview of the phenomenon of complexity, and then explore its ramifications in five key areas. First, there is the question of how services to safeguard children can be designed to manage complexity as it manifests itself on a case-by-case basis? Second, how should practitioners in the 'team around the child' collaborate in complex cases? Third, how can networks of practitioners combine their viewpoints and judgements in order to achieve a holistic

assessment of the child? Fourth, how do interventions in complex cases reflect the distribution of resources, skills and expertise in the safeguarding system? Fifth, what is the connection between complexity and risk, and how does the need to manage risk feed into communication between practitioners? Finally, the overall argument will be summarised before moving onto the concluding chapter.

7.2 The phenomenon of complexity

As noted in Chapter 4, a small-scale qualitative study can hardly claim to state a definitive account of what complexity 'is' and how professionals should deal with it. Rather, it is hoped that the in-depth analysis presented here may contribute to an understanding of the 'real' characteristics of complexity, in the critical realist sense explored in Chapter 3, i.e. the 'necessary relations' without which a complex case would not really be complex. The findings have pointed to some common and divergent elements in the experience of practitioners working together on such cases. The discussion that follows will attempt to hold up a critical mirror to what has been said elsewhere in the literature, and in that way contribute to the debate on how best to support and protect vulnerable children and families.

The analysis in Chapters 5 and 6 looked at complexity from two perspectives. Firstly, an interpretative phenomenological approach examined the experience of dealing with complexity in an ongoing child protection case. Secondly, a critical discourse analysis showed how practitioners constructed complexity in their accounts. This allowed their experiences to be connected to the socio-linguistic practices through which they understood their work and identified themselves as practitioners. To take an example, the finding that practitioners experienced a lack of control over events in these cases was partly rooted in their inability to frame the situation within conventional narratives, e.g. of client problems and professional efficacy, or of clinical assessment and evidence-based intervention. This finding supports the idea that complexity is about more than just about cases being 'difficult', or children having 'multiple needs'; rather it emerges from the organisational and institutional context in which interventions take place (Reeves et al., 2011). It follows that complexity goes beyond the unique properties of the 'exceptional' case, or the 'outlier', but can also tell us something about the functioning of the systems in which such cases occur. Complexity will have particular meanings in the sphere of children's services, for instance, which it may or may not share in other contexts, such as science (Coveney and Highfield, 1995) or

engineering (Rasmussen, 1997). These issues will have a bearing on the discussion of socio-technical systems in the next section.

So what are the 'particular meanings' of complexity for practitioners working together on child protection cases? As we have seen, complexity was pervasive throughout all stages of collaborative casework, from initial assessment to the withdrawal of services. It was associated with a range of other phenomena, such as multiple presenting problems, or antagonistic relationships, which could be experienced independently of each other, and might not necessarily be a feature of every complex case, but which were interconnected to such a degree that it is plausible to see them as different facets of the same phenomenon. For example, uncertainty about contributing factors and the significance of information could be expected to generate different interpretations and explanatory accounts. This in turn might lead to internal debates about the acuteness of need or the appropriate intervention. Equally, a perceived loss of control over events, due to their volatility and unpredictability, could be experienced as 'concerning' (or stressful) by practitioners. As a result, the core group would strive to contain and stabilise the situation in order to promote positive change. In other words, complexity is not confined to the standard features of non-linearity associated with complex systems, such as feedback loops, self-organisation and transitional states (Cilliers, 1998, Elliot and Kiel, 1997, Haynes, 2003). It is also about how these characteristics drive the activity of the professional network, a social process in which discursive practices play a fundamental part.

The analytical framework in Chapter 3 presented complexity as a dialectical interplay between causal and social complexity. In the findings, it was seen that practitioners built up theories about what was happening in the case on the basis of knowledge that had been constructed at different points in time – recorded, known, told, observed – by them or by others (see Chapter 5, Section 5.4.3). In doing so, they drew on pre-existing frameworks of interpretation and made assumptions about professional identity and involvement. They were neither dispassionate observers of empirical events nor unwitting instruments of institutional surveillance and control, but were seen actively to employ such concepts as clinical detachment or statutory authority in order to make sense of problems and try to influence events (see Chapter 6, Section 6.8). Complexity undermined the conventional patterns of cause and effect, and was seen as limiting the ability of practitioners to control events. On the other hand, complexity also forced them to use their initiative and make creative use of the resources available to them. It was a phenomenon that

constrained but at the same time *emphasised* the agency of the individual practitioner. Complexity was often experienced via relationships. Uncertainty and ambiguity emerged through the dynamics of the professional network and in the interaction with family members. As such, it also problematised the relationship between system and individual, epitomised by different conceptualisations of ‘behaviour’ – i.e. whose behaviour, what it meant and how to change it. Perceptions of risk were very salient for practitioners coming together to work on these cases, so that collaboration was often geared towards managing complexity in the interests of safety.

Up to now, complexity has been explored in terms of the interplay between the causal dynamics of complex systems and the social dynamics of constructing knowledge about the world. But the findings also suggest a further dimension, which is bound up with the nature of the child protection case as an ‘emergent structure’ (see Chapter 3, Section 3.2.2.2). What this means is that any such case is the product of a unique constellation of events, characterised by the interaction of complex social systems. More specifically, one system (or set of systems), delineated by the institutional activities of professionals and their organisations, attempts to intervene in (i.e. change the behaviour of) another system, loosely constituted by service users, family members and other people connected to the child or family. Here it may be useful to recall Pincus and Minahan’s (1973) distinction between the ‘change agent system’ and the ‘client system’ (see Chapter 2, Section 2.3.4). Of course, both are open systems which are interconnected in a general sense, as per Bronfenbrenner’s ecological model (1979). However, under the particular conditions arising in the complex case, these two systems become so closely entwined that they start to act upon each other in an unusual way. Not quite separate but not quite conjoined, client system and change agent system engage in a dynamic process of mutual differentiation and co-constitution, in which boundaries, identities and relationships are constantly shifting and under negotiation. In other words, the two systems start to interact *reflexively*, in the sense that there is no longer a straightforward, linear connection between the system that is ‘known’ and another separate system that is doing the ‘knowing’ (Lash, 2003).

In what ways does this reflexive state manifest itself? Going back to the findings, it has already been shown how discursive practices helped to shape practitioners’ understanding of the case, for example in the differential attribution of dangerousness and vulnerability (see Chapter 6, Section 6.5). This not only means construction of knowledge *about* the client system, but also identification of people *within* the client system, most obviously in terms of diagnostic labelling

(‘conduct disorder’) but also through socially significant categories (‘young offender’). Of course, reflexivity worked the other way round too. The client system exerted an influence on the change agent system, most notably through the onus placed on practitioners to engage with families and secure their cooperation. Qualities such as neutrality, integrity, competence and empathy were not so much fixed attributes, i.e. *of* practitioners working *with* families, as co-constructed or even negotiated, i.e. *by* practitioners *and* families in their involvement with each other. The sub-theme of ‘being heard’ in Case 2 was a good example of this – parents and practitioners alike were dependent on each other not only to acknowledge their respective viewpoints, but also to validate a particular role and identity, e.g. as a practitioner who ‘listens to’ families, or a parent who ‘cares for’ a child (see Chapter 5, Section 5.3.3).

Social complexity therefore has the effect of creating a reflexive interconnection between the interprofessional network (change agent system) and the family (client system). It points to the co-constitutive nature of the ‘double hermeneutic’ in which practitioners are engaged. In striving to understand the child/family/case, practitioners impose categories of knowledge and identification onto service users. At the same time they are being understood, as professionals/people/service, and this also shapes how they conceptualise their own activity and identity. Problems do not just present themselves for professionals to solve; they are presented, discussed and enacted by people, whose objectives and intentions may not be evident or even consciously pursued. Likewise, interventions are not administered, as a medicine or treatment might be; they are social transactions willingly or compulsorily entered into by their participants. Elsewhere in the literature, the nature of this interconnection has often been analysed in psychodynamic terms, as for example when patterns of interaction within the family are ‘acted out’ in the professional network (Granville and Langton, 2002, Woodhouse and Pengelly, 1991), or experienced symptomatically by the individual practitioner (Cartney, 2011: 22). Such phenomena are unpredictable, in the sense of being emergent, but may prove significant in shaping events.

In summary, complexity is a phenomenon that is experienced by practitioners in complex cases, and is also constructed in professional discourse about such cases. It can be seen as a dynamic interplay between causal complexity and social complexity. Causal complexity derives from the characteristics of non-linear cause and effect in complex adaptive systems, while social complexity refers to the reflexive-hermeneutic activities of social agents in those systems. Furthermore, the complex case itself generates a reflexive interaction between the change agent system, i.e.

professionals and their agencies, and the client system, i.e. families in their community. This points to the idea that complexity is not simply an aspect of the problematic situation, i.e. a separate problem to be solved by professionals, but rather emerges from the entangled state in which the identities and practices of all those concerned are being negotiated and co-constituted. This raises the question of how interprofessional networks should be organised to manage complexity conceived as such. The sections that follow will be largely occupied with answering this question.

7.3 Managing complexity through the socio-technical system

The previous section gave a picture of complexity as a phenomenon of the 'complex case' in child protection. The discussion will now turn to the question of how practitioners and their agencies can (and indeed already do) work together to deal with complexity, drawing on the findings in this study and elsewhere in the literature. The main emphasis will be on interprofessional working as an adaptive response to complexity at the level of the 'the child protection case'. To begin with, however, it is necessary to take a look at the overall context in which this work takes place. This includes the policies, organisations, resources and constraints within which practitioners are operating (Hallett and Birchall, 1995, Cooper et al., 2003, Ferguson, 2011, Parton, 2011). Indeed this has been a principal concern of recent systems approaches to reviewing and improving the child protection system (Munro, 2011, Fish, 2008). Such approaches have drawn on developments in the field of risk management and accident analysis (Rasmussen, 1997, Reason, 1997), which place a premium on a system's ability to cope with complexity at the 'sharp end' of practice (Woods et al., 2010). In highlighting the importance of effects such as unintended consequences and feedback loops, a critique emerges of the conventional 'technical' approach to complex problems, which assumes linear causal relationships and tends to focus on the reliability of human operators within supposedly 'safe' systems.

The critique of 'technical' (or 'technocratic' or 'rational-technical') approaches, and the comparison with alternative perspectives, has been a central feature of the debate on child protection practice over recent years (Ferguson, 2011, Munro, 2010, Webb, 2001). It is therefore worth recapping the main features of this critique. Munro (2010: 13) draws a comparison between 'atomistic' and 'holistic' approaches to child protection, which may be paraphrased as follows:

- A narrow emphasis on individual or isolated problems (atomistic), instead of trying to understand how multiple elements interact and combine to produce system events (holistic).
- A linear view of causality in terms of proximal cause and effect, rather than an appreciation of non-linear behaviour in complex systems, e.g. feedback and cascade effects.
- A technocratic emphasis on guidelines, procedures and compliance, rather than a 'socio-technical' emphasis on the nature of professional involvement with service users.
- A limited ability to respond to the variety of needs presented by children and families, due to over-regulation and standardisation of practice and the erosion of professional discretion. This contrasts with an organisational learning culture that supports professionals and enables them to deal with variety.
- A defensive approach to risk management, as opposed to an 'acceptance of irreducible risk' (2010: 13).

According to this study's findings, such comparisons could be viewed in terms of a differential response to complexity. The 'atomistic' approach therefore corresponds to the 'simple realist' model outlined in Chapter 3, or the 'expert system' perspective discussed in Chapter 6. Its method is to do away with causal complexity by disaggregating the complex system into component problems that are not complex. This reinstates linear causality, which lends itself to standardisation and regulation of task performance, and a centralised organisational culture characterised by managerial controls. Social complexity is downplayed, in favour of trying to proceduralise and even 'computerise' cognitive tasks in order to eliminate human fallibility (White et al., 2011, Shaw et al., 2009). The 'expert system' also implies a transfer of expertise from the individual practitioner to organisational processes that administer a scientific 'evidence-base' to guide action and intervention. The technical approach to risk management is also consistent with a view of risk as a dangerous build-up of energy, which must be contained through layers of defensive barriers (Woods et al., 2010: 37). Centralised control and regulation of professional work are accordingly seen as a way of maintaining the integrity of those barriers.

