EXPLORATORY STUDY OF SOCIAL WORKERS' PERCEPTIONS OF COLLABORATION IN A LOCAL AUTHORITY

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A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements for the degree of MSc by Research

Copyright Statement

Abstract

This small scale study examines the perspectives of social workers from adult mental health services and childrens social care on collaboration. Eight semi-structured interviews were conducted to explore social workers' experiences of working with families and professionals both inside and outside their own agencies and their thoughts on the barriers to collaboration, as well as their ideas on how collaboration could be improved. Thematic analysis was used to create a coding process and generate patterns across the data, with perspectives on collaboration being found to be influenced by organisational climate and culture, professional identity and the narratives within each service. A common theme identified by all subjects was that they had a very limited understanding of each other's service, in terms of skills, roles and procedures and any improvements to their knowledge base in this regard would be welcome. The research found important differences in the perspectives of social workers from each service. Significantly, mental health social workers identified collaboration primarily as a process of co-production with their service users. Children's social workers, however, saw the primary purpose of collaboration as being to seek out information from other professionals for their assessment work in order for decisions to be made. These perspectives, in turn, fuelled how they viewed each other's service and promoted narratives that served to divide services rather than encourage collaborative work.

Recommendations include changing narratives and developing relationships across service boundaries for both services. There is also a team in place which has been set up to develop collaborative work by bridging the gap between adult mental health and children's social care services, and the conclusions and recommendations in this study will be used to influence the direction of their work.

Contents

Research context

For the past eight years I have led a pilot project in 'Robinscar', with a remit of finding out whether professionals working in adult mental health services with people who are parents, recognised any risks they presented to their children and referred accordingly to children's social care. Our assessment of the work has found that risk of significant harm is identified and appropriate referrals are made to children's social care by mental health workers. However, as a result of working alongside both organisations, I observed and experienced problematic interactions between professionals and between the services which resulted in poor communication, limited joined up working and restricted sharing of information. This seemed to be compromising assessments and plans created in respect of children who needed support from the Local Authority.

Over time, my role has evolved to meet the needs of the service with a focus upon improving the working relationship between adult mental health services and children's social care and the project has evolved also with the creation of a permanent team – known as the Mental Health in Families team. Upon familiarising myself with the work of Carolyn Oliver, I have increasingly become confident in identifying myself as a 'boundary spanner' - "...those who demonstrate[d] particular competence in greasing the wheels of inter-organizational collaboration by facilitating dialogue and negotiating shared goals and meanings amongst diverse groups" (Oliver, 2013, p6). This has meant that I have been able to observe and identify barriers to working together between these two services and address them in order to improve these working relationships on a case-by-case basis.

The need for improved collaboration between adult mental health services and children's social care is supported by the findings of the Ofsted and the Care Quality Commission thematic inspection in 2013 in relation to how well adult services for drug and alcohol users and adult services for mental health considered the impact upon children when working with their service users (Ofsted 2013). The inspection was carried out across nine areas of England and called 'What about the Children?' The findings of the inspection were of a service delivery model that had little evidence of joined up working – or even acknowledgement of understanding the person they were working with in the context of

their family. Overall, professionals from drug and alcohol services were more likely to consider the impact of parental behaviours upon children than those in adult mental health services. This was reflected in the quality of joined up work, with professionals not treating the assessment as a shared activity, and failing to share expertise with this reflected in the overall analysis and, therefore, the delivery of services to the family. The consequences included early and preventive support not being considered and, at the other end of the spectrum, children being returned to parents too early following crisis episodes and parents then being unable to meet their needs (Ofsted 2013). The findings of the thematic inspection mirrored many of my experiences within 'Robinscar'.

In a local context, the opportunity to conduct the research, which is the subject of this dissertation, was presented at a time when it was becoming increasingly clear that children's social work practice needed to change in 'Robinscar'. The full extent of this need for change was recognised in an Ofsted inspection of the authority[1], where it was found that 'Robinscar' was 'inadequate' in terms of its responsibility to ensure children received help and protection when it was required. One of the key factors highlighted was the poor quality of multi-agency working, which mirrored my own experiences in the project. It was also stated that risk was not recognised in assessment and planning for children which reflected my own findings about children's social workers' over-estimation or under-estimation of risk within their assessments and plans. This was due often to the failure to adequately explore with other professionals the parental issues and their impact upon children.

There appear to be persistent barriers to what we know is the most ideal way of working in the best interests of our families. There is a need for future research to explore collaboration to identify the causes for poor communication between agencies, and the factors that influence how they collaborate in order to identify mutually beneficial solutions (O'Reilly et al, 2017) and research to identify methods that openly support joined up working (Jeffry's et al, 2011). My intention in this research piece then, is to explore these

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[1] To preserve anonymity details are not provided

barriers on a local basis, analyse them in the context of what is already known, and attempt to find ways of overcoming them that address their root causes.

Current context of 'Robinscar'

Since the Ofsted inspection in the authority[2], children's social care has been on an improvement journey. There has been a recognition that the overall approach and ethos has needed to change, and there has been an adoption of the principles of restorative practice across the service as a whole. This is highly relevant for this study, given that restorative practice principles reflect the relationship based requirements for successful collaborative practice (Restorative Foundation, 2019).

Whilst the approach is increasingly being adopted in children's services across the UK, the lack of current research means little is known of its effect upon work with families (Williams 2019). To address this knowledge gap, Williams explored the use of a restorative approach in family service provision and found that using the approach engendered a whole family approach, relationship and strength based practice and most families fed back that the service was a positive help, suggesting families are more likely to engage (Williams 2019). In 'Robinscar', I have observed restorative principles becoming increasingly evident in the improved communication and support between levels of management and front line workers, increasing overall wellbeing within social work teams. There is a demand for this approach to influence casework with families and improve the quality of interagency work. The outcomes of this study, therefore, will contribute to understanding these relationships and lead to recommendations, advice and support for how to improve them. The openness therefore of the local authority at this current time makes this study even more relevant to improving practice. This research is in the context of front line practice, against a backdrop of change in children's social care.

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[2] To preserve anonymity details are not provided

Research aim

To explore perceptions of how social workers from adult mental health services and children's social care in 'Robinscar' currently collaborate with families and professionals and consider whether and how this can be improved.

Research questions

- What do social workers in 'Robinscar' understand by collaborative practice?
- What do they perceive to be the barriers to collaborative practice?
- How can these barriers be overcome in order to improve practice?

Literature Review

In my review of existing literature, I explored the development of contemporary understanding of collaboration. I started from a consideration of the political and practice background relative to social work, and explored how changes in these areas impacted upon the need to adapt collaborative approaches. I have considered efforts to clarify what is meant by collaboration in general, before turning my attention specifically to explore research into the way professionals from adult mental health services and children's social care collaborate. I have considered studies of practitioner experiences, with a focus upon the barriers to collaboration that they identified as well as any enabling features that have been identified in current practice. This has allowed me to locate my own study in the context of what is already known.

Changing context of practice – generic social work to specialist practice

Social work has changed considerably over the last half century, influenced by significant waves of change in Government, the economy and tragic events involving children (Community Care, 2005). The changes in the profession have had a significant impact upon how social workers collaborate with both families and professionals in their practice.

In 1968, the Seebohm Report inspired the creation of a generic social work model, doing away with specialist children's and adults departments in a bid to unify previously fragmented services in a co-ordinated, preventive, partnership approach (Dickens, 2011). The model required social workers to carry out their work in a family-focussed way and was generously funded to support families based on needs rather than a prescribed set of symptoms (Bamford, 2015), allowing social workers to build supportive relationships with families. Social workers were inspired and idealistic, believing in their roles (Community Care, 2005).

Unfortunately this was short lived. A range of factors contributed to this, including economic crisis and the tragic death of Maria Colwell (Bamford, 2015). Social workers themselves found the demand to know something about everything was too great, the needs of individuals being too diverse for social workers to hope to know enough about all

of them. The thirst for a return to specialist practice was inevitable from the workers themselves and a series of compounding and coinciding circumstances led to the demise of generic departments (Community Care, 2005). Economic decline and inefficient service provision fuelled Thatcher's argument for the privatisation of care services, reducing state responsibility. The Griffiths Report of 1988 introduced the concept of 'Care in the Community' and paved the way for the purchaser-provider market which inspired the privatisation of care homes and nursing homes (Bamford, 2015). The introduction of the Children Act of 1989 and NHS and Community Care Act of 1990 provided new legal frameworks for the return to specialist practice, followed by the actual split into Children's and Adults services in the early 1990's. The Children Act of 2004 consolidated this by requiring Local Authorities to appoint directors for Children's Services. Alongside the commitment to the specialist focus, there was an increasing demand for social workers to work together with other professions to assess the needs of individuals and plan jointly, an activity reliant on collaboration across service boundaries (Weinstein et al, 2003).

Alongside these governmental changes, a series of child deaths and subsequent enquiries gave fuel to the public demand for change in social work. The reputation of the profession was quickly deteriorating, with a loss of faith and increase in demand for accountability. Whole family work was blamed for reducing the focus upon the child and allowing children to be overlooked, whilst the needs of adults were now being increasingly acknowledged, allowing specialist services that had not received attention in their own right previously to receive attention (Weir and Douglas 1999). The re-introduction of specialist practice came alongside guidance under the New Labour government, and encouragement for services to take a joined up approach to service delivery, with partnership being a pervasive feature (Glendinning et al, 2002).

The demand to collaborate was placed firmly upon the agenda. In recognition of this, the expectation for collaboration between services has become embedded within guidance and recommendations issued by regulatory bodies for professions working with vulnerable people. The National Institute for Health and Care Excellence (NICE) issue guidelines for practice which advocates collaborative practice as the most effective approach for reducing health inequalities.

The Care Quality Commission (CQC) is responsible for monitoring, inspection and regulation of health and social care in England. One of their key lines of enquiry looks at how well services work together to achieve effective care and treatment for service users.

The Social Care Institute for Excellence (SCIE) produced "Think child, think parent, think family", making recommendations and suggestions to support joined-up working for the care pathway for any adult or child, considering existing challenges to this (Diggins, 2015). Further to this, SCIE produced its own e-learning education and guidance for services for effective collaboration in practice in 2009 – Inter-professional and inter-agency collaboration (IPIAC) (SCIE, 2009).

In January 2011, the Royal College of Psychiatrists released a report which determined the need for practitioners from all professional backgrounds working in mental health services to consider the adults that they were working with in terms of their parenting role and identity as a parent as well as a service user. Recommendations from the report included considering contact with children when parents are admitted and discharged from inpatient settings, factors to consider in terms of risk and focussing on the parenting role as part of assessment and planning with service users (RCPsych, 2011). In order for this to be of optimum benefit for children and families, collaborating with other professionals and working together with the family is essential.

As the current regulatory body for social work since 2012, the Health and Care Professionals Council (HCPC) outlines standards and details a code of ethics. Collaborative practice and the need to be able to work appropriately with others are identified clearly within the standards of proficiency for social workers (HCPC).

The Care Act and Children and Families Act, both in 2014, provide a framework for the consideration of young carers in the context of their families (Diggins 2015), however in 2015 the DoH, the Local Government Association, the Association of Directors and Adult services, the Children's society and the Carers Trust jointly produced explicit guidance to local authorities to adopt an approach involving the whole system, the whole council and the whole family approach in co-ordinating preventive services (Diggins 2015).

Despite these expectations and associated guidance however, in 2016 SCIE and the NSPCC formed the Learning into Practice Project (LiPP) which carried out an analysis of 38 serious case reviews published between May 2014 and April 2015 with a focus upon recognised practice issues with inter-professional communication and decision making. The analysis found examples where potentially useful information held by adult services was not shared with, or sought by, children's social care services (LiPP, 2016). There were clearly challenges in collaborating in practice which pervaded the demands placed by governing bodies and legislation. As Stanley et al had pointed out over a decade before, a gap remains between providing guidance and tools to professionals which are designed to promote interagency co-ordination and professionals actually achieving co-ordinated working in practice (Stanley et al, 2003).

Increasing recognition of barriers to collaboration: Research

Cleaver et al carried out a review of the impact of parental issues on parenting capacity in 1999, which influenced the development of the 'Framework for the assessment of children in need and their families' (DoH et al, 2000 in Stanley et al, 2003). The framework was designed to consider the child in the context of their family and community environments, with the ideal way of achieving this being to work with other professionals. However, there is a wide spectrum of approaches to how health and social care services 'work with' other services. Whilst there is consensus that we need to organise ways of working with each other in order to support families most effectively, the structure and organisation of individual services impacts upon the way that professionals interact with others and the variation from one area to another is huge, with influencing factors at individual, cultural and organisational levels. Consequently, there is inconsistency in the level and style of collaboration, with differences in what each service expects, demands and is used to given their individual service priorities (Coates, 2015).

As far back as 1994, Leathard had identified that there was an increasing appetite for combining professional skill sets in recognition of the split from generic social work practice into areas of specialism, with a view to reducing duplication of work and providing a more effective service for the benefit of service users and professionals. There was already a recognition that there were challenges to this however, which could potentially hinder

increased collaboration, including a fear of deskilling and loss of professional status and service cuts. Leathard's work identified the need for a theoretical framework in education and practice which enabled and facilitated collaborative work between specialisms (Leathard 1994). Leathard also highlighted the need for a common understanding of the terms used to describe joined up working. She found a great number of varying terms used to describe this approach, with little clarity on the different meaning applied to them (Leathard 1994). An increasing awareness of different levels of joined up working is evident in literature, with attempts to quantify these across a scale.

In 1998 Hudson suggested four levels of joint working, spanning from communication – where interactions are confined to the exchange of information; co-ordination – where professionals remain separated but develop formal ways of working across boundaries; co-location, where different professionals are co-located alongside each other, and at the deepest level of collaborative commitment, people from different professional backgrounds are commissioned to jointly with a shared approach to an activity (Cree, 2011).

Weinstein et al (2003) suggested that the terms 'collaboration' and 'partnership' were being used based upon the assumption of a common meaning. The relevance of this is significant in that Government policies use the term 'partnership' to determine that services should work together (Glendinning et al, 2002). Services may, therefore, assume that working in partnership means that they are collaborating. The term 'collaboration' however determines the active form of working together and how this is applied in practice. Weinstein et al suggested the following usages:

> *"Partnership is a state of relationship, at organisational, group, professional or interpersonal level, to be achieved, maintained and reviewed. Collaboration is an active process of partnership in action"* (Weinstein et al, 2003, p16)

Fitzgerald and Kay (2008) suggested there is a spectrum to reflect the level of integration and organisation involved in the working relationship between services. The spectrum ranges from multi agency working – which they described as a low level of integration, lacking an organised way of working together, through to interdisciplinary working which they defined has an extremely organised way of working together involving a shared identity and objectives fully involving service users.

The National Evaluation of the Children's Fund (2004) differentiated between the following: co-operation, co-ordination and collaboration, with integrated services being the optimal condition for effective service delivery. Within their definition, collaboration is "Working together on joint projects, recognising a common aim and the different contributions that can be made towards achieving it" (Edwards et al 2009).

More recently, a Canadian venture funded by Health Canada's Inter-Professional Education for Collaborative patient-centred care gave rise to an inter-professional collaboration (IPC) training curriculum, designed to develop practice through education for health and social care professionals. They developed the Continuum of Inter-Professional Collaborative Practice in Health and Social Care. They recognised that in developing a framework there must be an agreed understanding of what collaboration is. However, they also clearly acknowledge the ongoing confusion in this area. They recognised the earlier work of Leathard and acknowledged the increasing range of terms evolving over the years (Careau et al 2018).

The Continuum of Inter-Professional Collaborative Practice in Health and Social Care separates four components – 1) The complexity of the situation being worked with; 2) The intention underlying the collaboration; 3) the interaction between individuals and 4) disciplinary knowledge. The idea is that practitioners must be able to operate at all levels on the continuum based on the complexity of the person's situation that they are working with. The more complex a person's circumstances, the more intentional efforts should be made towards agreed objectives, decisions and actions. With increasing complexity, the interaction between individuals should be greater with more concerted efforts towards in depth interactions and communication. For the fourth component, the more complex a situation the more professionals need to have an in depth understanding of the services they are working alongside (Careau et al, 2018).

Given that the services I bridge are working at the most complex ends of the child protection and mental health spectrum, the Continuum would suggest that professionals need to be working intentionally towards a common objective, with agreed goals based on a good knowledge of each other's services and support mechanisms, shared responsibility for

decision making and planning with an overarching authentic and meaningful involvement of the service user and their family.

Literature specifically relevant to collaboration between mental health services and children's social care

In the mental health arena, the need for close collaboration between professionals from different specialist backgrounds stemmed from the closure of secure institutions over the 1950's and 60's (Burns, 2004). Community mental health teams necessitated the inclusion of both health professionals and those from social care, leading to the evolution of multi-disciplinary teams. The social workers included in these teams were from an adult background, however, and it was through increasing understanding of families living with parental mental health that awareness was raised with regard to the impact upon children.

During the 1990s, psychiatrist Dr Adrian Falkov carried out a study of children killed by their parents, discovering that one in three involved a parent with a mental health problem (Weir and Douglas, 1999). He asserted that the failure of adult psychiatric services and child protection agencies to understand each other and collaborate adequately was one of the main contributors of risk to children whose parents have a mental health problem (Weir and Douglas 1999). In 1998, Falkov designed the Family Model to provide practitioners with an integrated approach to providing support to mentally unwell parents and their children. A training package, Crossing Bridges, was made available for local authorities to commission and implement within their own services if they felt this was required (Falkov 1998).

Contemporaneously, Reder and Duncan wrote a guide for mental health professionals to help them consider their contributions to assessments of parenting, in which they recognised the intergenerational impact of mental health – that is, children growing up with a parenting suffering with a mental health difficulty needed to be protected against the effects or else they were very likely to go on to develop their own mental health problems (Reder and Lucey 1995) Further to this, Reder et al wrote a book which acknowledged the interactions between children and parents, recognised the ways that issues overlap and the implications for service delivery in a world where services were operating separately. Importantly, the book recognised that the specialised skill sets of clinicians working for

separate child and adult mental health services were precluding an integrated approach, missing opportunities for secondary and tertiary prevention of children at risk of developing mental health difficulties (Reder et al, 2000).

In 1999, Hetherington et al carried out a cross-country study comparing how different countries address the welfare of children where there is a mentally unwell parent, and specifically how services work together to support families. One feature common to all countries which stood out was that practitioners working for children's services did not recognise adult mental health problems, and adult focussed professionals did not recognise or think about children. They asserted that all professionals need to develop their understanding in these areas as well as all involved "talk to each other, share their understanding and plan, taking into account the concerns of their colleagues" (Hetherington et al, 1999, p208). They recommended that practitioners working with these families require particular skills, including skills in consultation, in order to ensure services do not act independently of each other (Hetherington et al 1999).

There is an acknowledgement within the literature, then, that services struggle to work together effectively, at least in part because of the specialist nature of each service. Despite efforts to prevent silo practice developing, services have developed their own frameworks and priorities and these do not lend themselves well to collaborative work – indeed they have contributed to the barriers that exist between services.

Gopfert and colleagues (Reupert et al, 2015) stress that the intervention paradigm needs to shift from a focus upon individuals to a focus upon families, and that collaboration is critical to overcoming the current fragmentation between services. In a guest editorial to the Australian e-journal for the advancement of mental health, Gopfert wrote 'A message from Britain: Inquiries into child deaths – will it ever change?', where he highlighted that being family focussed would improve our collaborative relationships, and that serious consideration should be given to joint work for the purposes of risk assessment (Gopfert, 2009).

The concept of family focussed work is not new. However, there is increased recognition that we need to consciously maintain awareness of it in the specialism focussed, person centred structure of service delivery. There is progressive acknowledgement that collaboration ensures a family focus whilst also maintaining relationships with service users and making the most of specialist skill sets. In 2015, Falkov advised that practitioners with specialist skill sets need to learn to use their knowledge and understanding to enhance that of others in order to better understand and support families. The collaborative element here recognises the need for fully engaging with and understanding people in the context of their family and engaging with them on this basis.

Equally important is engaging with other professionals with a focus on creating a shared understanding of the root causes of a family's difficulties and a shared commitment to supporting in a way that benefits the whole family. It needs to be appreciated that understanding, and providing support to individuals in the context of their social systems, ultimately achieves optimal care (Hornby and Atkins, 2000); a family-focussed approach harnesses and builds on strengths and increases family resilience (Foster et al, 2011). In order for this to be successfully achieved, collaboration with everyone involved is critical.