The study's findings intersect with this critique in a number of ways. The influence of the 'expert system' perspective was evident in professional discourse, even as some of its assumptions were undermined by the actual experience of complex casework. An example was the idea of containing

risk through interventions designed to envelop or surround the client system (see Chapter 5, Section 5.5.1). This was pursued in both cases as a way of stopping events from spiralling out of control, e.g. through a structured programme of activities to keep the young person occupied in Case 1, or the steps taken by practitioners in Case 2 to encourage parental compliance with the child protection plan. At the same time, practitioners were struck by their continued lack of control over events, and noted the tendency for clients to 'break out' of the constraints placed on them (see Chapter 5, Section 5.5.5). Another example was the 'clinical' approach to assessment and intervention, consistent with the idea that practitioners could objectively evaluate problems within client systems, come up with rational solutions, and refer to specialists for appropriate treatment (Chapter 6, Section 6.8). Yet participants were also conscious of social complexity: the ambiguity of information, a sense of immersion in family dynamics, and the centrality of relationships in their work. This awareness led practitioners to criticise rational-technical assumptions and adapt the way they worked, e.g. by deploying therapeutic or relation-centred approaches, or by attempting to bypass the managerial control of resources.

Having considered how the findings fit in with an 'atomistic', i.e. rational-technical view of child protection, it is now proposed to do the same for the 'holistic' socio-technical approach suggested by Munro and others (Woods and Cook, 2001). Socio-technical systems often involve a more decentralised organisation in which practitioners at the 'sharp end' of practice have enough operational freedom to deal with non-routine problems that cannot be covered by a given set of rules (Perrow, 1984). A fundamental principle is that control of any complex system relies on having the 'requisite variety' (Ashby, 1956) to deal with the full range of situations that may be encountered. The findings might therefore provide some insight into the kind of 'requisite variety' demanded of professional networks when they come together to work on complex cases. The process of assessment illustrates this principle. Practitioners in this study were found to draw on a range of observations, hypotheses and case histories available within the core group, in order to construct a 'big picture' of the situation. But none of this was objective data whose meaning was unequivocal or unproblematic; it was qualitative material that required interpretation and critical analysis. The drawback of a technical approach to this issue is over-reliance on pre-ordained informational categories – the panacea of a 'common language' disseminated via computerised assessment templates (White et al., 2009). A socio-technical approach, on the other hand, would facilitate the kind of reflexive discussion held by practitioners in Case 2, for example, in the professionals meeting that helped them to formulate a joint approach to the family's problems

(see Chapter 5, Section 5.3.2). Of course, a requirement to hold professionals meetings – the procedural solution – would miss the point, since it was the nature and timing of the discussion that was crucial here. In other words, the ability of interprofessional networks to cope with complexity will depend on how they adapt in individual cases to the issues at hand.

As we have seen, the complexity of cases not only involves causal dynamics, in the form of volatile situations, unexpected consequences, or ‘crisis’ states. It also entails a flexible response to social complexity: the emotional resonance of the case, ethical dilemmas, conflicts of interpretation and explanation, and relational dynamics in the network. These are all questions to be explored in greater depth in subsequent sections of this chapter. Another important aspect of complexity is the reflexive interaction between client system and change agent system, which occurs when professionals and families become mutually involved in a complex case. Arguably this is something that distinguishes the child protection system from other complex operations that may be subject to socio-technical control. It has been observed that public services are not a commodity that can be ‘delivered’ to a customer, because outcomes are co-produced by the providers and recipients of a service (Chapman, 2004, Munro, 2010). In a child protection case, co-production of outcomes may prove particularly problematic. This is partly because parents might be uncooperative, hostile or superficially compliant (Brandon et al., 2008). Furthermore, there may be uncertainty about the nature of problems and solutions, conflicts over the authority to assess and diagnose, or to define categories of need and concern. Social roles such as ‘parenting’, with deep personal implications, may become the subject of negotiation and conflict, and the same goes for professional values and competencies. This type of complexity is not envisaged in the socio-technical operations that organisations tend to see as a ‘managed process’, e.g. a nuclear power plant or aircraft control (Woods et al., 2010). Aeroplanes might malfunction in all sorts of ways, but they do not have their own ideas about how they should fly.

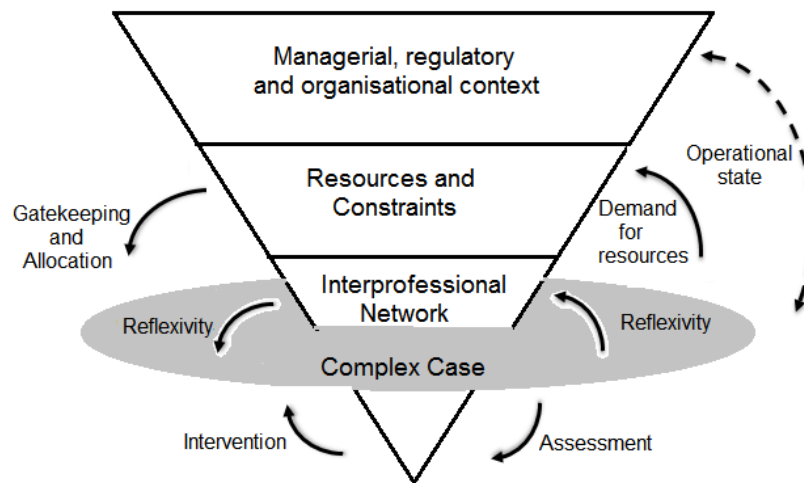


Figure 7a. Interprofessional working at the 'sharp end' of a complex system (adapted from Woods et al. (2010: 9-10))

Figure 7a illustrates the ways in which complexity in the process to be managed (i.e. the complex case) starts to impinge on the system designed to manage it. It draws on Woods et al.'s generic depiction of the sharp and blunt ends of a socio-technical system (2010: 9-10), but has been adapted to show a child protection system in relation to the individual case. The interprofessional network represents the sharp end of the system, responsible for carrying out assessment and intervention with the child and family. The sharp end is designed to manage the complexity of such work through various processes, such as identifying needs and matching them to different types of expertise (e.g. via referral to specialist services), or coordinating activities through the lead professional role. Resources are allocated through bureaucratic gatekeeping processes and so must be negotiated by practitioners with managers. The institutional and regulatory context of work constitutes the 'blunt end' of the system, and is what determines its operational state. A system's operational state is not fixed but emerges as a result of trade-offs between different organisational constraints and objectives, which in this instance might mean thresholds for action, average caseloads, or budgetary constraints. At the point where practitioners start to work with a child or family, the reflexive engagement of change agent system with client system is realised in the form of the complex case. As argued earlier, this means not only that outcomes are co-produced, but also roles, identities and relationships. Complexity emerging from the individual case starts to shape the behaviour of the interprofessional network and can also feed into other parts of the system. A 'high profile' case (as one of the participants referred to Case 1), for

example, may induce managers to authorise extra resources and increase surveillance, in order to contain risks. The most extreme cases may even shift the operational state of the system, as the impact of serious case reviews and public inquiries has demonstrated (Stanley and Manthorpe, 2004, Birchall, 1995).

The findings illustrate some of the ways in which complexity can shape practice at the sharp end of the child protection system. In Case 1, for example, the core group was seen to unite around the perception that services had failed previously to address the young person's needs, and that he had the potential to do well if supported appropriately (see Chapter 5, Section 5.4.3). As a result practitioners were prepared to invest a lot of time and effort despite their workload, and agitate for resources even at the risk of antagonising agency managers. Sometimes, in the absence of an assertive lead professional, the network seemed to operate as a self-organising unit. At other times, organisational concern about risk mounted to the level where the case was being assigned strategic priority across a range of agencies (see Section 5.4.4). In Case 2, concerns about the children's welfare were seen to accumulate until a 'sentinel event' pushed it beyond the statutory threshold for intervention. Up till then, agencies had found themselves entangled in the parental tendency to solicit support from agencies and then 'fall out' with them when their requirements were not met. Once the core group was established, the dynamic of acceptance and rejection continued to influence roles and relationships within the case, as well as the willingness of services to remain involved (see Section 5.3.1). What such examples illustrate is that what happens in a complex case is emergent, arising from the interplay between characteristics of the system (e.g. resources, skills, supervision) and characteristics of the case. Every case is both constituted by and constitutive of the system, and on rare occasions may even have the capacity to make the system revolve around it.

In summary, the discussion of complexity can be placed in the context of two contrasting approaches to organising children's services: firstly, as an atomistic/technical system, or secondly, as a holistic/socio-technical system. A technical approach would correspond to the 'expert system' perspective discussed in Chapter 6, in which complexity is disaggregated so it can be addressed via professionally and managerially mediated processes, such as referrals and resource panels (see also Chapter 3, Section 3.3.2). A socio-technical approach, on the other hand, would aim to equip the system with the requisite variety to deal with complexity where it mainly occurs, i.e. at the frontline, or 'sharp end' of the system. However, in child protection the process to be managed,

the 'complex case', exists in a state of reflexive interconnection with the system that is supposed to be managing it. This makes the system sensitive to characteristics arising in the case itself, accentuating causal and social complexity, and suggesting a need for adaptability towards the blunt as well as the sharp ends of the system. Nonetheless, a great deal rests on the interprofessional networks that deal with complexity on a case-by-case basis. It is to these networks that attention turns in the following sections.

7.4 Interprofessional working in the team around the child

Up to now, the chapter has examined the characteristics of complexity as a phenomenon and its implications for a holistic approach to child protection. In what follows, these ideas will be applied to the interprofessional network, or 'team around the child' (TAC), which is established to carry out assessment and intervention in such cases (see Chapter 2, Section 2.2.7). In other words, the TAC represents the 'sharp end' of practice, the context in which a range of services are provided in order to protect children and promote their welfare. For children with additional or complex needs, the TAC is brought together through referrals to specialist services and is coordinated by a lead professional from the most appropriate agency (DfES, 2005). For a child considered to be 'at risk', the TAC becomes the core group that implements a child protection plan, and is usually coordinated by the statutory social worker (DfES, 2006). There are various ways to conceptualise the TAC within this general framework, as will be seen below, and this also leads interprofessional networks to adopt different ways of dealing with complexity.

The findings from the previous chapter allow us to consider the team around the child from three perspectives, namely the 'expert system', 'clinical' and 'relation-centred' approaches to interprofessional working (see Chapter 6, Section 6.8). To begin with, an 'expert system' perspective would view the team around the child in terms of functional processes that enable professional expertise to be matched to areas of identified need. The TAC is set up as a technical system, relying on 'integrated tools' such as the common assessment framework (CAF) and integrated children's system (ICS), in order to simplify access to services, facilitate a shared understanding of children's needs, and provide 'seamless' care. It is the type of collaboration promoted by *Every Child Matters* (see Chapter 2, Section 2.2.5), which among other things sought to establish clear protocols for interprofessional working in cases of multiple need. The tiered approach to service provision (Hardiker et al., 1991) has implications for the way that the TAC

undertakes its work, because of the assumption that complex needs can be disaggregated and dealt with by individual specialists. As a result, the TAC does not alter the primacy of single-agency lines of control and supervision. As a result, to use Webb's distinction, coordination of the TAC is more likely to be 'routinised' than 'radical' (Webb, 1991), being geared towards exchanging information and allocating tasks, rather than questioning information and finding creative solutions. Practitioners, especially in the lead role, may also have (or feel they have) responsibility for outcomes in the case, but without the commensurate authority – e.g. to command resources or mandate the activity of other members of the network (Woods et al., 2010)³. As was noted in the findings, particularly in Case 1, practitioners in complex cases may become aware of their lack of influence over important decisions that turn out to be the province of multiple managerial hierarchies (see Chapter 5, Section 5.3.3).

Another view of the TAC is from a 'clinical' perspective, which draws on the medical model of diagnosis and treatment (Pollard, 2010). Here the TAC is envisaged as a multi-disciplinary team, whose members gather information from a range of sources and contribute this information to an overall assessment of need. The idea of a clinical team (Miller and Freeman, 2003) is compatible in many respects with the 'expert system' approach to organising services, but there are some important distinctions. Firstly, the clinical approach emphasises professional expertise and discretion, rather than managerial processes of referral and resource allocation. Secondly there is the question of clinical oversight, i.e. who has the role of clinical lead, an issue which is further discussed in the next section. Despite their high status, medical practitioners (e.g. GPs, paediatricians, psychiatrists) do not always assume a leading role within child protection core groups (Hudson, 2005, Hallett and Birchall, 1995, Whiting et al., 2008, Worrall-Davies and Cottrell, 2009). This finding was reflected in both cases, where GPs were nominally part of the network, but did not attend case conferences, and CAMHS as a tertiary service withdrew following their assessments. The social worker might seem the most obvious professional to perform the lead role; however, as the findings made clear, they do not have the authority to pronounce on medical matters, nor do they have the final say on risk thresholds, nor do they command direct access to specialist resources. All of this falls under the aegis of 'higher powers', as one of the participants put it (see Chapter 5, Section 5.6.2). Finally, whereas the expert system would consider all practitioners to be discharging roles within a rational-technical framework of 'evidence-based'

³ Woods et al. (2010: 130) refer to the 'responsibility-authority double-bind', in which practitioners have limited authority to act but may still be blamed for adverse outcomes.

intervention, the clinical approach, through its privileging of knowledge and expertise, lends itself rather more to a hierarchical arrangement with the 'clinician' at the top. Given the ambiguity surrounding the clinical role in TACs and core groups, this leaves considerable scope for the tensions around status, power and responsibility that have been known to affect multiprofessional teamwork (Anning et al., 2006).