In an effort to seek out why collaboration is still not evident in practice between adult mental health and children's social care services, a series of studies have taken place to date in the UK and Australia which involve consultation with professionals from mental health services and children's services with findings that identify barriers to collaboration and suggest facilitating factors. I shall provide an overview of the studies I have considered and identify common themes that have emerged.

In 2003, Stanley et al conducted a survey of professionals to identify their thoughts on the barriers to inter-professional collaboration (Stanley et al, 2003). They had already carried out a pilot study in 1999 where they conducted detailed audits of the files of mothers with mental health difficulties to determine their experiences of being in the system and how professionals worked together (Stanley and Penhale, 1999). Barbour et al held inter-professional focus groups with a focus on perspectives on assessing risk where parents had a mental health problem (Barbour et al, 2002). Darlington, Feeney and Rixon carried out

interviews with professionals to explore factors that challenged and factors that assisted collaborative work (Darlington et al, 2005a). They carried out a further study where they surveyed professionals with regard to the facilitating and hindering factors in the collaborative process, as well as exploring worker's attitudes to and experiences of collaboration (Darlington et al, 2005b). Darlington and Feeney surveyed professionals in 2008 and carried out a qualitative analysis of best practice, identifying suggestions for improving interagency relations (Darlington and Feeney, 2008). Alakus et al conducted a series of focus groups and workshops for clinicians and service users which considered the needs of parents with a mental illness with children under five (Alakus et al, 2007). Webber et al surveyed practitioners regarding the impact of joint protocols upon practice (Webber et al, 2011). Rouf et al interviewed mental health workers in 2012 with regard to their decision making regarding parental mental health and when to involve children's services (Rouf et al, 2012). In 2014 Reupert and Maybery held interviews and focus groups with professionals exploring the issues faced when using a family focus, also considering effective strategies to successful collaboration (Reupert and Maybery, 2014). In 2015 Coates held interviews with professionals already involved in collaborative partnerships to explore barriers and facilitators (Coates, 2015). Alongside these specific research pieces, I shall highlight key findings regarding collaboration from a Research in Practice research review. The review, carried out by Tunnard in 2004, considered 35 studies concerning the impact of parental mental health upon children.

Further to these research studies, Davidson et al (2012) carried out an evaluation of an initiative in Northern Ireland aimed at facilitating joint working between adult mental health and children's social care. The initiative involved identifying an interface champion from each team in each service to provide information, promote joint working and identify obstacles to co-operation (Davidson et al, 2012). In Sweden, collaborative projects were initiated between 2004 and 2009, with a focus upon benefitting service users whilst also reducing waiting times and costs. Basic evaluated one of these services which had used a co-ordinator, analysing how and when workers in Sweden collaborate and 'what works' in this process (Basic, 2018). I shall consider the findings of these evaluations alongside the themes from the research projects I have identified in a later section.

A concept for considering the essential ingredients for collaboration: Communities of Practice

In 2005, Frost carried out a review of how professionals in front line child and family services work together and what factors influence how this is done. The review provided a useful overview of the issues and dilemmas faced by professionals and, in identifying barriers, aimed also to provide some suggestions for facilitating increased collaborative practice. Frost used the concept of 'Communities of Practice' developed by Wenger. A community of practice can be created across different teams, in spite of the polarised nature of the specialist services we currently have.

Communities of practice are created by learning through practice, based on a "sustained pursuit of shared enterprise" (Frost, 2005, p21) and involve three key elements of mutual engagement, joint enterprise and a shared repertoire. This concept is particularly useful for this study because it offers a way of framing 'how' the two services that I work between can embed a collaborative approach in working practice. With this concept in mind I have considered the findings from the studies I highlighted and shall now identify how the findings themselves reflect these essential ingredients for collaboration. I have also considered the findings from a methodological overview of 28 research projects carried out by Maybery and Reupert (2009).

Mutual engagement

In order for people to work well together across organisational boundaries, relationships are critical. Positive relationships display features of friendliness, helping, negotiating, compromising (Darlington and Feeney 2008), listening and actively being there (Stanley et al, 2003). Relational skills involve open and honest communication and team working (Thomas et al, 2014), with trust, openness and respect (Darlington and Feeney 2008) being fundamental. Relationships are strengthened and enhanced through frequent interaction and familiarity (Basic, 2018) and these dynamics continue to be reinforced through ongoing communication (Reupert and Maybery 2014). Construction and reconstruction of collaborative identities is an ongoing process (Basic, 2018). Whilst relationships are dynamic and reproductive in nature, these are based on an investment by the individual (Basic,

2018). It is widely accepted that a non-judgemental approach is most conducive to a healthy relationship (Stanley et al, 2003).

Joint enterprise

For collaborative relationships across service boundaries to work most effectively, there needs to be a shared vision (Basic, 2018) with agreement on what needs to be achieved and who will do what. In order for this to happen however, there needs to be embedding of an approach based on the interests of the family as a whole within the foundation of each organisation (Maybery and Reupert 2009); (Tunnard, 2004). An enhanced knowledge of professional roles, performance and boundaries of those we are working alongside is critical to collaboration, as is a knowledge of policy developments and wider service issues that impact upon the way they operate (Thomas et al, 2014). Information sharing is key, both in regard to individual casework, processes and procedures but also in advising how to engage with someone who has a mental illness. Communication needs to be ongoing and be clear, regular and timely (Darlington et al, 2005b) whether this is in a spoken or written format.

Shared repertoire

Collaboration works best when individuals are invested in and motivated towards working together as an absolute priority. In terms of attitudes, there must be willing participation, trust and mutual respect and personal and professional confidence (Thomas et al, 2014). Feeling a sense of belongingness and alliance enhances collaborative relationships, which creates a shared identity (Basic, 2018).

Barriers found to collaboration in existing research

As I have already identified, research has found there are significant barriers between services which need to be addressed and overcome to improve the way that people work with each other. Whilst many of the features identified for successful collaboration appear to be dependent on the approach of individual practitioners, individuals themselves are influenced by the organisations and environments that they work within (Gautier, 2015).

Barriers to mutual engagement

Issues of power have a significant impact upon the formation and perception of relationships. It is widely accepted and acknowledged that the power associated with professional knowledge and legal frameworks puts social workers in an automatic position of perceived authority (Lonne et al, 2016) and, therefore, some consideration needs to be afforded to the mitigation of this when developing relationships with families. In collaboration with other professionals, recognition should be given to the fact that in certain situations, some professionals hold dominant positions, leaving others feeling intimidated or unable to influence decision-making (O'Sullivan, 2011).

There is an identified theme amongst professionals of families 'splitting' professionals who are working with them (Reupert and Maybery, 2014). Workers find themselves in disagreement because service users have projected a different overview of their needs to different professionals. One of the possible reasons for this is a reluctance to involve their children in discussions relating to their mental health (Maybery and Reupert, 2009). This prevents professionals from sharing information in the absence of consent, which creates further obstacles for working across service boundaries.

Barriers to joint enterprise

By nature of being specialist and separate, each service has a different agenda and prioritises different individuals within families (Diggins, 1999) which has led to an overall competition between the needs of individual family members (Reupert and Maybery 2014). Professionals describe an overall lack of understanding or knowledge of each other's specialist area (Darlington et al, 2005b) (Stanley et al, 2003), and roles and boundaries are particularly misunderstood (Darlington et al, 2005b); (Maybery and Reupert 2009). There is an overall difference in knowledge base, approach and experience between social workers from different fields of practice (Tye and Precey 1999) which has its origins in education and informs professional approaches (Frost 2005). This is further enhanced by differences in theoretical paradigms (Coates, 2015); (Reupert and Maybery 2014), contrasting thresholds, codes, concepts and remits (Barbour et al, 2002); (Davidson et al 2010).
The interpretation of diagnosis leads to misunderstanding and assumptions which fuel divisions between professionals and lead to differences in assessment of risk presentation

(Barbour et al 2002); (Rouf et al 2012); (Coates 2015). Furthermore, children's professionals lack trust in the assessment, diagnosis and treatment delivered by health professionals (Stanley et al 2003) and can impose unrealistic expectations for change on parents (Weir and Douglas 1999).

Where collaboration lacks a joint enterprise, communication is generally poor (Darlington et al, 2005b) (Darlington and Feeney 2008) (Stanley et al, 2003) (Davidson et al 2010), on either a written or verbal basis. There are inherent challenges with information sharing and confidentiality (Coates, 2015); (Diggins, 1999) (Darlington and Feeney 2008) (Davidson et al 2010) (Stanley and Penhale, 1999) with information being generally inadequate for understanding the family and decision making (Diggins, 1999). The separate nature of services and their recording systems mean that the complexities and legalities of seeking consent, data protection and patient confidentiality are not negotiated easily and have been identified as a barrier to effective information sharing (Darlington et al, 2005b); (Coates, 2015).

Barriers to shared repertoire

Whilst everyone seems to be in agreement over the importance of collaboration, in practice, the research demonstrates that there are other priorities. From a service perspective, high staff turnover and overall workload impact on people's capacity to collaborate, as well as simply a lack of time and resources (Darlington et al, 2005b, Alakus et al, 2007, Davidson et al 2010, Diggins, 1999). There is often a lack of agency level structures conducive to collaborative work (Darlington et al, 2005b, Maybery and Reupert 2009).

Other barriers reflect differences in perspectives arising from the divisions of specialism. There is an overall difference in workplace culture (Maybery and Reupert 2009) reflected in existing dominant narratives and approaches to other professionals (White and Featherstone 2004). These narratives perpetuate and enhance stereotypes (Weir and Douglas 1999) and maintain the 'us and them' culture which directly opposes the approach required for a collaborative relationship. The narratives between the services often reflect poor experiences of working together and the difference in perceived status between professionals is additionally enhanced (Weir and Douglas, 1999).

Thomas et al (2014) identify the anxieties felt by professionals in the demand for collaborative working being projected by an individual or a group onto another, which Hornby and Atkins (2000) say can impede communication and disrupt collaborative attempts. Whilst this is important for the formation of a group identity and sense of belonging for those 'in' the group, it also creates a barrier to collaboration with those 'out' of it.

Whilst families present the same difficulties to different professionals, the often conflicting models of assessment and understanding of the problem can lead to different conclusions about the best way to provide support. Hetherington et al (2002) identify that professionals from mental health services and children's services have very different perceptions and understandings of mental health, leading them to respond differently in terms of risk assessment. Similarly, Stanley et al (2003) found different conceptualisations of similar difficulties led to a difference in appreciating the needs of service users, later echoed by Maybery and Reupert (2009) who identified that different approaches and conceptualisations of the same 'symptoms' lead to an alternative and potentially conflicting service response. A lack of policy in mental health services around people's identity as parents, as well as clients (Maybery and Reupert 2009) means that people are not being considered in respect of the systems and social circumstances in which they live.

Suggestions in existing research for improving collaboration
Mutual engagement
Professionals and families have made a range of suggestions about improving collaborative relationships when families are affected by parental mental health. Regular contact is needed to increase communication and cultural understanding (Darlington and Feeney 2008) and familiarity (Davidson et al 2010) (Britten and Cardwell 2002). Understanding and empathy for all individuals in a family is crucial in understanding the family as a whole and being able to support the unit effectively (Reupert and Maybery 2014). Social workers from children's services need to develop ways of working supportively rather than punitively and focus on creating relationships with service users (Maybery and Reupert 2009).

Joint enterprise

Given that information sharing is a challenge, there have been suggestions for organisations to create joint information systems and joint training on knowledge and skills (Davidson et al 2010), as well as everyone involved contributing to and combining their knowledge and skills to create a common care plan (Reupert and Maybery 2014). This would rely upon the development of protocols between the two agencies (Darlington and Feeney 2008) which may be seen as a positive way forward. In Webber et al's survey of practitioner experiences following the introduction of joint protocols, respondents reported that these had improved inter-agency working but that positive interpersonal contact with practitioners from other agencies was equally important (Webber et al 2011).

Suggestions have been made for having a key liaison person (Darlington and Feeney 2008) or interface champions (Davidson et al 2010) in order to support the wider workforce. It would also help to have easily identifiable contact points within each service (Darlington et al, 2005b). Clarity is needed for everyone involved around each other's roles and some agreements around confidentiality (Darlington and Feeney 2008).

Shared repertoire

Organisations themselves need foundations based on and embedded in collaborative principles (Maybery and Reupert, 2009) that are the bedrock of family sensitive practice. Policy, guidelines and protocols need to be developed in this regard. The attitudes, approaches, knowledge and skills of individual workers can then build on these and be influenced by them (Maybery and Reupert, 2009).

Those professionals working within mental health services need to acknowledge the identity of their clients as parents, be aware of the family as a system and be prepared to support other members of the family based on an understanding of what they need (Maybery and Reupert 2009). A strengths based approach (Reupert and Maybery 2014) would be helpful to focus everyone on what the family are doing well and encourage solution seeking.
In child and family social work, Munro's review of child protection in 2011 clearly identifies the need for professionals to share professional expertise, with the 'Reclaiming Social Work' model of practice being identified as a good practice model (Munro, 2011). Essentially, the

model has a shared value base, fundamentally rooting itself in collaborative work, identifying the creation of relationships as critical to the work social workers do (Goodman and Trowler 2012).

For 'Robinscar', an Ofsted inspection of children's social care services[3] demonstrated the extent to which the legislation and procedural guidance had not been translated into practice. There were findings of inadequacy directly related to poor inter-agency collaboration. The inspection report stated that "MASH is not sufficiently robust"; and that within strategy meetings there is insufficient contribution from other services; Assessments are over optimistic about the parent's capacity to make and sustain change; multi-agency planning is poor. The report specifically identified there is a "lack of information requested from services outside the MASH, such as adult MH services".

Clearly, collaboration is still not easy to achieve in practice, despite the demands placed upon us as professionals working with vulnerable people, frameworks to facilitate this and detailed differentiation of the depths of collaboration required in order to be of most benefit to the families we are working with. Perhaps then, there needs to be some guidance around not 'what' social workers should be doing in order to practice most effectively, but 'how' they should be doing it, with support for them to get it right.

With an increased understanding now of the barriers to collaboration between mental health services already identified in research, and awareness of what collaboration could – and should look like, I intend to explore this specifically within 'Robinscar'. The outcomes of this work will inform the work of the Mental Health in Families team and influence collaborative practice in front line social work in 'Robinscar'.

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[3] To preserve anonymity details are not provided

Methodology

My intention in this study is to explore the perceptions of collaboration held by social workers in children's services and adult mental health services in 'Robinscar'. I want to find out what they understand about collaboration and their experiences of it in the context of their practice. I intend to discover who they collaborate with, how they do this and identify any barriers that they highlight, as well as consider thoughts they have with regard to ways of overcoming these barriers.

People are influenced by their experiences which are dependent on them as individuals learning from their environments, cultures and interactions, the complexity of 'knowing' being shaped by an infinite number of factors. I believe that what is 'known' by one person may be different to what is 'known' by another, and for the purposes of this study it was important for me to capture the knowledge held by social workers in order to identify any themes reflective of each service (Braun and Clarke 2013). Whilst individual views are important, I wanted to develop a wider understanding that may identify issues in organisational culture and attitudes to collaboration generally within the services. This is critical if I am to be able to address the barriers to collaboration between the two services. For this reason, I planned to seek the views and opinions of those delivering the services on the front line as it is they who have the richest sources of experience and are best placed to see what is working, what is challenging for them in completing their roles most effectively and ideas about how to overcome these challenges. In order to capture this information, it was necessary to use a qualitative approach.

Eliciting the perspectives of several social workers from each service would allow me to consider individual views as well as identify any themes that may be influenced by their collective profession as social workers or their experiences working within separate services as workers for either children or adults. I knew that if I was intending to use my findings to then determine how collaboration in practice could be enhanced, it was important to get a deep and rich sense of where individual practitioners were 'at'. To achieve this, I chose to carry out semi-structured interviews with social workers from both adult mental health and children's social care services in order to provide an environment for discussion and

expression. I was interested in the range and diversity of people's experiences and hoped to capture this through a series of open-ended questions. My interest was in learning about people's own perceptions, although I was aware of my role as the interviewer and that this would impact upon the interviewee and what they chose to say, and therefore co-construction could not be avoided (Braun and Clarke 2013).

This study is a Masters by Research completed, on a part time basis, whilst I continued to work full time. Due to the inevitable limits of time and resources, I planned to interview four social workers from each service for around an hour. I felt it important to have an equal number if possible so that each service had an equal opportunity to contribute. Social work is a female dominated profession and as such the majority of participants would be women, although one participant was male which is broadly representative of national statistics. Sampling was important to consider and I discussed this initially with my supervisor as I had an existing working relationship with social workers from each service and wanted to ensure selection of participants was only on the basis of capturing a breadth of experience. Options were more limited from mental health services as there were fewer social workers within the service. Exploring the perspectives of workers who were not employed by the local authority would have required ethical approval from their employing authorities which was a level of complexity that I did not have the resources for. Following discussion with my supervisor, I used purposive sampling to approach practitioners who between them held a broad range of experience at different levels of their service (Braun and Clarke, 2013). The sample included front line practitioners with first hand experiences, those who had recently qualified as well as those with many years of experience – some had qualified further as senior practitioners or approved mental health professionals, some had experienced management.

Given that I work within the services that I intended to conduct this study and my job is to network between professionals, there was the inevitable influence of being an insider and an acquaintance of my participants (Braun and Clarke' 2013) that I needed to consider. As an insider, I have my own experience and knowledge of the services that I am researching, and whilst I endeavoured to ensure the data I collected was not influenced by my own perspectives, I am also aware that no research is value neutral (Costley et al, 2010).

In order to guard against unduly influencing the study, I was very concerned not to use leading questions and limit my intervention in the interviews so that the data I received was as genuinely practitioner led as possible. It was in my interests to provoke as genuine a response as possible from practitioners without my own influence, in order to both generate new perspectives and challenge my own. I maintained an openness to learning, with my position being not about proving myself right, but getting things right for social workers, the service and ultimately service users (Costley et al, 2010). I maintained an awareness of how participants may be influenced rather than say what they genuinely thought and felt, and tried to mitigate these factors as far as possible.

By nature of my insider status, participants knew of my role and I had an existing relationship on some level with each of them. I was aware that for this reason participants may be influenced by wanting to do a good job for me and in some way provide an evaluation of the Mental Health in Families team (Costley et al, 2010). Whilst I could not find any one way of minimising this, I did not encourage them to use this as an opportunity to praise my team. I made this clear before the interviews and ensured that they understood I was not evaluating the service we provide as a boundary spanning team and that my interests lay more specifically in working out how social work practice could be improved.

I was aware, however, that, under research conditions, people can wish to be seen in a positive light (Robson and McCartan, 2016). The only way I felt I was able to moderate this impact was to explain to them that their experiences and perspectives were of greatest importance, whether these be positive or negative. I also explained that in order for us to ultimately provide an improved service to those who need us, it was essential for us to understand the realities of practice on the front line. This of course meant that I had to consider the potential for social workers to be influenced by the nature of them giving their opinions about the service that they work for as well as opinions about the other service (Costley et al 2010). I framed the questions using a solution-focussed approach rather than concentrating on a critique and thus I hoped to encourage honesty and openness.

Whilst I do not consider myself to have a position of power over the participants in a work setting, it is important to recognise the power in an interview situation is weighted in my favour as the interviewer, and that there is likely to be some anxiety among those being

interviewed in terms of how the information they provide is recorded, stored, collated, analysed and distributed (Costley et al, 2010). I understood the vulnerability of the participants from the outset and felt that my ethical responsibility ensured that I took all measures available to me to ensure that there were no harmful impacts of taking part in the research upon them (Braun and Clarke, 2013).

As a researcher, I felt that I had a responsibility for the care of my participants, and whilst there was a requirement to apply for ethical approval through the University which I adhered to, I was also mindful that as colleagues we already had a relationship that I did not want to manipulate or damage and that I did genuinely care about how people may be affected by taking part (Costley et al, 2010). Having an existing professional relationship based on a mutual rapport and professional respect ideally added to the authenticity of my engagement with each person in the interview, which, in turn, hopefully enabled an environment where participants were trusting enough to share their thoughts openly. In caring for participants, I assured that I would do everything I could to maintain their anonymity, using initials in the transcripts then numbers for referencing in writing up. Occasionally references were made to people or services that needed to remain confidential, or may give clues as to the identity of the interviewee and in the transcripts these are represented by a series of dots. Given the recent experiences of social workers in children's services, I recognised their potential fear of being identified and assurances were given. I addressed the issue of confidentiality with the caveat that, if during discussions it became evident that either the participant or anyone else was at risk of harm, the need to safeguard would override the responsibility for maintaining confidentiality. In keeping with this theme, I considered the emotional impact of participation and made efforts to suggest where people might access for support if required following the interviews. Further to this, I made myself and my tutor accessible for further questions and clarification. I left it up to participants if they informed their managers about their participation and a Manager's information sheet was available if requested.