The third order of discourse outlined in the conclusion to Chapter 6 was the 'relation-centred' perspective. This would see the TAC in terms of a web of interprofessional relations mediated through the core relationship between practitioner and service user (Morse, 1991, Ruch et al., 2010, Colley, 2003). The relational element shifts the emphasis to the interpersonal involvement of professionals with families, unlike the more detached, impartial standpoint of the clinical practitioner. It also means that each member of the core group will experience the TAC in a different way from their colleagues. As was seen in both cases, an informal layer of roles and functions may be generated within the group, over and above the formal roles and responsibilities that come from agency remits or areas of clinical expertise (see Chapter 5, Section 5.5.2). These more informal patterns of behaviour, and their connection to what is going on for the family and child, may or may not be discussed in multi-agency meetings and acknowledged in the agreed plan. Under this perspective, the 'human factors' affecting professional work with vulnerable families become prominent, including the impact of emotions and what Ferguson (2005) calls the 'psycho-social dynamics' of child protection work. Practitioners may feel afraid of service users who are hostile, sympathetic to those who are needy, or repulsed by those who are abusive, and such responses may feed into patterns of collusion, conflict and denial within the network (Brandon, 2009). On the other hand, networks may become aware of emotional and relational factors and be in a position to deal with them constructively, for example by incorporating them into case discussions and assessments (Ruch, 2007). A good example of this occurred in Case 2, in the professionals meeting where practitioners helped each other to understand the family's problems and formulated a joint strategy for engaging the parents (see Chapter 5, Section 5.3.2).

While all of these perspectives were influential in the accounts of participants, it has already been noted that none was predominant. Interprofessional working was construed in different ways according to the aspect of work that was being described. When it came to obtaining resources and specialist services, for example, most practitioners encountered referral criteria, managerial authorisation, and other gatekeeping procedures seen as characteristic of the expert system.

When it came to managing risks and addressing needs, there was a tendency for the network to perceive itself along clinical lines, i.e. as a multidisciplinary team headed by the practitioner with main responsibility for judging and being accountable for outcomes. This in turn put pressure on the lead professional – usually the children’s social worker – not only to coordinate the plan and act as a conduit for information, but also to take on the concerns about child safety expressed by other members. The absence or disregard of a lead professional – as apparently happened early in Case 1 – led to practitioners feeling anxious about risk, or frustrated that their expertise was not being recognised (see Chapter 5, Section 5.3.3). Another important source of clinical guidance was CAMHS, but again this could lead to consternation if CAMHS completed their assessment and immediately decided to withdraw from the case. Finally, practitioners described their individual work with service users in relational terms, commenting on the effect of interpersonal dynamics on the behaviour of the network and how this led to blurring of their official roles and remits (see Chapter 5, Section 5.5.4).

While individual relationships are the foundation of casework, the practitioners making up the team around the child will be subject to change, even during the lifetime of a case. When it comes to interprofessional working, the key question may therefore be how to conceptualise the TAC itself. Is it the functional offshoot of an expert system, a clinical team headed by the lead professional, or a web of interprofessional relations subject to psycho-social dynamics? If, as the findings here seem to indicate, the TAC is neither one thing nor another, but some sort of hybrid, then how to reconcile the resulting tensions and misunderstandings? Furthermore, how do these attributes help the team around the child deal with complexity *as a network*? Again, the findings offer some conflicting evidence on this front. On the one hand, practitioners in these cases were all engaged in individual, agency-determined pathways of assessment and intervention. On the other hand, the networks also exhibited self-organising behaviour, in dealing tactically with circumstances that could not be foreseen. On other occasions, they were able to operate on a strategic level, in the sense of coming to a collective view on the case and pooling their resources in support of a tailored intervention, e.g. parenting support in the home, or a residential school placement. In the process, the networks were able to exhibit reflexivity, *applying their problem-solving capacities to their own functioning* in order to manage a complex situation.

In their review of reflexivity, D’Cruz et al. (2007) point to variations in the way the term has been used and understood in social work contexts, often in conjunction with related concepts such as

'critical reflection' and 'reflectivity'. Common elements include a critical awareness of self, a regard for the emancipation of clients, and also of practitioners, from oppressive power relations, and a concern with how knowledge is constructed and used in practice. Reflexive or reflective practice can help practitioners to manage uncertainty, and remain aware of the influence of emotional as well as cognitive factors on their actions and decisions (Parton and O'byrne, 2000, White, 2002). Generally, this literature has focused on the development of individual expertise, usually in conjunction with supervision and perhaps additional training and support (Sheppard, 1998, Fook, 1999, Schön, 1991). However, building a 'reflexive network' would not simply consist of gathering together practitioners who are able to work in this way. As observed above, networks would need to develop a collective self-awareness and critical capability, similar to what professionals might aim for in their own practice. In this way, interprofessional working could go beyond 'routinised' coordination and become 'radical', in the sense described by Webb (1991: 231), characterised by a search for innovative solutions rather than conformance to procedures. In other words, the reflexive network would seek to engage with complexity, rather than trying to disaggregate it into linear problems to be resolved through technical means.

In summary, the team around the child (TAC) constitutes the sharp end of child protection practice, through which practitioners come together to try and manage the complex process of the case. Considered as an amalgam of expert system, clinical team and relation-centred group, the team around the child offers a range of capabilities but also the potential for conflicts and misunderstandings to occur. Reflexivity is an unavoidable aspect of working with complex cases, but networks can develop their own reflexivity to a greater or lesser degree. The challenge is to negotiate the tensions between different perspectives on interprofessional working within the TAC. The technical approach would be to focus on the expert system as a means of producing the conditions for consistent collaboration – as in the 'barriers and facilitators' approach discussed in Chapter 2 (see Section 2.2.7). Conversely, the socio-technical approach accepts that complexity cannot be managed out of the system, and so shifts the focus to producing the 'requisite variety' to deal with it. The sections that follow will explore the idea of the reflexive network as a way of doing this, drawing on the study's findings on assessment, intervention and risk in complex cases.

7.5 Assessment and the reflexive network

It was argued earlier that the team around the child might need to operate reflexively, as a network, if it is to deal with complexity in certain types of case. What this means in practice will now inform the rest of the chapter, starting with the process of assessment. In child protection work, assessment frameworks drawing on developmental and ecological perspectives have become increasingly prominent (Rose, 2009). The informational categories in these frameworks (e.g. health, education, social presentation) have also shaped integrated tools to promote collaborative casework. These include the common assessment framework (CAF) and integrated children's system (ICS), which have greatly influenced interprofessional working in the team around the child (Anderson, 2005, Shaw et al., 2009, White et al., 2011). The tendency to rely on procedures and templates to guide the assessment process is consistent with an expert system approach to interprofessional working, as described above. The findings of this study would support the view that practitioners use a variety of approaches in order to manage complexity.

For instance, practitioners highlighted the often problematic and ambiguous nature of information in complex cases (see Chapter 5, Section 5.4.1). By implication, it is not enough to share information, important as this is. Assessment means trying to synthesise different viewpoints, however difficult this may prove. It is precisely this heterogeneity, both of information and analysis, that potentially confers the greatest strength of the core group, offering an opportunity to weigh up different hypotheses in the light of accumulated evidence (Munro, 2008, White, 2009a). On the other hand, there are the potential drawbacks of conflict, groupthink or hierarchical divisions, any of which might constrict the amount of genuine dialogue that can go on (Janis, 1982, Reder and Duncan, 2003, Bell, 2001, Skjorshammer, 2001). Both the strengths and drawbacks of this process were evident in participants' accounts. Practitioners seemed largely to be conducting their own assessments, and while they were keen to compare and discuss their conclusions with each other, it was often a challenge to reconcile contrasting or opposing viewpoints.

The contested issue of diagnosis also provided a good example of how difficult it can be to conduct holistic assessments using the team around the child model. Arguably this is linked to a question that was raised earlier: who has the role of 'clinical lead' in child protection cases? Does this necessarily have to be a medical practitioner? After all, in cases where multiple social, environmental and individual factors are closely interlinked, it is not always feasible – or desirable – to narrow these down to a medical cause. Child protection cases tend to involve a tension

between identifying need and assessing risk (Stafford et al., 2012: 159), with the latter often being the province of statutory social workers. On the other hand, the salience of medical issues in such cases, as well as the status accorded to the opinions of doctors – not least by the family courts (Butler-Sloss, 2002) – does make it important to have a medical perspective as part of the assessment. The two cases studied here point to the significance of CAMHS, and indeed adult mental health services, in providing support to vulnerable children and families. This is backed up by other research (Milburn et al., 2008, Worrall-Davies and Cottrell, 2009, Salmon, 2004, Darlington and Feeney, 2008). However, the difficulties around diagnosis also suggested that such input was not always forthcoming when practitioners felt they needed it. The role and function of CAMHS as a tertiary level service was perhaps partly to account for this. It meant, for example, that CAMHS would usually withdraw once their assessment was complete, or if the family did not attend in-clinic appointments. This proved a source of frustration for other members of the core group – not only because of the perceived need for therapeutic support (both cases), but also due to the difficulty of reopening the dialogue around assessment (Case 1). For the network to operate reflexively, it was the contribution of medical expertise to the group's *evolving* knowledge and understanding of the child that was felt to be lacking at times.

A related problem was inconsistency around the lead professional role. In both cases, it was found that without a committed lead professional, with an overview of the case and the ability to unify the core group's activity, the network started to 'self-organise', with unpredictable results. In theory, the lead role can be held by any practitioner in the team around the child (DfES, 2005). Indeed, in Case 1 another agency (FIP) did serve as lead professional for a while – although it meant a period of transition after that worker moved on. While various mechanisms for allocating the lead professional role have been outlined in government guidance, it was seen here to be quite dependent on the involvement of children's social care – the 'baton' being so much being 'passed on' as enclosed with the referral form (see DfES, 2005: 9). The role is also significant in terms of what it shows about the reflexive network. As the core group developed a sense of common identity and purpose, based on identifying the children's needs and arriving at a common understanding of the problem, it also started to require a professional with the necessary expertise and authority to articulate that understanding and coordinate a joint response. In other words, the lead professional embodied the network's reflexive activity, which otherwise lacked a focal point.

It may be instructive at this stage to consider the team around the child, constituted as a reflexive network, in terms of the organisational team types identified by Ovretveit (1993; see Chapter 2, Section 2.3.4). Since the team around the child forms more or less spontaneously around a particular case, it is hardly a formal team at all. It instead resembles what Ovretveit describes in his typology as a 'network association', consisting of different professionals who happen to have a case in common but continue to be managed and supervised through their own agencies. In contrast, the 'multi-professional teams' examined by Anning et al. (2006) shared, to varying degrees, general functions of coordination, management and supervision. What the findings in this study suggest is that as the network develops a reflexive response to complexity, it starts to assume some of the characteristics of more formally organised teams. This could be seen, for instance, with the increasing importance of coordination by the lead professional, the development of a 'core and periphery' within the group, and the growing distinction between clinical consultation (sought from CAMHS) and managerial responsibility (social care) – see Chapter 5, Section 5.5.4. However, these traits developed informally and often proved unsustainable when there was a change in personnel, which would then have a knock-on effect on how the network functioned. In short, the network was trying to turn itself *into* a team, albeit without recourse to many of the integrative structures and processes that might be expected to facilitate the process (Robinson et al., 2008).

A final attribute of the reflexive network was its awareness of, and emphasis on, the relationship with the child and family. This was clearly evoked in both cases: Case 1, in which practitioners saw direct work with the young person as the key to understanding his needs; and Case 2, in which the children's needs were bound up with how their parents responded to professional support (see Chapter 5, Sections 5.2.1 and 5.3.3). Just as clear was the challenge of negotiating and managing these relationships, particularly in a way that could accommodate disagreement and distrust. In this respect, discussions of partnership working in the literature have tended to emphasise the need for a two-way dialogue instead of an 'expert model' approach that privileges the knowledge and opinion of professionals (Cunningham and Davis, 1985, Dale, 1996, Davis and Meltzer, 2007). The argument made here is that in complex cases it is not only important for the *individual* practitioner to be able to have this kind of dialogue with parents and children, but also for the *network* as a whole. This demands reflexivity, because the family is itself part of the network, meaning there will always be some form of partnership, even if it is limited or dysfunctional. This was recognised by many of the participants, who commented on the need for practitioners to give

a consistent message to families. Practitioners who focus just on ‘their’ relationship may unwittingly be doing so to the detriment of others – an example of unintended consequences but also of a lack of reflexive awareness.