For each participant I explained the purpose of my research, what it would involve and requested their contribution, making it okay to say no and providing them with a period of time where they could withdraw their interview. I considered the venue in terms of

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convenience and acknowledged that the interview would inevitably take time away from work responsibilities in discussions with each participant.

Whilst all the issues outlined above were discussed verbally with prospective participants, they were additionally provided with a written information sheet. Within the information sheet it was made clear that participation was voluntary and that they were able to decline or withdraw at a later stage without any impact upon their employment. For the preservation of the data for the study, there had to be a final date for withdrawal, however none of the participants withdrew. The interview data was stored on a dictaphone and once transcribed the transcriptions were saved in a secure drive at the university, with an agreement to destroy after five years which is standard protocol. The dictaphone itself was wiped following transcription.

Data analysis

I used Braun and Clarke's Reflexive Thematic Analysis as my method for identifying codes, and patterns across the data, aiming to generate themes from the data itself rather than prove or disprove anything I previously believed (Braun and Clarke, 2013).

In order to become familiar with my data, I recorded and transcribed the interviews myself, being able to then to re-hear and re-read what I had been told, to be as sure as I could be that I was understanding what was being said. This was followed by further immersion in screening each entire transcript for anything of interest to my research question. I felt that this was the best way to use as much as possible of what my research participants felt was relevant in answering the questions I asked, rather than being prescriptive myself about what I needed. Complete coding in this way allowed the data to elicit its own themes. Using selective coding in this piece of work I feel would be restricting and limiting to my outcomes – I wanted to be stimulated by the feedback I received and provoked in thought rather than using the evidence to prove what I had already considered myself. In doing this, I have indeed opened up influences on collaboration that I had not previously considered (Braun and Clarke, 2013).

Whilst my approach was initially more inductive than deductive (Braun and Clarke 2013), with my interest being very much in people's expression of their own experiences, I found in later transcripts I was already aware of some similar views and experiences being represented and became more purposeful in recognising similarities. I found that there was an ongoing process of reflection, where the more I listened/read, thought and went back to read and hear again, the more I was starting to see commonalities between the interviews. Further to this, my critical approach meant that as the codes developed, I was becoming more analytical about influences upon people's truths.

In thematic analysis, the process of coding is interactive and organic, with the codes being built and actively generated through the lens of my own experience and perspectives (Braun and Clarke 2013). I am aware that eliciting themes from my codes filters information further through my perceptions, and I cannot extract this from my data. As an insider researcher, I believe this adds a richness to the analysis because of my existing knowledge base and experience in the service in which I am conducting my study (Rouf et al, 2012). Having a solid understanding of each service by way of experience, as well as the interface between them, meant that I was able to align myself as closely as possible with each interviewee. I was able to put myself in their shoes and interpret what they were telling me, using my understanding of the complexities and tensions of social work on the front line (Costley et al, 2010). I did also get my supervisor to read some transcripts in order to bring a degree of independence and rigour to the process.

As someone who appreciates visual representation, I developed a method which initially involved highlighting chunks of text in each transcript. As I became more familiar with the data, I was able to start grouping these chunks into common areas of interest relevant to my research questions. I moved on to using index cards to pull together the common areas, allowing some of the 'interesting' - though not as relevant – information to be dropped. As I considered and analysed these further, I used flip-chart paper to start grouping codes into broader areas with a deeper understanding. At this stage I was able to recognise that there were certain characteristics that were common to childrens' workers, and others that were common to those from adult services. This started to form further analysis about how professional practice was being influenced by organisational backgrounds, including their

views and experiences of collaboration. The themes I started to create from this were reflective of these differences. Throughout this process I kept revisiting the raw data, allowing for opportunities for reflection to check that the themes I was now defining were reflective overall of what was being said. I recognised my thematic analysis as complete when I felt that I had captured the essence of what was being said in each interview, relative to my research aims.

Reflections

I was surprised by how nervous I was in the interviews, and, reflecting upon this, I had not anticipated feeling the pressure of asking the right questions and exploring what was being said further at the right moments in order to capture the richness of the information being shared. I found that there was much in my conscious awareness that detracted from being able to fully invest in the interview – being aware of my responsibilities and determination not to lead, skew or effect the responses I received. I recognised that it would not be helpful to engage in a conversation given my existing knowledge and awareness and inevitable interest on the subject, and resisted my instinct as a social worker to enter helping mode, using my knowledge to solution seek (Fook, 2016).

I become increasingly aware of the value of silence, allowing more time for this over the course of the interviews as I become more comfortable in my position as an interviewer. As my focus was not on the content of the interviews as I took part in them, the process of transcribing drew my attention to the richness of information I was collecting. I noticed several 'light bulb' moments happening within some of the interviews. Whilst I did not lead nor provoke a particular view, as people were talking, thoughts and ideas were stimulated and I witnessed moments where they verbalised these reflections in action.

Ultimately and reassuringly, social workers provoked me to challenge my own thoughts, offering different interpretations and analyses of my own experiences. I was intrigued particularly with how people develop their own meanings and understandings, and the variation in the degree of reflection generally that social workers afford to what they do in practice.

Ethical dilemmas

Whilst I had carefully considered the impact of my research upon participants and put in measures to avoid revealing their identities, I came across challenges to this as the study evolved. Whilst promising anonymity, some participants had unique experiences as practitioners that I recognised would make them identifiable. For one interviewee, I had to remove the information completely, which meant I was unable to refer to a point that I felt was particularly useful.

In considering the anonymity of the local authority I have used a pseudonym for wider public availability, however the content will be shared inside the local authority and the Teaching Partnership.

How my research findings will be used to influence practice

It is my intention to provide a conclusion and recommendations for practice as an outcome of this study. As it is supported and funded by the teaching partnership between the Local Authority and the University, there are recognised routes for presenting findings and ways of doing this which recognise the value and validity of my work. I have made clear that my motivations lie in improving service delivery for the benefit of families in our community, with the ideals that I hope to achieve with 'Robinscar' being evidence based. The support from the teaching partnership will add credibility to my findings. The advantage of being an insider researcher will be in supporting 'Robinscar' to implement the recommendations (Costley et al, 2010).

As 'Robinscar' is already on an improvement programme, there is some degree of readiness to change (Wodarski and Hopson, 2012). As an insider, I am well placed to propose effective change strategies, being able to assess what is possible to achieve with my existing knowledge of how things work currently (Costley et al, 2010).

The Teaching Partnership will help me to devolve my research findings into the appropriate services where they will be presented in due course.

Findings

In analysis of the data collected from the eight semi-structured interviews, I was able to identify 28 themes which I then grouped to represent responses my research questions. In order to present the findings, I have therefore used the subheadings of - why collaborate, what are the barriers, and what could help overcome them.

In comparing the perceptions of social workers from adult mental health services and children's social care in 'Robinscar' on collaboration, I have found stark differences relative to the service they work for. Despite professional backgrounds being the same, the influence of professional identity and organisational climate and culture was evident and shall be explored in a later section. I have made it clear in the findings where themes were identified by social workers from one service or another. The greatest similarity was in recognition of participants expressing an overarching awareness that they did not understand the other service, in terms of skills, roles and procedures and that any improvements to this would be welcome.

No participant sought to define collaboration but the themes of 'collaboration underpins everything we do' and 'collaboration is more than speaking with someone' were reflected in conversations with all participants, irrespective of their service background.

Collaboration underpins everything we do

All the social workers identified that collaboration was an integral part of their practice, underpinning social work as a profession. "It's kind of the essence of everything we do, really" (#7:159). Whilst nobody sought to define collaboration, there was an overarching sense of collaboration being about doing things together and an inclusive, contributory concept involving communicating within formal and informal networks.

Collaboration is 'more than' speaking with someone

There was an acknowledgement that there was something about collaboration that involved a degree of effort and relied on more than having a conversation with someone. "We can all make a phone call can't we and say 'hm! I'm multi agency working'" (#1:399) There were

however distinct differences in how social workers from each organisation went on to explain collaboration through their experiences of it and what it meant to them in their practice.

There were also distinct differences between who social workers from children's services (CSWs) or mental health services (MHSWs) thought about first when asked about what collaboration meant to them in practice.

MHSWs: Collaboration is with the service user

MHSWs first instinct was to think about collaboration in terms of how they interact with and support service users, with one worker speaking about co-production as being the ultimate way of collaborating with service users. "the most important way of working is in a co-produced way, which means you allow an equal an equal influence on the design and delivery of services by people who experience the, the use of them" (#8:20)

CSWs: Collaboration is with professionals

For CSWs their initial description of collaboration demonstrated that their first thought was with professionals and whilst collaborating with the family was then mentioned, the examples of what they felt were positive collaborative experiences very much reflected value of information from professionals.

Why collaborate?

Reasons for collaborating also reflected differences between those who worked for adult services and those who worked for children's.

MHSWs: It supports someone towards recovery

Within mental health services, social workers talked about being part of multi-disciplinary community teams made up of colleagues from different professional backgrounds. They identified that this was valuable for drawing on each other's strengths, knowledge and expertise in order to help them understand the person they were working with in the context of diagnosis and managing risk. This also helped them to understand what they could expect in terms of recovery and limitations of the use of medication. There was clear

identification of the value of being familiar with their fellow team members and being co-located and accessible. They talked about colocation increasing opportunities for case discussions, with an added benefit of having informal interactions with colleagues in the workplace which they felt enhanced the relationship between them. This means that they can confidently share ideas and thoughts and have in depth case discussions. They valued the support of these collaborative relationships they had experienced as they were not making decisions alone.