In summary, the reflexive network has been defined as a group of practitioners able critically to evaluate and adapt their own collaborative activity *as a group*. This should enable the network to function in a flexible, creative way that goes beyond information-sharing and routine coordination. Nonetheless, reflexivity entails a considerable amount of interprofessional activity: building a collective picture of the child and family in order to identify the main needs and risks; discussing different hypotheses and explanations and trying to reach a consensus; agreeing a joint approach to addressing the main problems; reviewing progress and, inevitably, reacting to unexpected events and information. Critical self-awareness may not always be easy to develop and maintain in complex cases, partly due to limitations in the team around the child model. The findings in this study highlight the challenges faced by core groups with a large and variable membership, ambiguity about the role of clinical lead, inconsistent coordination, and only infrequent meetings to resolve these issues. What is more, such groups are often dealing with emotionally-charged situations, involving anxieties about risk to children (Reder and Duncan, 2003). Under such circumstances, it is often difficult to maintain a systemic understanding of the case; practitioners might well feel pressure to work in a more procedural way, focusing instead on their single-agency roles and remits (Pendry, 2012).

7.6 Intervention and the distribution of expertise

Having looked at assessment from the perspective of the reflexive network, the chapter will now move onto the subject of intervention in complex cases. The question of risk will be addressed separately in the next section, so for now the emphasis will remain on the use of expertise within the network to address need. Many of the themes explored above remain pertinent to the discussion, since assessment and intervention are viewed as conjoined rather than separate processes. As the findings suggest, the ability to intervene in a ‘holistic’ way will be linked to the network’s ability to function as a strategic unit, rather than as a bundle of tactical operations (Chapter 5, Section 5.7). Again, this means focusing on relationships as well as technical knowledge, and retaining a systemic awareness of how the work of each member of the network impacts on that of the others. The implications will be used to develop a critique of the team

around the child as a model of tiered intervention, and point towards alternative ways of distributing professional expertise in complex cases.

Treating complex needs in a holistic way is one of the implications of considering complexity to be a unitary phenomenon, rather than a label for multiple problems that end up being tackled separately. That is not to try and reduce or simplify such situations to a 'single' cause, e.g. a medical condition, or a social/personal deficit, but relates to the central problem of how to organise services so that appropriate support is provided as quickly as possible. Recent research into child safeguarding suggests that in practice it is not always easy to provide intensive, well-coordinated support services (Davies and Ward, 2012, Farmer and Lutman, 2012, Ward et al., 2012, Wade et al., 2011, Daniel et al., 2011, Thoburn and Brandon, 2008). Farmer and Lutman (2012), for example, found a scarcity of services to help children returning home from care to deal with issues such as substance misuse, independent living skills and mental health problems. Davies and Ward (2012: 81) note that there is 'too little help with critical issues such as parenting skills, parent-child relationships and children's behaviour problems'. They also find that the episodic nature of social care interventions, with their emphasis on swift withdrawal and case closure, is often unsuited to the chronic nature of the problems with which they were dealing. Children's needs tended to get lost in the bureaucracy of referral and gatekeeping procedures, with practitioners on the one hand clamouring that 'something must be done', while specialist services ponder whether the case 'meets the threshold' for action (Daniel et al., 2011). With resources held by bureaucratic systems rather than by practitioners, the focus of activity often becomes about assessment and case management, bound up with official time-scales and anxieties about risk.

These issues suggest that, notwithstanding the shift towards more integrated children's services, when it comes to individual cases it can still be difficult for the team around the child to 'pull in' expertise as and when it is needed. Referrals may not be accepted; it may take a while for additional resources to be authorised; there may be high turnover of workers; the family may not engage, or only comply superficially; and so on. This was seen in Case 2, for example, in which practitioners were all agreed on the assessment of 'parenting' as the main problem – but the only agency able to provide parenting support in the home, with the cooperation of the family, actually withdrew from the core group because of concerns about role blurring and referral criteria (see Chapter 5, Section 5.4.4). Studies have tended to relate such issues to defects in implementing the tiered model, such as the persistence of 'silo' working mentalities (Brandon et al., 2008), local

differences in thresholds for intervention (Farmer and Lutman, 2012), or a deterioration in planning when practitioners get overwhelmed by complex problems (Davies and Ward, 2012). Social work academics have also pointed to a dearth of child protection specialists with the time, skills and confidence to work directly with children and families (Ayre and Preston-Shoot, 2010, Munro, 2011). What has perhaps not been so discussed is whether some of these issues arise out the tiered model itself. For example, an inherent feature of the model is to split up the work with highly vulnerable families and share it around a number of agencies, relying on 'integrated' tools (e.g. CAF) and processes (e.g. TAC meetings) to deliver services through the team around the child. As we have seen, the result may be an uneasy oscillation between the opposing pulls of fragmentation and integration.

In his book on systems thinking in the public sector, Seddon (2008) explains the consequences of dealing with pieces of work in a fragmented way, rather than putting expertise at the 'front' of the system to deal with problems as they occur. The result is what he calls 'failure demand', as issues that are not resolved straightaway keep reappearing and cumulatively start to overload the system's ability to cope. The analogy in the context of children's services is with prevention/early intervention and patterns of referral and re-referral to specialist agencies (Lord, 2011). While the model of tiered services is designed to promote collaboration, its pyramidal structure reflects the assumption that the expertise to deal with complex problems is held by professionals in the higher tiers. Under these circumstances, specialist agencies might be expected to worry about being overwhelmed by referrals and be correspondingly rigorous in their gatekeeping and case management, particularly in periods of heightened public anxiety about child abuse (Association of Directors of Children's Services, 2010). In Seddon's terms, 'failure demand' will start to mount up and put pressure on services, if interprofessional networks have been unable to intervene quickly and effectively at the point that families start to experience problems. In an example of the kind of negative feedback loop examined by Munro (2010: 13), this eventually has the counterproductive effect of increasing the number and severity of cases entering the system.

This analysis shows how complex cases reveal inefficiencies in the distribution of expertise in the 'preventative system' of child safeguarding. Seddon (2008) advises that public services should be 'designed against demand', rather than organised in a hierarchical, top-down manner. One of the most important tenets of this kind of approach is that the expertise required to solve problems is placed at the 'front end' of the flow of work, where it can be easily 'pulled out' of the system by

the service recipient. The tiered model of intervention, on the other hand, appears to locate expertise at the back of the system, where it must be accessed through professionally and managerially mediated processes. As a consequence, multiple referrals, initial assessments and administrative decisions must be made before resources can be allocated to a particular case. None of the latter is 'value work' in the sense of addressing the needs of families, although non-value work may be intrinsic to the way the system currently operates. In contrast, a system designed against demand would locate expertise where it can rapidly address the problems with which vulnerable families present, without bureaucratic delays or interagency wrangling over remits and thresholds.

What would be the characteristics of such a system? Despite the political emphasis on partnership and collaboration in children's services, the argument presented in this thesis is that current models of integration are too wedded to the idea of an expert system in which problems are managed in a technocratic way. Ironically, some of the procedures and processes set up to encourage interprofessional working may even have exacerbated the removal of expertise from the 'front end' of the system, so that the team around the child often lacks the 'requisite variety' to deal with complexity (see earlier, Section 7.3). The result is the pattern of delay, escalation and periodic crisis that was observed in both cases in this study. Correcting this imbalance might entail a number of remedies. Expertise currently held higher up in Tier 3 services could be made readily available within Tier 1 and Tier 2 services, so that social workers are easily able to get clinical consultation and improve assessment and planning in cases that end up in court (Family Justice Review Panel, 2011). Teams working with vulnerable families could have *embedded* expertise to address typical issues such as non-engagement, parenting skills, drug and alcohol misuse, behavioural disorders, and mental health problems (C4EO, 2009). The system would be geared towards getting practitioners to do preventative work with families themselves, rather than assessing, case managing and referring on. In complex cases, interprofessional collaboration would take place through the type of reflexive networks described above, which have the capacity to undertake joint assessment and strategic intervention, as well as critical self-evaluation.

The cumulative logic of this argument points towards the kind of integrated multi-disciplinary teams that are already gaining credibility as a model of working with vulnerable families in parts of the UK. Examples include Family Recovery Programmes/Projects (FRPs) (Local Government Leadership and City of Westminster, 2010) , Family Drug and Alcohol Courts (FDACs) (Harwin et al.,

2011), and Social Work Units (SWUs) (Goodman and Trowler, 2012). All of these have been piloted and evaluated in recent years as effective ways of working with complex child welfare cases. Although these teams have different professional memberships and engage with families at different stages of the prevention process, what they do have in common is a focus on intensive and targeted intervention in multiple domains. Teams are co-located and under unitary management, hold joint accountability for cases, and promote reflective practice and joint case discussions. Individual practitioners receive clinical supervision, as distinct from guidance on case management. As a result, these teams are established as reflexive networks from the outset, and have a range of expertise that can be drawn on immediately, instead of via multiple referrals. It is worth noting that FRPs and FDACs are in effect Tier 3 services, since families tend to be referred to them via children's social care. On the other hand, SWUs were designed as an alternative to the conventional structure of local authority services for children in need. In other words, areas using this model have tried to reorganise their child protection service as a whole, rather than creating further layers of specialised (i.e. tiered) intervention for the most complex cases.

The last point is an important one, because it refers to the difference between designing a system against demand and modifying the existing system to cope with 'extra' demand. The risk with the latter approach is again that by reserving the 'best' services for the most acute cases, they may unwittingly generate failure demand because problems are not properly addressed when these cases first enter the system. There is an interesting parallel here to the issue of 'evidence-based interventions' (EBIs), i.e. programmes that have been rigorously evaluated in terms of their effectiveness for specific problems or client groups (Davies and Ward, 2012: 96). For child safeguarding, such programmes might include the Enhanced Triple P-Positive Parenting Programme, and Multi-Systemic Therapy for Child Abuse and Neglect (Barlow and Shrader Mcmillan, 2010). Despite their merits, even these interventions have shown 'significant rates of recurrence of maltreatment and poor outcomes in the follow-up studies' (Davies and Ward, 2012: 113). But that is perhaps unsurprising if they are only being deployed when problems have multiplied and escalated to the stage where routine services are unable to cope. Returning to the findings in this study, it is worth recalling that Case 1 had become the subject of various specialist interventions, including the Family Intervention Project (FIP). However, since this service was not able to resolve the family's problems at the stage when it received the case, responsibility reverted to the team around the child led by the statutory social worker (see Chapter 5, Section 5.5.4). In some ways, Case 1 presented almost a classic illustration of failure demand, showing

how the tiered model of services had been unable to respond early or quickly enough to the needs of a family.

The tendency to deliver evidence-based interventions through 'boutique' operations can be seen as a corollary of the de-skilling and 'de-professionalisation' of standard child protection interventions (Ayre and Calder, 2010). For the same reason, it is perhaps a little perverse to criticise individual practitioners for not 'using' EBIs when the latter are often designed to be implemented by multi-disciplinary teams set up precisely for that purpose. In this respect, Davies and Ward (2012) suggest that a possible way forward is a 'common elements' approach, which attempts to reconcile adherence to a given EBI template ('programme fidelity') with the diverse experience of 'real-world cases' (Garland et al., 2010, Chorpita and Daleidin, 2009). Importantly for the current context, the focus is on improving the standard of what Garland et al. (2010), referring to mental health settings, call 'usual care', rather than on providing standardised evidence-based treatments in cases when usual care has proved insufficient. The idea is to distil common elements from existing EBIs, in consultation with the original developers of those programmes, and train practitioners to apply these flexibly and innovatively in individual cases. Although the approach has not yet been rigorously tested, the hope is that it would enable practitioners to create tailored interventions that are still grounded in research evidence. Interestingly, the 'Hackney model' of child and family social work draws on a similar principle, suggesting that social work units should consist of small multidisciplinary teams, and use a systemic approach based on several proven methods of intervention (Goodman and Trowler, 2012).

In summary, this section has explored the principle of organising services for children in such a way as to locate expertise at the front of the safeguarding system, where it can be easily accessed by families and practitioners. On this basis, a critique has been developed of the tiered model of provision. In theory, tiered services should be able to match specialist interventions to a range of different needs; in practice, specialist resources can only be accessed through referral and gatekeeping processes that tend to hold expertise at the back of the safeguarding system. This in turn affects the work carried out by the team around the child (TAC). Shortfalls in expertise within the TAC may reduce its capacity to undertake direct work with vulnerable children and families around commonly assessed problems (e.g. parenting style, mental health issues, drug and alcohol misuse), cause delays in provision, and lead to premature withdrawal of services from cases of chronic need requiring longer-term support. An argument can be made for redesigning

systems ‘against demand’ so that appropriate expertise is either embedded in multidisciplinary teams undertaking preventative work with families, or is readily available to them in the form of clinical consultation or managerial authorisation. Likewise, evidence-based interventions need not be reserved for extreme cases, which are referred to ‘boutique’ Tier 3 services, but could also be incorporated into the ‘usual care’ provided to families entering the system at an early stage.

7.7 Risk, accountability and communication

The discussion so far has been predominantly about how to address the complex needs of children and families, focusing above on the distribution of expertise in the safeguarding system. A case was made for establishing reflexive networks to deliver interventions to children and families as part of ‘usual care’ in the early stages of a family’s involvement with services, rather than through specialist tertiary services when problems have escalated out of control. This final section will now consider the implications of risk for the team around the child. It has already been noted that the child protection process endeavours to balance addressing need and managing risk (Stafford et al., 2012; Bell, 1999), although the two are interlinked to such a degree that the distinction is not always clear. Children at risk of abuse and significant harm are by definition in need of protection and remedial support, even if they do not end up in statutory care. Social investment discourse has also been influential in reframing the general concept of need in terms of ‘risk factors’ that require intervention to avoid adverse outcomes in later life (see Chapter 2, Section 2.2.4). However, even if need and risk are two sides of the same coin, the distinction is still worth making for several reasons.

Firstly, as suggested by the findings in this study, complex cases can generate tension between addressing need and managing risk. Issues of care and control become tangled up with practitioners’ efforts to establish constructive working relationships with children and families. A cycle ensues, in which volatility and unpredictability are met by ever more stringent efforts to re-establish stability and control (see Chapter 5, Section 5.5.1). When it comes to implementing child protection plans, there is a dual focus to the work done by practitioners. They must provide *support* in order to address the *needs* of *vulnerable* children and families, as well as elicit *cooperation* in order to reduce the *risks of harm* to self and others. Core groups discharge complementary duties in this sense, which gives group members a certain amount of license to interpret their own role and that of their colleagues in ways that go beyond the realm of official

remits and tasks allocated in the plan itself. As was seen particularly in Case 2, a lack of reflexive awareness about such issues can lead to misunderstandings and disagreements, e.g. about whether different practitioners can undertake 'supportive' and 'authoritative' roles while still giving a consistent message to parents (see Chapter 5, Section 5.5.4).

Secondly, there is the question of whether and how reflexive networks can undertake collective risk assessment. Assessing risk involves questions of probability that are counter-intuitive and challenging even for experienced and knowledgeable practitioners (Munro, 1999, Macdonald and Macdonald, 1999). It has also been argued that risk in the field of child protection is bound up with complexity (Stevens and Hassett, 2007, Spratt, 2009). Causal complexity means that outcomes cannot be pinned down, but should be envisaged more as a spectrum – a distribution of probabilities – rather than as specific events and values. Furthermore, risks are reflexive, in that they change over time and in response to the assessments and interventions carried out by practitioners, and are subject to moral and cultural evaluations (Adams, 1995, Douglas and Wildavsky, 1983). All this means that assembling different practitioners in a meeting might improve risk assessment, but will not necessarily do so. Such meetings may enable professionals to discuss different hypotheses and judgements – an important activity, since information (both old and new) may be ambiguous and open to competing explanations. On the other hand, the discussion may become characterised by groupthink, or a reluctance to contradict high-status practitioners (Janis, 1982, Prince et al., 2005). Such tendencies might be even more pronounced in pressurised and anxiety-provoking situations (Gardezi et al., 2009). In other words, risk assessment is fraught with difficulties around interprofessional communication, as will be explored further below.

The third point about managing risk, as opposed to addressing need, is the thorny issue of accountability. In a general sense, professionals are bound to be accountable for their actions and decisions as a *quid pro quo* for their authority as 'experts' in a particular field (Freidson, 2001, Irvine et al., 2002, Taylor, 2002). Unfortunately, the influence of child death inquiries on safeguarding practice means that the term 'accountability' has become associated with devastating but infrequently occurring outcomes. Arguably, this has skewed the system not only towards avoiding a repetition of such events, through the rigorous investigation of cases of potential abuse, but also avoiding blame for them when they do occur. Rothstein et al. (2006) refer to systems becoming 'colonised' by institutional risk, while Hood et al. (2000) show how this

leads to 'risk regulation regimes' based on demonstrating adherence to guidelines and procedures. Such regimes may also contribute to an emotional climate of fear and blame in child protection work, which is inimical to focusing professional expertise on the needs of children (Ayre and Calder, 2010).

Such issues have a number of implications for the present discussion. As the findings in this study suggest, complex cases may involve unstable, volatile situations, which present a challenge for practitioners under pressure to 'ensure' that risks are managed appropriately (see Chapter 2, Section 2.6.6, and Chapter 4, Section 4.5.3.7). Because complexity raises the stakes in terms of institutional risk and accountability, it is not difficult to understand why 'clinical leadership' might sometimes be hard to come by in such cases. It was suggested earlier that under a tiered model of intervention, expertise is assumed/perceived to be held in the higher tiers of service, which in fact would be consistent with a clinical model of collaboration. However, it was also argued that services are organised as an expert system, with authority and responsibility (for decision-making and resource allocation) dispersed across agencies and up through hierarchical management lines. This means not only that expertise, authority and responsibility are distributed across different parts of the system (some of them very inaccessible to frontline practitioners), but also that accountability is dispersed in the same way. While this might not be a very efficient way of organising services to address need, for reasons that have already been discussed, it is perhaps an understandable way of organising services to manage institutional risk in a climate of fear and blame. As a brief aside, it was noted in Chapter 4 that procedures for approving research in the field of health and social care appear to have followed a similar route (see Section 4.6.1).

The findings did reflect some of the impact these issues have on interprofessional working. Communication and information-sharing between practitioners, for example, was sometimes found to contain coded messages about risk and accountability. The term 'concern', in particular, was quite loaded in this regard: 'I am concerned about...' may mean 'I am worried about...', as well as 'something must be done about...', but it might also imply 'I've now told you about', or even 'it's now your job to sort out...', and so on. This was not just a feature of interprofessional 'talk' but was also implicit in the way that referrals to specialist services formalised the 'pushing' of risk and accountability up to where expertise and decision-making responsibility were felt to be located. Again, such efforts might be expected to meet with some wariness and resistance, as illustrated by the CAMHS psychiatrist's reluctance to deal with phone calls 'out of the blue' in Case 1 (see

Chapter 5, Section 5.4.2). Whatever their informal nature, such phone calls could well be recorded by an agency in terms of having 'shared their concerns' with the specialist service, even if information was not clearly delivered. On the other hand, the requirement to communicate with CAMHS via formal channels (e.g. referrals, letters) would not necessarily address the need of the core group for clinical consultation. Generally speaking, the 'siege mentality' generated by such issues seems likely to exacerbate the gatekeeping activity and hold-up of expertise at the back end of the safeguarding system (Morrison, 2000).

In summary, it has been argued that the requirement for interprofessional networks to manage risk adds an extra dimension to the collaborative work of the team around the child. Professionals have to maintain a dual focus on providing support to families to address need, and securing cooperation to reduce the risk of harm. While reflexive networks may endeavour to collaborate on risk assessment, this demands a high level of critical awareness and the capacity to evaluate a range of possible outcomes in the light of new and old information. The issue of accountability can affect interprofessional working in a number of ways. On a systemic level, institutional anxiety about risk may increase the tendency to try and control professional work through procedures and protocols. On a casework level, institutional anxiety may feed into interprofessional communication, for example with practitioners seeking to convey messages about risk through referrals and information-sharing with other agencies. This in turn might be expected to lead specialist agencies to apply strict gatekeeping criteria, reinforcing the 'back-loaded' distribution of expertise that was examined earlier. Finally, it has been surmised that the dispersal of authority, responsibility and expertise throughout the system, while not conducive to value-work from the point of view of the service user, is understandable in terms of potentially (though not always successfully) helping to disperse accountability for adverse outcomes.

7.8 Conclusion

The discussion in this chapter has examined the phenomenon of complexity in relation to findings from the study and the literature on interprofessional working in children's services. The findings have helped to establish a picture of complexity as a dynamic interplay between causal and social complexity, which gives rise to a range of experiences and constructions at the level of the complex case. Attention then turned to the task of managing complexity, which falls to a range of practitioners and agencies working together with children and families. It was shown that

managing complexity could take the form of a technical or socio-technical approach. The technical approach would be to try and disaggregate complex problems, reconstructing them as separate workflows that can be controlled by expert systems. A socio-technical approach, on the other hand, would focus on maintaining the requisite variety to deal holistically with complex problems as they occur at the 'sharp end' of the system, where interprofessional networks are working with vulnerable children and families.

In line with other critiques of the child protection system, it was argued that complexity requires a holistic approach to assessment and intervention, and that collaboration should go beyond routine information sharing and task allocation. Instead, reflexive networks should have the ability to evaluate competing hypotheses, come to collective decisions, and undertake strategic interventions. A critique was also developed of the tiered model of matching specialist services to complex needs in the team around the child. This tends to locate expertise and resources in the upper reaches of the system, where they are mediated by managerial and clinical processes. There has been a similar tendency for evidence-based interventions to be developed as boutique services for especially problematic cases. An argument was made instead for redistributing expertise towards the front of the system to address need where it arises, allowing practitioners to tailor preventative support packages incorporating the common elements of these specialist programmes. This would suggest that teams of practitioners should be undertaking systemic assessment and intervention at an early stage in families' contact with services, rather than reserving such provision until problems have escalated out of control.

In conclusion, the argument can be summarised as follows. Complexity is a systemic phenomenon and therefore must be managed in a systemic way. There are no technical solutions that will eliminate complexity and allow outcomes to be predicted and controlled in every case. Furthermore, complex cases emerge in a reflexive encounter between families and the services involved with them. This puts an onus on interprofessional networks at the front of the system, i.e. the team around the child/family. These networks must not only have the necessary knowledge and expertise to address a range of problems, but also the reflexive awareness required to make decisions about need and risk, and to maintain critical self-awareness in anxiety-provoking situations. It is doubtful that such capabilities can develop quickly and consistently in networks established through a tiered model of specialist services, whose functioning is susceptible to turnover of workers, access to clinical and managerial support, and the contribution of a lead

professional. The principle of requisite variety instead points to the 'front-loading' of expertise and authority towards the sharp end of the system, for example by delivering early interventions through reflexive networks. One difficulty in making this shift is that the protocolisation of child protection practice, as well the 'back-loading' of specialist input and dispersal of decision-making, may be a structural adaptation to manage institutional and professional risk.

The implications for policy and practice will now be summarised in the concluding chapter, which presents an overview of the thesis.

8. Conclusion

8.1 Introduction

The starting point for this thesis was that interprofessional working in children's services could be seen as a response to complexity. It was proposed to carry out a study to explore the meaning of complexity for professionals working together on complex child protection cases. The aims of the study were: firstly, to find out how practitioners experienced complexity; and secondly, to examine how complexity was constructed in their accounts of collaborative casework. The study adopted a mixed qualitative methodology, combining an interpretative phenomenological analysis (IPA) to look at practitioners' lived experience, with a critical discourse analysis (CDA) to deconstruct their accounts. Practitioners in the team around the child in two ongoing child protection cases were approached to take part in interviews. Interview transcripts were analysed using IPA and CDA, and the findings were reported in separate chapters oriented towards the research objectives. The findings were then amalgamated in a discussion of complexity as a phenomenon and its relevance for policy and practice in the field of child safeguarding. This chapter will now conclude the thesis with some reflections on the study's limitations and contribution, implications for policy and practice, and areas for further research.

8.2 Limitations of the study

As with any piece of research, there were both strengths and limitations in terms of design and implementation. The focus on two ongoing child protection cases enabled the study to draw out the contextualised nature of professional work, i.e. the 'here and now' of the complex case. Findings from interview data were therefore representative of experience and discourse in relation to those cases. In putting an onus on inclusion criteria relating to multiprofessional involvement in specific cases, however, the study design weakened representativeness in relation to the professional background of participants. The fact that only two cases were studied also calls into question whether these could be seen as 'typically' complex cases. Such issues suggest caution around taking the findings to be generally applicable to complex cases, or to the professionals involved in them.