> *"…if for example someone needs some support around employment, I might get the occupational therapist involved, if they're someone who is really anxious, they're struggling to get on and off buses, I might ask a support worker... Often I get asked lots of things about medication which I can't answer so I might ask a community psychiatric nurse – the CPN - to come on a visit with me. And sort of with the psychologist often when you get a new referral, I'll sit down with them and just try and think about a formulation of, you know, where that person's from, where we think they are, where we think they might want to go and what kind of psychological interventions might be helpful"* (#2:71)

MHSWs: Collaboration helps their client to be understood in the context of their family

MHSWs were used to involving families in their work with their clients and identifying how collaboration could be used to build on strengths, including adding strength to the family unit as a whole which would in turn help to maintain wellness. They were also able to see the identity of their client as a member of a wider system. "we've got to build that whole resilience in the family rather than just working with that one particular person" (#7:145)

They saw their collaboration with professionals as contributory, in terms of helping others to understand the mental health of the parent. They felt that collaboration helped them to influence the achievability of planning and expectations of the family when plans are being made by children's social workers and ensure the perspective of the parent is heard and supported. "I always try as much as I can to go to some of the meetings with the mum just so they've got someone there who knows about their mental health and can perhaps better communicate, you know, what that impact is" (#2:172)

Case examples of working in this way were felt to be positive and increased understanding for all involved. "so we had meetings with all those people so they had an update of what I

was doing as well, and what risks the person that I was working with may pose in the future and how that was going to work. So that worked really really well…" (#3:155)

MHSWs: Collaboration is empowering and influences inclusivity – the client is the expert

It was felt that collaboration reduced anxiety for families, particularly when workers from mental health services could offer reassurance around the involvement of children's social workers as they understood what was happening. "I think families see – I think it can be less threatening. They see us as a service that is working together to support" (#3:103)

Having a worker advocating the needs of the parent also helped to recognise the client as the expert. Mental health social workers felt that their involvement helped towards destigmatising their clients, and when families were able to see that professionals were working together it was less threatening and more empowering.

MHSWs: Collaboration shares responsibility for decision making

MHSWs actively encourage sharing case accountability and appreciate that others have skills that can enhance their own casework and approach. They value the opportunity to discuss and analyse what the best way of supporting someone is, both with professionals and the client themselves. Because it's not all about me and what I can do on my own, and it's always better to build that network (#2:89)

CSWs: Collaboration is for obtaining information from professionals

CSWs felt that collaboration was essential for finding out valuable information in order to help write an assessment they were working with, and this influenced the plan of work. "you don't realise how much vital information other services hold. And without that information you think that you have everything that you need and you think that you know what's going on and then you'll speak to a service that you've potentially not been able to speak to before and it actually changes a lot" (#5:47)

However, there was acknowledgement that there was sometimes a 'lip service' attitude, and of it being an exercise to tick the box on obtaining information "we do the least we can do for multi-agency and fluff it up and say we've done it" (#1:387) or passing responsibility -

"it did feel a bit one sided in respect of that because it was like – they gave information but yet we ended up doing all the work" (#6:65)

The referral pathway into children's social care involves a multi-agency team, previously referred to as the 'MASH', which includes professionals from social care, the Police, health and education, the purpose of this being to share information at the point of referral to make decisions about what level of intervention is required. This was seen as a positive experience of using each other's information "I think us requesting information works really well in MASH" (#6:146)

Participants felt that building and maintaining networks helped them to be able to access important information. "I'll go back to the source and say I need a bit more this, or a bit more on this. And because I've got names and I've got that relationship because we worked well, I think that's really benefitted to me in my assessments" (#6:218) When discussing potential solutions, improving relationships with other professionals was seen as the key to obtaining more information. "we need to strengthen those relationships so that we can immediately get that information" (#4:425)

To this end, one reflection was that having adult services sat in duty and advice services might be helpful in order to obtain information. "the ones that have got children are the adults but yet, there's sometimes history on parents that are known to adult social care" (#6:36)

Most social workers identified that they themselves were proactive in wanting to find out more information therefore were more probing – "I want a bit of meat on the bones" (#6:247)

CSWs: Collaboration with professionals helps our relationship with service users
For children's workers, it was felt that trying to work more closely with their mental health colleagues and align themselves with them in direct work helped them to be more accepted by service users. "I think the difference has been that we've not come across as good cop - bad cop" (#1:192) There was a sense that CSWs felt that when all professionals were in

agreement this helped in their relationships with families "everyone sang from the same hymn sheet" (#4:47)

Ultimately, it was felt that collaboration helps families to see that professionals are working together and are there to support "I think that families see that actually everyone's there to help you, we're not here to sort of target you or victimise you we're here to help and unless we get together we can't do that" (#5:56)

CSWs value the expertise of their mental health colleagues

There was a recognition of the value of the information and expertise that each professional brought to the case and social workers saw this as developing the picture of the family that they shared "...it's like a jigsaw so if you're missing a piece of that puzzle you're missing quite a key area of somebody's life, then you're not going to create a really – you're not going to create the best plan in place for that person" (#4:30) Sharing in this way helped professionals see the importance of the information held by others involved and that this led to them all having an equal influence on what was determined in the plan. "I would never work with somebody with a mental illness without having a discussion with the mental health worker… because that's not my specialism and I learnt that I need to respect other people's professionalism" (#1:143)

Social workers from children's services talked about mental health in a context of fear and misunderstanding "she was a scary person" (#1:212). It was acknowledged as a complex issue that children's workers readily admitted they needed support to understand and the assumption was that people could be 'broken' if you didn't know what you were doing. It was felt to be fraught with risk and something that needed specialist input.
Being able to have open discussions around risk was seen as particularly helpful which in turn lowered professional anxieties across the board. "… you get very worried about what that experience for that child is and potentially the harm that that parent can cause, and then I find that when I speak to mental health professionals they reduce my anxiety" (#5:16) "Our anxiety is quite high, because it's mental health because it all unknown and it's all very risky" (#6:356)

Collaboration helps CSWs to get other professionals to 'do' something

Children's social workers felt that other professionals were often quick to 'pass the buck' to them, and they found that all too often they were left being the ones with responsibility for working with the family. Their view was that having more professionals involved meant that they could share out responsibilities within the plan.

What are the barriers to collaboration?

There was an extensive degree of understanding and empathy expressed for colleagues – and for why things could be more difficult at times between the two services. However, themes were identified that reflected poor experiences of collaboration.

Social workers do not understand enough about the 'other' service, nor what each other does

All social workers interviewed identified a lack of understanding of the 'other' service as a barrier to collaboration, because they did not understand what the other service did, the roles and responsibilities of their colleagues, nor the legal and procedural frameworks they use. "that's a big issue that we don't really know what each other does" (#5:338)
There was a complete misunderstanding about the role of social worker in mental health services. "they are health; they are not social care" (#4:209)

This may have its origins in the training that they received. As students they were expected to make a choice very early in their education and from this point on there was very little included in their training that encouraged acknowledgement of how the service fit in with other areas of social work. "in my degree by the second year you chose children's or adults and you went down one pathway or the other and they were taught separately" (#4:267); in terms of knowing what colleagues in children's services would be doing, it didn't leave me with any particular knowledge (#2:250)

Our individual services don't prioritise collaboration

Mental Health social workers all reflected on how it felt to be a Local Authority employee in a service run by health and the frustration of a complete lack of support from their

employer which reflected an absence of collaboration between the service structures. "it doesn't feel like a partnership between the Trust and the local authority" (#8:332) "I feel a little bit left if you know what I mean because my identity is with social care but I don't feel like they've taken ownership of me" (#7:406).

There was a shared view that social work was heavily influenced by the expectation of the organisation in terms of workload, targets and timescales and these being the measure used for effectiveness. "but I think we struggle with it sometimes, when we've got excess pressures, and there's people coming from all over and we've got really high caseloads - there is an expectation to get people in and through and out other side without the sort of whys and where's and that's sort of stifling" (#7:164).

Whilst children's social workers did not directly identify that their organisation did not embed collaboration, they did allude to their assessments being driven by targets and timescales, and to work collaboratively required standing up against this. "if you've got courage enough to say 'I've gone over timescales because for me its crucial that I work with the mental health worker' then you get it back tenfold in that assessment. It will be an all singing, all dancing proper single assessment. Not a lip service assessment to meet government targets" (#1:439).

MHSWs: Children's social workers can be unpredictable and inconsistent

There was an overarching view from MHSWs that mental health difficulties did not preclude good parenting and that perhaps sometimes people simply needed a little more support, however, having a children's social worker involved made them apprehensive. "my clients in trouble because they're with social care" (#7:322) None of them identified that they felt this meant children would be removed from their parents' care, however, they were clear that their anxieties were raised because of this as a potential outcome and led to some uneasiness about making referrals. This was because their experiences were that children's social workers were unpredictable and responses were inconsistent - "workers just change so frequently… you didn't know when it had been completed, what the outcome was… because they'd changed, disciplines had changed, and you're thinking- that makes it really really difficult" (#3:224).

MHSWs: Children's social workers make decisions without explaining their reasons

Mental health social workers were concerned not by the responsibilities that children's workers had, but in the way that they communicated their decision making. "a lot of decisions are made in a private manner, they're beyond challenge" (#8:96) There were persistent issues about a general lack of communication, about meetings and sharing written information. Many case examples were given where decisions had been made on a case with the MHSW not being included in decision making nor understanding the reasoning.

This theme was extended further to identify that children's workers didn't understand mental health issues and their implications and often, as a result of this, they set targets for parents which are simply not achievable. "often you go to meetings where, you know, someone's been put on some new medication but then there's also a target set by children's services that will do x, y and z by this time, and you know, if I go I can say well actually that's really unrealistic" (#2:190) There was a similar frustration about children's social workers demanding a parent access mental health services thinking that this would address what they felt was a risk. This led to mental health social workers feeling that children's social workers could be judgemental and punitive in their approach.

MHSWs: Children's social workers are responsible for their own poor image

There had been experiences of children's social workers turning up to meetings as new workers to a case and not being prepared, leading to them being seen as unprofessional by the range of other professionals attending. "… sometimes they've been unimpressed with the children's worker though… that worker then becomes a bit alienated" (#3:395).

CSWs: MHSWs don't want to damage their relationship with their client

Children's workers expressed frustrations around mental health workers not wanting to compromise relationships with their clients which they felt led to a reluctance to share information. They felt mental health workers typically 'hid' behind data protection and patient confidentiality, using these as reasons not to collaborate. This reluctance to damage relationships with parents also meant that children's workers had experienced mental health workers refusing to have challenging and difficult conversations with parents, even if

the children's social worker felt they were better placed to do so. It was felt that mental health workers are seen by service users as "lovely" (#5:192), highlighting a difference in the way that they think they are seen themselves.