Practical and ethical limitations precluded a bigger sample of participants, or other methodological components, which might have added to the depth and quality of findings. This perhaps points to the difference between a 'case-based' study, using a defined but restricted qualitative approach, and a full-blown 'case-study' with a more open-ended design. After all, there are many options for studying cases in the academic sense. Another researcher might have wished to conduct interviews with stakeholders such as service users and managers, collect ethnographic data such as videos or notes of participant observations, analyse transcripts of meetings and obtain written documents, such as case records and assessments. It might also have been preferable to track cases all the way through from initial referral to case closure. As with most PhDs, there are inevitably going to be limits on what can be achieved by a sole researcher with restricted time and access to field settings, particularly in a sensitive area such as child protection.

Doing research is also a way of learning about research, as well as learning about oneself, and this study was no exception. Some lessons were learned in time to contribute to the current study, while others will hopefully feed into future projects. Speaking now as the researcher, an example of the former was an increasing awareness of my use of self during the interview process, and how this might be affecting my rapport with participants and their responses to questions (see Chapter 4, Sections 4.6.6, and 4.7.1). An example of the latter was the aspiration to work more in partnership with professionals and their organisations in future, rather than coming to them with a fully-formed set of proposals. In personal terms, doing a PhD has involved a shift in identity from being a practitioner to being a researcher, which I initially equated with moving from an 'insider' position to that of an 'outsider'. When arranging access to field sites, I became worried about intruding into the professional sphere of others, or about the practical relevance of what I was doing. Perhaps more disturbing, in some ways, was the suspicion that I had simply moved to a different position in a broader system of surveillance. In that sense, my research made me a different kind of 'insider', whose role was to explore and critique the activity of professionals and their organisations. Finally, my experience of obtaining ethical approval was instructive, since this process seemed to replicate some of the systemic behaviour I was interested in studying in relation to child protection (see Section 4.6.1). Like any other socio-technical system, the act of research itself requires us deal with complexity, to work with others and to manage risk.

8.3 Contribution of the thesis

Bearing in mind its limitations, this thesis has sought to add in various ways to the state of knowledge about collaboration in children's services. Chapter 2 presented a critical review of the literature on complexity and interprofessional working, and illustrated the linkages between them. Chapter 3 made an effort to contribute to the theoretical literature in this area, outlining a model of complexity based on a critical realist perspective. Chapter 4 developed a little-used methodological approach by attempting to combine phenomenological and discourse-oriented perspectives on the same qualitative material. Drawing on this theoretical and methodological foundation, a study of interprofessional working in complex cases was carried out. The findings in Chapters 5 and 6 provide a detailed account of what complexity means for two groups of practitioners working together on a complex child protection case. This is an important contribution because much of the literature on collaboration has focused on general outcomes and processes, rather than on the individual casework context. The discussion in Chapter 7 then set out to position the findings in relation to the literature on interprofessional working in children's services. The contribution here was to draw out some implications for policy and practice in relation to the team around the child. The following section will summarise and develop this critique.

8.3 Implications for policy and practice

A small-scale study such as this one can only claim to have 'implications' through a critical re-engagement with the literature, which was undertaken in the previous chapter. There it was suggested that the findings on complexity were congruent with a view of child safeguarding as a socio-technical system, in which complexity at the 'sharp end' of the system serves to undermine rational-technical efforts to reduce uncertainty and risk. Drawing on systems approaches to public services (Seddon, 2008), a critique was made of the model of tiered services that most often underlies the 'team around the child'. The problem with the tiered model is that it tends to (with)hold resources at the back rather than at the front of the safeguarding system, so that interprofessional networks often lack the expertise, authority and adaptability needed to manage complex situations. This tendency may have been exacerbated in children's services by institutional defensiveness about risk, leading to a 'siege mentality' among specialist agencies. Counterproductively, these issues may result in the system's becoming overloaded with 'failure

demand' in the form of complex and high risk cases. An argument was made instead for early intervention carried out by 'reflexive networks', drawing a link with other research carried out on multiprofessional teams working with vulnerable children and families. From the standpoint of the reflexive network, evidence-based interventions should not be reserved for 'boutique' specialist services, but could potentially be applied to a 'common elements' approach to targeted intervention.

In terms of concrete suggestions for systemic practice, an argument has already been made for using integrated multiprofessional teams to carry out preventative work, rather than employing them as a last-ditch resort for 'problem families'. But even then, there will always be cases that escalate and develop the kind of characteristics discussed in this thesis. Even if an integrated team is undertaking the core work of assessment and intervention, this does not preclude other agencies from becoming involved. Indeed, there is likely to be a 'core' and 'periphery' in most extended child protection networks (Stevenson, 1989). When such cases become stuck, mired in antagonism, or consumed with uncertainty, they may benefit from a senior practitioner with appropriate expertise acting in a consultative capacity, helping the group to reflect on its own processes or advising on particular issues of concern. What kind of professional should this be? In the cases studied here, it was noticeable that both core groups were keen to have CAMHS involved, even though the family was refusing to engage directly with the service. This may have been in order to clarify questions about diagnosis (Case 1) or provide guidance around psychotherapeutic intervention (Case 2). Yet it was apparent that a purely consultative role would be unlikely to fit within the remit of a Tier 3 medical service. The findings also suggested that efforts on the part of core groups to reorganise themselves in a traditional clinical hierarchy, headed by a medical specialist, were connected to anxieties about accountability and risk – and as such were likely to be resisted by the service in question.

While there is often a need for medical expertise in child protection cases, this does not mean that the interprofessional network itself has to be supervised by a medical practitioner. Indeed, a supervisory role already exists for such cases, in the form of a dedicated professional who chairs child protection conferences. Research involving conference chairs has usually focused on their contribution to the conference's decision-making process (Bell, 1999, Hallett and Birchall, 1995). However, their role also includes speaking to parents and children before the meeting, as well as holding discussions with social workers and their managers, e.g. around risk thresholds in cases

being considered for conference. Chairpersons are experienced child protection practitioners who do not have operational or line management responsibilities for the case (DCSF, 2010b). They possess a combination of knowledge, expertise and authority that should enable them to provide additional consultation and support when progress seems to have stalled. In formal terms, this might mean expanding the role of conference chairs to encompass interprofessional processes as well as the planning and review of outcomes, allowing them to contribute to meetings and discussions outside of the conferences themselves. Alternatively, local authorities might consider allocating an advisory role on particularly complex cases to consultant social workers, or placing such cases under the purview of the designated principal social worker (Munro, 2011).

Looking at cases in terms of complex systems reinforces the shift to collaborative professionalism that has taken place over the last two decades. For the 'systemic caseworker' (Ferguson, 2010), this means developing an appreciation of how one's own practice feeds into the activity of the network on a *case-by-case* basis. In the terms developed here, it is as much about the reflexivity of the network as that of the individual practitioner, with the aim of moving collaboration beyond routine communication and information sharing. In a gestalt sense, if networks are to become more than the sum of their parts, they need to have the capacity to evaluate and adapt their own collective endeavours. Otherwise they may encounter paralysis, delay and drift. It is therefore not enough for practitioners to use identikit assessment templates, or to learn generic 'competencies' for interprofessional working, unless these tools and skills are deployed in a working context that encourages innovative and adaptive solutions.

Such issues lend credence to the emphasis on relationships and the emotional dimensions of safeguarding work, which has been a subject of renewed interest in a variety of professions (e.g. Ruch, 2007, Colley, 2003). It is important to note that relationships are those between all the members of the network, as well as those between professionals and service users. If the case is viewed as the crucial site where individual practices combine with system complexity to produce outcomes, it follows that casework is not about isolated acts of judgement and intervention, shaped by thresholds, protocols and guidelines. Instead, practitioners participate in a web of interconnected activity, and must understand and adapt their actions in a systemic context. This creates new challenges for professional supervision and case management, which will often prioritise single-agency responsibilities and individual practice issues.

8.4 Areas for future research

The findings from this study suggest some avenues of further inquiry into the nature of complexity and its impact on interprofessional working. Here the focus was on the team around the child, a rather unstable product of the referral-based model of tiered services, whose membership was constantly evolving through the turnover of professionals and agencies. It would therefore be interesting to examine similar processes in a more stable kind of team, namely the kind of integrated, multidisciplinary units discussed in Chapter 4 in relation to assessment and intervention with vulnerable children. In particular, it would be worth focusing on how systemic casework was managed and carried out by such teams, being attentive to the difference that the case itself can make to the processes and outcomes of collaboration. The practice implications explored in the previous section could also be explored in a number of ways. For example, it would be interesting to consider the various contributions that conference chairs already make outside of the actual conferences, which might point to their potential to act as a catalyst for interprofessional working. Another potential research project might be a pilot study into the allocation of a consultant practitioner to advise core groups on process issues in cases where complex and dysfunctional dynamics appear to be stifling progress.

8.5 A final reflection...

To sum up in metaphorical terms, there appears to be (as ever) a divergence between the 'swampy lowlands' of frontline practice (Schön, 1991) and the linear causal thoroughfares of official discourse, in which integrated processes and their outcomes have come to substitute for the myriad interactions of people. It is perhaps not so much a matter of 'top-down' versus 'bottom-up' paths to implementation (Waldfoegel, 1997), but of an engagement at all levels with the inherent messiness and ambiguity of everyday practice. This study constitutes a small effort to redress this imbalance. After all, complexity means that the same intervention may have a positive effect in one case but not in another, or the situation may improve for a while and then get worse; professionals may collaborate very intensively and still not be able to save the situation, or do very little and see things improve nonetheless. Yet to advocate a case-based perspective, as this thesis does, is not to present a negative or relativist view of what organisations, professionals and indeed services are able to do. Rather the intention is to point to the intrinsically social nature of what

happens in cases, a reminder that outcomes are determined by a multitude of actions and interactions, and indeed that people, no less, are what one finds at the heart of every case.

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Appendices

Appendix 1: List of key search terms

#1

Complexity

Interprofessional working

#2

Integrated working

Joint working

Integration

Coordination

Collaboration

Partnership

Multiagency

Interagency

#3

Integrated services

Children's Services

Children's Trusts

Every Child Matters

Child Protection

Children and Families

Safeguarding

#4

Risk

Risk management

Uncertainty

Decision-making

Group dynamics

Terms in each group were entered individually and also in combination if there were too many results, e.g. #complexity & #child protection,

Appendix 2: Database searches

CSA Illumina web-based information system – search engine platform for searching many different databases at same time

Applied Social Sciences Index and Abstracts (ASSIA)- index of articles from over 600 international English language social science journals

Education Resources Information Centre (ERIC) – sponsored by the US department of Education to provide access to education literature and research, index to over 700 periodicals as well as government documents, books, reports and conferences

International Bibliography of the Social Sciences (IBSS) – online resource for social science and interdisciplinary research, indexing 2,800 journals and 7,000 new books included each year

CSA Social Services Abstracts – coverage of current research focused on social work, human services, and related areas including social welfare, social policy, and community development, abstracts and indexes over 1,300 publications including journal articles, dissertations and book reviews

CSA Sociological Abstracts – abstracts and indexes international literature in sociology and related disciplines in the social and behavioural sciences, provides abstracts from over 1,800 publications as well as books, book chapters, dissertations and conference papers

Child Data – abstracts of over 75,000 books, reports and journal articles, covering the literature on children and young people

SCOPUS – large interdisciplinary abstract and indexing database containing citations of journal articles, including 2,700 social sciences, psychology and economics titles

SCIE Social Care Online – bibliographic database covering all aspects of social care, including government documents, inspection reports and good practice guidance

Social Policy and Practice (via OvidSP) – bibliographic database covering social policy, social care, children, families, material mainly from the UK, oriented towards applied research

Social Science Citation Index (SSCI) (via ISI Web of Knowledge) – multidisciplinary index to the journal literature of the social sciences, indexing over 1,950 journals across 50 social sciences disciplines

Appendix 3: Manual searches

Journals:

British Journal of Social Work, Child Abuse and Neglect, Child & Family Social Work, Children and Youth Services Review, Children and Society, Journal of Integrated Care, Journal of Interprofessional Care, Journal of Children's Services

Government websites:

Department for Education (DfE), Department for Children, Schools and Families (DCFS), Every Child Matters (ECM), Home Office

Research websites:

Social Care Institute for Excellence (SCIE), Joseph Rountree Foundation (JRF), National Foundation for Education Research (NFER), Centre for Excellence and Outcomes in Children's and Young People's Services (C4EO), Children's Workforce Development Council (CWDC), Centre for the Advancement of Interprofessional Education (CAIPE), National Evaluation of Sure Start (NESS), National Evaluation of the Children's Fund (NECF), Research in Practice (RIP), Children's Workforce Development Council (CWDC)

Appendix 4: Evaluation of empirical studies of interprofessional working in children's services

Author	Interagency context	Method	Sample / Inclusion criteria	Focus of study	Main Findings	Limitations
(Anning et al., 2006)	Multi-professional teams: Health, social care, education, youth offending, CAMHS	Documentary data, observations of team meetings, semi-structured interviews, critical incident diaries, focus groups	Five multi-professional teams working with different service user groups in the same city	Explore how professionals share knowledge, resolve conflicts and generate new working practices	Key dilemmas common to multi-professional teams need to be addressed for services to work effectively	Focus on team processes, rather than inter-agency strategy and governance, or outcomes for users. Most teams had strong health focus
(Allnock et al., 2006)	260 Sure Start Local Programmes (SSLPs) from 2000 - 2005	Mixed methods evaluation study	All SSLPs included	Explore implementation of SSLPs focusing on partnership building	Partnership-building affected by five overarching themes	
(Asthana et al., 2002)	Health Action Zones: Health, social care, education, voluntary organisations	Literature review to develop evaluation framework, qualitative study of Health Action Zones (HAZs)	Three regional Local Strategic Partnerships operating HAZs – including statutory, voluntary and private sector agencies	Develop and implement a practical approach to establishing and strengthening local partnerships	Applicability of framework to HAZs Most HAZs able to develop a culture of interagency working	Focus on developing an evaluation model rather than on empirical research questions

(Atkinson et al., 2002)	Multi-agency activity in local education authorities (LEAs): Health, education, social services	Audit of multi-agency activity Interviews with staff from 30 initiatives. Case studies of six initiatives	Cross-section of different models of multi-agency activity. Perceived effectiveness and range of target groups also criteria for inclusion	Analyze different models of multi-agency activity, rationale for development, and the nature of organisational and individual involvement	Models of multi-agency working were identified, along with barriers and facilitators for effective working	Generalisation difficult due to variation in initiatives and practices with 'multi-agency' nomenclature
(Bachmann et al., 2009) (O'Brien et al., 2009)	Children's Trusts: Health, education, social services, youth services, CAMHS, voluntary and private sector organisations	Quantitative analysis of yearly trends based on service outputs Qualitative analysis of professional perceptions	35 Children's Trust 'pathfinders' from 1997 to 2004 (Children's Trusts introduced 2003)	Explore whether more integrated arrangements were associated with better outcomes for children	No consistent quantitative evidence, but some local examples of improved outcomes	Effect of other variables unclear, e.g. increased expenditure and other interventions e.g. Sure Start during same period
(Edwards et al., 2006)	Children's Fund (CF) national evaluation	Three strands: Quantitative data sets, case studies, themed services for selected target groups	Large scale databases used for impact study 16 case studies of partnerships 5 marginalised target groups	To evaluate impact of CF initiatives on social exclusion, and explore structures and processes of partnerships	Difference between 'stable' and 'developing' partnership boards. Some innovative and beneficial services developed	Evaluation length cut short, limiting exploration of impact. Conceptual tension between 'targeting' and 'inclusion'
(Ghate et al., 2008)	'On Track' national evaluation:	Mixed methods: quantitative data on risk factors	Eight research strands drawing on 23 On Track projects in high	Implementation and delivery of On Track: effectiveness evaluated	Positive results at the level of families, e.g.	Ambitious and complex research design. Variations

	Education, social services, youth offending, health, statutory and voluntary sectors	and outcomes combined with qualitative data on service user experience	crime/high deprivation areas of England and Wales	in terms of reducing risk and increasing protective factors	parenting factors. Little impact at level of individual child behaviour	in local implementation made it hard to assess programme fidelity
(Glisson and Hemmelgarn, 1998)	Children's service systems: Agencies involved with children entering state custody	Quasi-experimental mixed methods, comparing pilot areas with control areas	Services provided over 3 year period to 250 children by 32 public children's service offices in 24 counties in Tennessee, USA	Explore effects of organizational characteristics on the quality and outcomes of children's service systems	Quality of organisational climate more important for outcomes than inter-agency links	Limited time period for longitudinal study of outcomes Difficult to operationalise outcome measures
(Halsey et al., 2005)	Behaviour and Education Support Teams (BESTs): Education, social care, (mental) health	Two phase approach: audit and evaluation interviews with staff	Initial sample of 20 BESTs out of 87 nationally, then 12 teams chosen for evaluation based on representative criteria	Audit of BEST operational models Evaluation of impact and effectiveness	Contributions, e.g. streamlined referral systems, and difficulties	Not possible to interview every type of professional on each team, i.e. selective interview sample
(Hallett and Birchall, 1995)	Child protection networks: Education, social services, health, police	Case study design: case files, semi-structured interviews and questionnaire	Two local authority sites, 48 cases taken from child protection registers, sample of 90 staff for interviews and questionnaires	Qualitative study of experiences and perceptions of respondents in relation to interagency coordination	Shortage of resources, high degree of consensus and routinized coordination	Focus on 'intermediate outputs' rather than outcomes
(Harker et al.,	'Taking Care of	Longitudinal mixed	Data from 3 local	Develop and evaluate	Awareness raising,	50 % attrition in

2004) (Dobel-Ober et al., 2006)	Education' - Looked After Children (LAC)	methods evaluation study, two phases	authorities, two samples of young people tracked over 6 years, interviews with profs and carers	'whole local authority' approach to improving education outcomes for LAC	importance of lead officer role, teachers significant source of support for LAC	sample of young people over course of project
Lord et al. (2008)	Local authority children's services	Impact model used to evaluate support. Workshops and interviews with practitioners and service users	Three key service user groups in 14 local authorities: looked- after children (LAC); children with autistic spectrum disorder (ASD); and with high school non-attendance	Explore views on early impact of integrated service. To provide some early indication of outcomes from integration	Evidence of process of culture change in local authorities, and some evidence of improvements in support to individual children.	Lack of quantitative evidence on outcomes to back up qualitative data. Early stage of implementation in many LAs
(Lloyd et al., 2001)	Interagency work with secondary school children at risk of exclusion	Collaborative case study design. Interviews, document analysis and observation	30 case studies selected from 6 schools in 3 local authorities in Scotland	Explore issues of effectiveness and perceptions of success relating to interagency meetings	Some evidence of support and reduction in exclusion, but 'no single answer'	Focus on meetings rather than other forms of interagency work
(Milbourne, 2005) (Milbourne et al., 2003)	Interagency initiative with primary school children at risk of exclusion	Case study design: interviews, focus groups, direct observations	1 local authority area and 8 primary schools, 41 interviews and 46 observations	Benefits and problems from interagency perspective (2003) and children and families viewpoint (2005)	Some valuable support provided, but limited overall benefits due to range of difficulties	Limited scope of case study
(Ofsted, 2009)	Children's	Evaluation	20 children's centres in	Evaluation of impact of	Positive impact on	Small scale study

	Centres: Early years, education, health, social care	according to inspection criteria: interviews, observations, survey	England and Wales visited by inspectors from	integrated services on children and families and of partnership links	children and families, more difficulties with onward links to other agencies	
(Sammons et al., 2003)	New Community Schools (NCSs) in Scotland: Education, health, social care	Mixed methodology: Surveys of 37 pilot NCSs in Scotland Case studies of six projects	Surveys sent out to all pilot sites Cases study projects selected on basis of different organisational models, local contexts, size, scope of activities	To explore the extent to which NCS pilots were meeting the programme goals. To provide data as benchmark for future evaluations	Barriers and facilitators grouped under five headings. Professionals perceived an improvement	Short lifetime of pilot projects - evidence of improved pupil attainment would require a longer study
(Sylva et al., 2004)	Pre-School Education (EPPE project): Education and nursery care, health, family support	Longitudinal study using standardised child assessments Interviews with staff and carers Case studies of projects	6 English local authorities in 5 regions on basis of geography (rural, urban, suburban), range of ethnic diversity and social disadvantage	To explore impact of pre-school on development Are some models of pre-school more effective than others?	Pre-school experience enhances development Quality overall is higher in integrated settings	Study aims not specifically about integration, though findings compare integrated and non-integrated settings
(Tisdall et al., 2005)	New Community Schools (NCSs) and family centres (FCs) in Scotland	Case study design: interviews and discussion groups with staff, parents and children	4 sites (2 NCSs and 2 FCs) selected 24 staff and 26 families with children participated	Explore integrated children's services by focusing on impacts on children and families	Importance of continuity in services and relationships	Focus on integrated teams rather than networks for families with multiple difficulties

(Townsley et al., 2003)	Disabled children with complex health care needs: Health, education, social care	Exploratory phase on multi-agency working in UK. Visits to 26 sites and case studies of 6 services	Geographical spread across different UK countries Services had a range of approaches to multi-agency working	Explore experience of multi-agency working for disabled children, their families, and professionals who support them.	Better support for health needs and access to education but limited impact on families' quality of life	Most of interviews with professionals (73%) so that data largely about professional perceptions
(Webb and Vuillamy, 2004)	Home-school support workers in secondary schools: Education and social work	Qualitative evaluation methodology: interviews, questionnaires observations, document analysis	Project involved seven schools in four areas, selected on basis of indicators e.g. rate of exclusions, admission of pupils from socially deprived areas	To explore both processes and outcomes of the project, with an emphasis on the experience of those participating	Benefits: financial savings, support to pupils and reduced exclusions Links to external agencies more problematic	Difficulties in operationalising 'exclusion' Most of the data collected from school-based sources
(Wilkin et al., 2008)	Extended schools Education and social care	Four phases: Audit of local authority practice Telephone interviews Case-studies Literature review	All 150 Local Education Authorities (LEAs) in England contacted. Interviews with staff from 38 LEAs. In-depth case studies in 6 LEAs	Audit of coordinated and multi-agency activity between social care professionals and extended schools	Generally positive evaluation. Four main models of social care practice, and challenges and benefits identified.	Extended schools at early stages of integration. Further longitudinal studies needed to confirm findings

Appendix 5: Glossary of terms relating to integrated services

- **Joined-up:** deliberate and co-ordinated planning and working, takes account of different policies and varying agency practice and values. Can be thinking, practice or policy development.
- **Joint working:** professionals from more than one agency working directly together on a project.
- **Multiagency/cross-agency working:** more than one agency working together. Service provided by agencies acting in concert and drawing on pooled resources or pooled budgets.
- **Multiprofessional/multi-disciplinary working:** working together of staff of different professions, background and training.
- **Interagency working:** more than one agency working together in a planned and formal way.
- **Cross-boundary working:** agencies working together on areas that extend beyond the scope of any one agency.
- **Integration:** Agencies working together within a single, often new, organisational structure.
- **Networks:** Informal contact and communication between individuals or agencies.
- **Collaborative working/collaboration:** Agencies working together in a wide variety of different ways to pursue a common goal while also pursuing their own organisational goals.

- Cooperation: Informal relationships between organisations designed to ensure that organisations can pursue their own goals more effectively.
- Coordination: More formal mechanisms to ensure that organisations take account of each other's strategies and activities in their own planning.
- Partnership: two or more people or organisations working together towards a common aim

(Source: Percy-Smith, 2005, Robinson et al., 2008, Atkinson et al., 2007)

Appendix 6: Glossary of terms relating to critical discourse analysis

- Discourse (abstract) – language use conceived as social practice
- Discourse (singular or plural) – a way of signifying experience from a particular perspective
- Discursive event – instance of language use, analysed as text, discursive practice, social practice
- Text – the written or spoken language produced in a discursive event
- Discourse practice – the production, distribution and consumption of a text
- Interdiscursivity – the constitution of a text from diverse discourses and genres
- Genre – use of language associated with a particular social activity
- Order of discourse – totality of discursive practices of an institution and relations between them

(Source: Fairclough, 2010: 95-96)

Appendix 7: Research ethics approval

NHS
National Research Ethics Service

Central London REC 2
REC Office
Block A, South House
Royal Free Hospital
Pond Street, London
NW3 2QG
Telephone: 020 7784 0600 x34847

Mr Rick Hood
Doctoral student
Royal Holloway University of London
Egham Hill
Egham
TW20 0EX

28 February 2011

Dear Mr Hood

Study Title: Complexity and Interprofessional working in children's services
REC reference number: 11/H0713/6

Thank you for your letter of 21 February 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.r4forum.nhs.uk>.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for the National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.

for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Response to Request for Further Information		21 February 2011
Participant Information Sheet: Children and young people 11-15	1	18 February 2011
REC application		20 February 2011
Assent form (Children 6-10)	1	18 February 2011
Participant Information Sheet	2	18 February 2011
Participant Information Sheet: Research - children 6-10	1	18 February 2011
Participant Consent Form	2	18 February 2011
Participant Consent Form: Service user (Children and young people 11-15)	1	18 February 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review - guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study


The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/H0713/6 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



Dr Joe Brierty
Chair

Email: georgina.marshall@nhs.net

Enclosures: "After ethical review - guidance for researchers"
Copy to: Professor Ravinder Barn

Application no: 05/2011

**ROYAL HOLLOWAY
University of London**

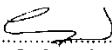
ETHICS COMMITTEE


Result of Application to the Committee

Name of Applicant: Rick Hood
Department: Health and Social Care
Title of Project: A study of complexity and interprofessional working in children's services

This is to notify you that your research project:

<input checked="" type="checkbox"/>	Has been approved by the Committee
<input type="checkbox"/>	Has been approved under Chair's Action, this decision to be reported to the Committee at its next meeting


.....
Professor Geoff Ward
Chair, Ethics Committee


.....
Date

Appendix 8: Participant information sheet



South West London and St. George's **NHS**
Mental Health NHS Trust



Participant information sheet

Research Project: Complexity and interprofessional working in children's services

You are invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to consider the following information carefully.