CSWs: Our role is misunderstood

Children's social workers see themselves as "fixers" (#1:141) and "bullet firers" (#1:168) and all expressed this in some way, reflecting a feeling a responsibility both imposed by others and expected of themselves. This burden extended to feelings of having to be in control and whilst this came from a sense of wanting to protect, there was also a sense of this being forced upon them "there's quite a bit of 'over to you because it needs a response and we can't deal with it'" (#5:67). This was felt to reflect their own perception of their roles as children's social workers as well as what families and other professionals demanded. When asked about how they feel they are seen by other professionals, children's social workers believe that they are seen as "renegades" (#4:235) who were "harsh" (#1:341; #4:238) "cruel" (#1:345) "brutal" (#1:527). They also felt they were seen as "kiddy snatchers" (#5:444). Interestingly, whilst mental health social workers felt children's social workers had a poor understanding of mental health and set unachievable targets, none of them in this study used this language and instead recognised that children's workers had a job to do. Whilst there was criticism of the way they went about their roles, there was no criticism of what they knew children's social workers were trying to achieve.

Children's social workers recognised that they had power through the duties and responsibilities imposed by their profession. They felt that other services tried to influence how their power was used. There were experiences of other services going as far as telling them what to do under some circumstances - "police will send things in and say "this is a section 47" – well that's not your decision mate, that's ours" (#5: 305).

Children's social workers all felt that other services expected them to be punitive, despite them trying to move away from this identity, and actively used threats of social care - "you do it or else. Do it or social care will come back. Work with this early help or else" (#6:286).

CSWs: Families don't like having us involved

Children's social workers felt that the parents they worked with engaged through fear of repercussions if they didn't and identified 'disguised compliance' as a product of this. Further to this, it was acknowledged that the stigma of having a social worker involved for their children was automatically stressful, regardless of whether someone already suffered with mental health difficulties. They also recognised that the fear and stigma associated with having social workers involved stops people asking for help at an earlier stage which may have prevented later involvement. There was a feeling that families saw social workers as just dealing with concerns raised by other professionals – "think they think we're just an organisation that swings in because they've had a complaint" (#6:96).

There was an appreciation by children's social workers that this came from what they believe is a previously more punitive approach within their organisation - all children's social workers reflected on the threatening nature of plans that social workers used to impose upon families. "…what a threat that is! Work with us or we'll take your kids!" (#6:270) Children's social workers alluded to the changes that their service was going through and they recognised that the restorative principles that that they were now using encouraged a better relationship with service users.

CSWs see themselves as 'there for the child'

A couple of the children's workers were clear that their 'client' was not the parent and felt that there were boundaries to what they could and should do for parents. "that was my agenda. It was child led, really, not parent led. I was child led. But to get that child what she wanted I had to be adult focused" (#1:229).

There was no apparent appreciation of the complexities of the impact of one individual upon another and of the dynamics of relationships within families and how these need to be understood in order to assess and plan with service users. The approach was almost divisive in the way that this influenced casework. "our views of adults is - 'well you stick to your bit we'll stick to our bit and we'll all be specialists in our areas, and we'll just meet when we need to and that's it" (#4:157).

Social work is a tough job and our wellbeing can often be neglected

All the participants identified in some way that the quality of their work – and therefore their motivation to collaborate – was impacted by their own wellbeing. If the organisational demands of the work are so heavy that social workers have to resort to a 'lip-service' response, social workers can hardly be expected to enhance the quality of their work above and beyond these demands, particularly if they are not being looked after by their own organisation.

As students and then newly qualified workers, despite having protected caseloads, the actual demands upon people were huge. "it's a really difficult job in terms of what you give personally as well as what you have to do and what you're up against" (#7:119) "I felt coming out that it was more about survival than thriving as a social worker" (#8:351).

One social worker was influenced by a difficult experience in work that required them to take some time out for themselves but this was not supported by their organisation. "I needed some time out of work, so I took some time off work… but in the process of fixing myself, my team manager felt my emotional resilience wasn't as it should be, and questioned that…" (#1:79).

Social workers expressed having to just get on with the job when things are difficult, inferring a lack of support. "I never realised how draining it was. And it really is draining… But you've just sorta get on with it don't you" (#5:28).

A MHSW had experienced being contacted by a CSW when they were supposed to be off. "What's happening with supervision and management structures if they're allowing that and if that's a given practice, that you can be contacted on your time off" (#3:477).

There was more of a sense from MHSWs that they felt good about the service they delivered and, whilst their wellbeing was not nurtured by the local authority, they nevertheless felt confident that the people they worked with would feel that they were getting a good service. "I'd hope the people that I've worked with would see me as approachable and that, you know, I'd communicate with them…" (#2:228).

<u>What could help overcome these barriers?</u>

<u>Better understanding of each other's services, roles and responsibilities</u>
All social workers were able to identify a positive experience of cross-boundary collaboration. The features of this working well had been about reaching an agreement, where the case had been discussed and debated at length between them, and they each understood the family circumstances and goals had been agreed across the board.

Several social workers felt that this could be achieved more consistently by having a jointly run service that recognised and embedded collaborative principles. "I think integrated partnership is really interesting, I think it would be better if we had an organisation that did health and social care as one" (#8:359). This idea was taken further by some, who felt that sharing the co-ordination of care, but with one person from either service taking the lead role, would increase understanding through better integration. "why can't they coordinate a plan and we're all working with that plan and they're commissioning us – you know all the other services" (#3:364).

In terms of seeking solutions, opportunities for getting to know each other, each other's services, roles and responsibilities were seen as very important, and several ways of doing this were suggested, including joint training and shadowing opportunities as well as creating joint assessments and plans.

When discussing suggestion for improving collaboration, all reflected that relationships between the services needs to be enhanced at all levels in order for a greater understanding to be had by all.

<u>Relationships are helped by familiarity</u>
Of real significance for people in this study was the importance of familiarity in building and maintaining professional relationships. In fact, several participants expressed that they would specifically seek out those who they knew would communicate with them and give them the information they needed. "I've got good links now with the keyworker there... I've

found working with them really good in terms of helping me understand better the legal process, and what the courts are doing and what the social workers are doing" (#2:148).

Where these ingredients for positive collaborative relationships were in place, social workers talked about having increased faith and trust in those they were working with, feeling that agenda's driven by organisational culture were less of an issue and that they were investing in the casework in the best interests of the whole family rather than the individual service user allocated to them.

Face to face contact builds relationships

The most successful way of building and maintaining relationships was through face-to-face contact with people, including joint visits and meetings - "when you see people face-to-face… that does help" (#3:96). This was compared to sharing written information as well as sharing verbal information over the phone. "… I think that when you're trying to collaborate and work together over the phone compared to when you sit down and when everyone gets together that's when you really reap the benefits of it" (#5:52) "being there, you've just to walk across and get the information. You'd send a document round as well to record it on, but face to face, interaction, can't beat it" (#6:53).

MHSWs: Maintaining awareness of social work values

Perhaps due to their being embedded within a health focussed service, there was a view from MHSWs on the importance of social work values for influencing ongoing collaboration, and there was a risk of them becoming devalued within such a service – "some of the social workers are 'mental health practitioners' rather than social workers… I think that's potentially the danger, is that we start to lose that professional identity and just become NHS…important to…maintain that contact with other social workers and experienced social workers and to be able to have that conversation about what are our values, what are we doing here, why are we, you know what's the methods that we're using that's separate to the CPN's and separate to the OT's" (#7:85).

CSW: A collaborative experience that addressed issues of power

One social worker had experienced being part of an initiative based on collaborative relationships between professionals and service users which addressed power imbalances between whom there would ordinarily be a recognised hierarchy.

> *"…the power was very much with the service user and not with us. So, we gave them all the tools they needed to move things forward, but they were the ones who ultimately would lose their child. And from the feedback from the parents, they felt in control. And of the 15 families we worked with only one family the children didn't go home, but all the parent – the parents said at the final hearing, 'it's not that we weren't given every chance to change ourselves, and to be supported in changing ourselves, we're just not there yet to stop the addiction"* (#1:652).

However, interestingly, whilst this social worker was able to identify the positive effects of this level of collaboration on outcomes for families, and identify the benefits of this way of working, there was no explanation of how this was then used to influence their own practice back in front line child protection.

Mental Health in Families team

As previously identified, my practitioner role is with the Mental Health in Families team. Whilst participants were not encouraged to identify the value of having the team co-located, all of them alluded in some way to the benefits of having the team available. The ingredients that had been identified throughout the interviews for successful collaboration were referred to, including developing their understanding of not only their casework but the expectations of the 'other' service, and what the context of their involvement was. Having information not only shared face-to-face but discussed and explained in the context of the family was highly valued, helping decision making and supported collaborative relationships with colleagues from the 'other' service as a result.

Discussion

Whilst social workers from both services identified some common barriers to collaboration and suggestions for improving it, there were also marked differences between workers from mental health services and those from children's social care. Organisational culture and professional identity are key influences upon the depth and quality of how individual practitioners collaborate and influence the way that casework is carried out with families (Thompson, 2015). In particular, this study suggests that organisational culture and professional identities affect who the social workers identified primarily as the people they collaborate with and what collaboration is for.

The specialist nature of each service is in itself divisive, and has led to a lack of understanding of each other's services, roles, responsibilities, identified in some way in all interviews in this study. Divided priorities and completely separate agendas determine ways of working which do not lend themselves well to working together. This was highlighted in LiPP's analysis of difficulties in inter-professional communication, where the reasons suggested for professionals not communicating when needed were around a lack of understanding, specifically of: roles and responsibilities, modes of information and collaborative working (LiPP, 2016). This was also highlighted in a literature review carried out by Kings College, London, of roles and issues within the social work profession in England, who added that the lack of understanding could lead to a less than positive view of social work (Moriarty et al, 2015), which will inevitably impact upon working relationships across service boundaries.

In the absence of in-depth discussions with and about the families that social workers are supporting, there is a consequential lack of understanding or agreement by other professionals involved about what can and should be done to provide the most effective support. Children's social workers use the powers that they hold under the Children Act 1989 to allocate tasks to other professionals and to the families that they are working with in multi-agency forums, even without a level of agreement being reached. This leads to tensions in the working relationship between professionals, with children's social workers being seen to make decisions that other professionals don't understand (Darlington et al,

2005a). This was taken further by one of the mental health social workers in this study (#8), who had experienced children's workers making decisions that were beyond challenge. This use of power reflects identified barriers to mutual engagement between individuals involved.