What is the research project about?

- Professionals in children's services often have to work together in order to meet the needs of children and families – particularly in 'complex cases', where multiple, interlinked problems overlap organisational boundaries.
- Complexity has been linked to the high degree of uncertainty and risk present in such cases, as well as the dynamics of the multiagency network itself
- Current policy and guidance often seems to overlook the perspective of practitioners and more research needs to take into account the realities of interprofessional working in complex and challenging situations.

What is the purpose of the study?

- The purpose of the study is to explore what complexity means for interprofessional working, as experienced by professionals working together in complex child protection cases.
- In order to capture some of the reality of frontline work, the research will examine collaboration in a small sample of ongoing cases, rather than review closed cases or explore general attitudes to interprofessional working.
- One of the aims is to examine how professional networks respond to some of the features of complex cases, e.g. critical incidents, escalating concerns and unpredictable change.
- The findings will hopefully contribute the perspective of frontline practitioners to knowledge about interprofessional practice

Who is conducting the research?

- Rick Hood, a registered social worker who is doing a PhD at Royal Holloway University of London, will be carrying out the research.
- Rick is supervised by Jan Fook, who is professor of professional practice research at Royal Holloway University of London, Ravinder Barn, professor of social policy and social work at Royal Holloway, and by Ray Jones, professor of social work at Kingston University.

Why am I being approached?

- The researcher is approaching all the members of professional networks in a sample of ongoing 'complex' child protection cases, which have been identified in consultation with the lead agency for child protection.
- Hopefully all the members of the professional network for each case will agree to participate, social worker, teacher, school nurse, health visitor, police officer, and so on. It might not be possible for everyone in the network to take part, but the study only makes sense if at least four or five different professions are represented, including social work, education and health.

What does participating involve?

- The researcher would like to conduct two interviews with each member of the professional network.
- Each interview would last 45-60 minutes and would ideally be recorded in order to produce a transcript for data analysis. Alternatively, the researcher could take notes during the interview.
- The two interviews would ideally be held about three or four months apart, in order to allow for developments in the case to feed into the data
- The researcher would also like to observe one multiagency meeting in each case

Do I have to take part?

- No. There is absolutely no obligation to take part in this study
- Participants are free to withdraw from the study at any time without giving a reason

What about confidentiality and anonymity?

- Research findings are intended primarily for inclusion in a PhD thesis but may also contribute to papers published in peer-reviewed academic journals
- All personal and place names will be anonymised, including in notes and transcripts
- All information gathered will be held in compliance with the Data Protection Act 1998
- As a qualitative study with a relatively small sample, complete anonymity is affected by the fact that people who are aware of the project will also have access to published material.

Has this study been approved?

- The study was discussed and endorsed by the local child safeguarding board on 8/12/10
- Ethical approval has been obtained from the NHS research ethics committee (28/02/11) and from the ethics committee at Royal Holloway University of London (07/06/11).
- Research governance approval will be obtained from the agencies whose staff are potential participants.

If I am interested, what do I do now?

- If you are interested in participating you can complete the expression of interest slip below or contact the researcher direct. I will then try and answer any questions you may have and you will be invited to complete a consent form.

Thank you for taking the time to consider this information sheet. If you would like to know more about the project or have any questions about it, please contact the researcher Rick Hood, rick.hood.2009@live.rhul.ac.uk, or complete the expression of interest slip below

Expression of Interest

I am interested in this project and am happy to be contacted by email or phone.

My email is:.....

My contact telephone no. is:.....

Print Name:.....

Appendix 9: Participant consent form



South West London and St. George's **NHS**
Mental Health NHS Trust



CONSENT FORM for participants

Title of project:

A study of complexity and interprofessional working in children's services

Name of Principal investigator: Rick Hood

Please initial box

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily
2. I consent to the anonymous information collected from interviews and observations of meetings being used, including the publication of direct quotations.
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
4. I agree for interviews to be recorded digitally, for the purpose of producing transcripts for data analysis.
5. I agree to take part in the above study

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

Appendix 10: Research information sheet (families)



Research information sheet (Families)

Research Project: Complexity and interprofessional working in children's services

Some of the professionals working with your family have been invited to take part in a research study. Although this study does not involve you directly, information concerning your child and family may form part of the research. It is therefore important for you to understand why the study is being done and what it will involve, so that you can decide whether to agree to it or not. Please take time to consider the following information carefully.

What is the research about?

The study looks at how professionals work together in 'complex cases', i.e. when children and their families need support in different areas, such as their health and education, which one agency cannot deal with on its own. The more complex the case, the more services tend to get involved, which is why research into joint working is important.

What is the aim of the study?

The aim of the study is to find out what is it like for professionals to work together on complex cases, e.g. doing assessments, communicating with other and making decisions. The focus is on what is going on for the *professionals*, rather than what is happening for the child or family.

Who is doing the research?

The research is being carried out by Rick Hood, a registered social worker who is also a student doing a PhD at Royal Holloway University of London. Rick will be the only person carrying out the research, although he has three academic supervisors: Professor Jan Fook and Professor Ravinder Barn at Royal Holloway University of London, and by Professor Ray Jones at Kingston University.

How does the project affect me?

Members of the professional network who are working with your family have said they are interested in participating in the project. This does not affect you directly because only professionals are being asked to participate. However, the researcher will carry out some

Final v1

RIS (families)

18/12/10

interviews with professionals, in which they will talk about working together on this particular case. This therefore does concern you, because information about your child and family might be mentioned. The researcher may also want to come and observe a multi-agency meeting at which you might be present.

This research has nothing at all to do with any assessments or services or other work being done with your family.

What will the researcher do with this information?

Any information collected during the study is confidential and will be made anonymous. This means that all names and locations, as well as sensitive personal information, will be changed to prevent people from being identifiable. This includes notes and write-ups. All information will be held securely in accordance with the Data Protection Act 1998.

The research will mainly form part of a PhD thesis, which is not published. Some of the material may contribute to published papers in academic journals. It should not be possible to identify any members of your family from information contained in published material.

What am I being asked to do?

You are being asked whether you agree to this research project involving the professionals who are working with your family. This is what the attached consent form is about. However, you do not have to consent to anything. Either way, it will not affect any assessment or service or other work being done with your family.

Thank you for taking the time to consider this information sheet. If you would like to know more about the project or have any questions about it, please speak in the first instance to your keyworker and they will arrange for me to provide you with more information.

Rick Hood
Doctoral Student
Royal Holloway University of London

Final v1

RIS (families)

18/12/10

Appendix 11: Consent form (families)



South West London and St. George's **NHS**
Mental Health NHS Trust



CONSENT FORM for families

Title of project:

A study of complexity and interprofessional working in children's services

Name of Principal investigator: Rick Hood

Please initial box

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I consent to the anonymous information collected from interviews with practitioners and observations of meetings being used, including the publication of direct quotations.
3. I understand that my consent to this study is voluntary and that I am free to withdraw it at any time, without giving any reason, without my care or legal rights being affected.
4. I agree that participants who have consented to take part in the above study may speak to the researcher about their work with my family

Name of Person giving consent

Date

Signature

Name of Person taking consent

Date

Signature

Appendix 12: Research information sheet (children and young people)



Research information sheet for children and young people

Research Project: Complexity and interprofessional working (how professionals work together in complex cases)

Some of the professionals working with you and your family have been asked to take part in a research study. Although this study does not need you to do anything, information about you may form part of the research.

We would therefore like you to understand why the research is being done and what it will involve, so that you can tell us what you think about it. Please take time to read this information carefully and talk about it with your parents or carers, or with your keyworker.

What is research?

Research is a way of finding out about the world. Scientists carry out research to try and explain how things work. Researchers can also study people in order to understand them better. This is called social research.

What is this research about?

This research is about professionals who work with children, young people and families. That means people like nurses, teachers, doctors and social workers. In what are called 'complex cases', several of these professionals work together in order to provide different kinds of services to one family or person at the same time. The research is trying to understand more about how professionals work together in this way. What we find out might give us ideas about how professionals can work together better in the future. And this will hopefully help the children and families who receive those services.

Who is doing the research?

The research is being carried out by Rick Hood, a social worker who is doing doctoral research at Royal Holloway University of London. Rick will be the only person doing the research.

Final v1 Information sheet CYP 18/02/11

Did anyone else check the study is OK to do?

Before any research is allowed to happen, it has to be checked by a group of people called a Research Ethics Committee. They make sure that the research is fair. This study has been checked by the Central London Research Ethics Committee. Rick also has supervisors at the university who will check his work and make sure he is doing it properly.

What does it have to do with me?

The research doesn't affect you directly. Some of the professionals who are working with you are interested in taking part. This means that the researcher will meet with *them* twice and ask *them* questions. The questions are about *their* work and are not about you. However, because they work with you, this means that they might mention information about you.

What happens to this information?

Any information collected during the research is made *anonymous*. This basically means that your name, places, names and personal details are changed so that no-one can tell who has been involved in the study. That includes the professionals taking part and it also means you and any members of your family. The results of the research are written up in a long report called a thesis and may also be shared with other researchers at a conference or in an academic journal.

What am I being asked to do?

You are being asked whether you agree to Rick interviewing the professionals who are working with you and your family. Also whether he can attend one meeting in which the professionals are present. This is what the *consent form* is about. Consent basically means 'agreement'. Your parents/carers have been told about the study and they have been asked for consent as well.

Do I have to give consent?

No. You don't have to agree to anything, even if your parents/carers have given consent. You can also withdraw your consent later, or at any point, without giving a reason. *Your decision will not affect any support or services received by you or your family.*

Who else will know about this?

Apart from the researcher and his supervisors at university, the only people who will know about this study will be your parents/carers and the professionals who take part.

Final v1 Information sheet CYP 18/02/11

Thank you for taking the time to read this information sheet. If you want to know more about the project or have any questions about it, please speak in the first instance to your keyworker and they will arrange for me to meet with you or provide you with more information.

Rick Hood
Doctoral student
Royal Holloway University

Appendix 13 Consent form (children and young people)



South West London and St. George's **NHS**
Mental Health NHS Trust



CONSENT FORM for children and young people

Title of project:

Complexity and interprofessional working in children's services

Name of researcher: Rick Hood

Please initial box

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I consent to the anonymous information collected from interviews with practitioners and observations of meetings being used, including the publication of direct quotations.
3. I understand that my consent to this study is voluntary and that I am free to withdraw it at any time, without giving any reason, without my care or legal rights being affected.
4. I agree that professionals who have consented to take part in the above study may speak to the researcher about their work with my family

Name of Person giving consent

Date

Signature

Name of Person taking consent

Date

Signature

Appendix 14: Interview schedule

Complexity (general)

1. What would you say is complex about this case?
2. How have other professionals informed your assessment?
3. What effect have interventions had?
4. What has been predictable/surprising about this case?
5. What has been the reaction of the family to professional involvement?
6. How are decisions being made?
7. How are risks and concerns managed?
8. How do professionals communicate in this case?
9. What are the key professional relationships for you in this case?
10. Who would you say is ultimately accountable for what happens?

Complexity (critical incidents)

1. Could you describe an incident that for you particularly demonstrates the complexity of this case?
2. Was this event predictable/surprising?
3. What actions were taken as a result?
4. What was the role of other professionals?
5. How were risks/uncertainty managed?
6. Who had/took responsibility for deciding what to do?
7. How did this incident affect what it was like to work on this case?
8. What (if any) was the impact on communication and relationships between professionals in the network?