Organisational culture

Children's social workers expressed being encouraged to prioritise timescales and targets, which detracts from the value found in working collaboratively and means the focus is primarily on the demands of the service. There is a lack of explicit priority given to collaboration from management in children's social care, even at this level the focus is on getting information, not on working together to develop an understanding of it. Despite the recommendation to "improve the quality of assessments of the impact of mental health difficulties on children, ensuring that children's social workers and adult mental health practitioners work together to assess and agree effective action plans" in Ofsted's 'What about the children' (Ofsted, 2013, p8), this is not a practice that is supported or embedded within practice or procedure in 'Robinscar'. The lack of organisational frameworks for embedding practices of working together mean that there is no structure for creating a joint enterprise or shared repertoire, both of which are required for successful collaborative practice (Frost 2005).

Children's social workers' initial responses identified collaboration as something they did with other professionals, with a focus on obtaining information. The discourse around information sharing expressed by children's social workers in this study reflects the language used in 'Working Together to Safeguard Children' (2018), and is also reflected in the in-house co-location arrangements in children's social care. The duty and advice part of the service is responsible for screening referrals into children's social care, and has been set up since the Ofsted inspection of the authority[4] with the inclusion and co-location of colleagues from Police, education and health services, who have access to relevant recording systems from their own services. This does enable information sharing, and the value of co-location to being able to share information quickly was identified by one of the

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[4] To preserve anonymity details are not provided

social workers who had experienced being part of this team. This demonstrates that the express priority is in gathering information with the social worker taking a lead role in what they do with the information they are given – this also means, however, that there is absence of a deeper discussion and analysis of the information being shared, demonstrating a lack of joint enterprise (Frost 2005). Thus collaboration is not happening in the most useful way and in considering the Continuum of Collaboration suggested by Careau (2015), does not reflect the complexity of the cases that are being considered.

Further to this, there was an expectation by children's social workers that other professionals had the responsibility for sharing the right information with them in order for them to better understand. Some workers took a more proactive stance on this and were aware of the need for further exploration and went about this with professional curiosity, whilst others felt that there was a need for other services to understand more about the information that social workers needed so that they could simply be on the receiving end of relevant information. Interestingly, LiPP's analysis of the difficulties in inter-professional communication identified practice issues around children's social care NOT checking with other relevant agencies for information as part of their assessment, as well as a lack of communication when needed between children's and adult services and a lack of understanding of the types of information required (LiPP, 2016). Reder et al suggest that there is a responsibility on both children's and adults' workers to carry out parallel assessments of the parent's mental health and the needs of the child (Reder et al, 2003).

Stanley et al (2003) take this idea further and argue that workers in children's services need to develop the confidence to use the assessments completed by mental health professionals to inform their own assessments. In this study, the perspective of the children's social workers was that they were there for the child, that discussion with adult workers was only on a basis of obtaining information from a specialist service, and that having specialists dealing with individuals in a family was the right approach. In my experience, this information is not routinely sought, nor shared or understood in enough detail in order to analyse the circumstances of the family and therefore ascertain the needs of the child. This leads to disagreements around risk presentation, misinterpretation of diagnosis and unrealistic expectations placed upon parents, all of which have been highlighted as barriers

to creating a joint enterprise. There does not appear to be enough rich contextual dialogue between professionals from the two services, and this could be due to a lack of time, a lack of prioritising the need for it or a lack of understanding the value of a deeper level of communication.

For those social workers working in mental health services, the overall service culture is supporting people towards recovery with the service user as the expert (Realpe and Wallace, 2010). Social workers from mental health services identified collaboration with service users as their primary focus, recognising and acknowledging that the client themselves was the expert on their own situation. This reflects the value base behind co-production, which was identified by one participant in this study (#8). Co-production requires service users to be considered by professionals as having the capability for making decisions for themselves and to be afforded the control over the care that they receive to this end. The strategy of the Mental Health Trust also identifies recovery and co-production as a focus of their principles (SWYPFT, 2018).

Professional identity

People have an identity based on their personal attributes, experiences and beliefs, defining who and what they believe themselves to be. Professional identity creates an additional layer of definition and belongingness that is maintained through the relationships they have and cultures they exist within in the workplace (Webb, 2017). A study carried out by Wiles (2010) involving student social workers identified that students recognised the influence of their personal journeys and the impact of social work training and experiences on who they actually were. However, students also constructed their professional identities in relation to desired traits demanded by the profession and through shared identity with other social workers (Webb, 2017). It would make sense, then, that professional identities are influenced by the cultures of the specialist organisations that people work within (Fitzgerald and Kay 2008).

Jones argues that the social work profession is fragmented and this begins with education (Jones, 2015). However, Howarth and Shardlow (2003) support this split form of education delivery, advocating for education to be specialist focussed in order for social workers to

develop their expertise. Similarly, Narey's review of the education of children's social workers recommends for those intending to pursue a career in children's social work to have all of their degree level education be geared towards this (DofE 2014). Whilst Thomas et al (2014) suggest that it is unrealistic to expect professionals to qualify with knowledge to meet all situations they will encounter, all participants in my study identified that their individual routes into the profession did not prepare them for the understanding that they would need of other services in order to practice collaboratively, supporting Jones's view. This may warrant further attention in future research, but, for the purposes of this study, social workers felt that they were encouraged early in their course to choose topics specific to either adults or children's services, and received little guidance on understanding the needs of or how to respond to other members of a family, nor any knowledge of the services likely to be working with them.

The consequences of social work specialism were reflected throughout my study. Children's social workers expressed some frustration with their roles being misunderstood and believed that they were viewed negatively by families and other professionals. According to one social worker interviewed, "we have allowed ourselves to have our roles as social workers to be defined by others" (#8), and this was reflected in the way that the children's social workers expressed both how they were seen by others and how they saw themselves. They reported an overall expectation that they will take a punitive approach, and reported situations where professionals from other services had threatened families with getting social workers involved in order to try and get them to comply. They talked about receiving referrals that over-emphasized issues which ensured cases were picked up by social care but also created an illusion of difficulties being worse than they were in order for social workers to visit families and address issues that the referring professional did not broach with families themselves. On a similar theme, once cases were being held by social workers, professionals would report their concerns to the case-holding worker and expect the social worker to address the issue, leading them to identify themselves as 'bullet firers'. While the examples given of professionals that acted in this way did not involve those from mental health services, it still serves to reinforce how children's social workers are perceived by other professionals, perpetuating the way that they are viewed by families.

Children's social workers expressed an appreciation of the expertise of their colleagues from mental health services, wanting to draw upon this in their casework in recognition that they lacked this understanding. This was particularly highlighted by one participant who identified that she had a completely opposing view on a parent's MH and she took some reassuring by the MH professionals around risk presentation (#5). Further exploration of this reflected an overall sense of fear around mental health, an acknowledged lack of understanding and awareness and highlighted the stigma that still exists within society around the danger presented by sufferers. 'Stigma Shout' was a project carried out by Time to Change, a partnership between Mind and Rethink. It sought to explore how people affected by mental health difficulties experience stigma and discrimination. The survey confirmed that stigma and discrimination is all pervasive, with 87% of people reporting its negative impact; 22% reported relationships with professionals being an area where they felt stigma and discrimination had an impact (Time to Change, 2009 - 2012). Despite children's social workers' expressions of valuing their mental health colleagues, they may come from a place of being influenced by the stigma of mental health and, currently, the quality of collaboration between the services is not enough to fully overcome and address this. The superficiality of information sharing does not allow for an understanding that would help to tackle these issues.

Within mental health services, in line with the ethos of co-production, the role of the professional is to work with service users to seek solutions rather than to be the "fixers of problems" (Realpe and Wallace, 2010, p9). Interestingly, in my study, children's social workers identified themselves as 'fixers', still seeing their role as coming in to put things right. This identifies a significant difference between the two services in their approach to the social worker role.

Social workers from mental health services in this study reflected upon the lack of ownership of them by the local authority. They were acutely aware of the absence of social care in their managerial framework although the day-to-day working culture of the teams that they were part of made them feel valued as members of the team and on an equal professional footing with their colleagues. This contradicts the findings of Frost et al, where social workers in his study expressed a feeling of exclusion from the culture of the team they

were located in (Frost et al, 2004). This reinforces the significance of shared identity and joint enterprise for collaborative working that has been achieved within the community mental health teams in 'Robinscar'.

The absence of ownership by the local authority gives rise to the potential for social workers to be located within a medical model of practice, with an impact upon how much professional respect they are afforded within this model and how much weight is given to their views in multi-disciplinary decision making settings. Whilst the mental health social workers in this study did feel valued by their teams in day-to-day casework, in some multi-disciplinary situations they found it more of a struggle to hold onto their views and protect their professional identity. This reflects the work of Beddoe, who found that social workers continue to feel marginalised within health settings, struggling to find traction and stand up for the social injustices and the recognition of their impact upon health (Beddoe, 2013).

The absence of ownership by the local authority gave further cause for concern in terms of social workers having the responsibility for maintaining their own value base without the opportunity for reflection within supervision, and a lack of access to appropriate resources, equipment and training with social workers from other services.

Absence of the child's perspective

None of the social workers in my study mentioned children in considering who they collaborate with. Whilst this was not particularly surprising from social workers from mental health services with their focus upon their adult client, it did reflect existing research findings in terms of an absence of acknowledging the identity of service users as parents as well as patients, and an overall lack of awareness of children within families (Slack and Webber, 2008); (Jones et al, 2016). It also demonstrates the lack of understanding of a whole family perspective.

For those social workers from children's services, it reflects the absence of appreciating the relative importance of the voice of the child, the significance of this being critical in view of the 'invisible child' phenomenon as seen in many serious case reviews. This reflects the work of Harry Ferguson, who carried out a research study observing social workers in their

practice, in an effort to find out why children are not held in mind in day to day practice. His findings concluded that children's social workers' engagement with children was influenced by organisational culture and, whilst obvious limitations due to time and caseload were identified, he also discovered that the space provided for reflective supervision was often not adequate for exploring social workers' emotional and visceral experiences which impact heavily upon the development of their analyses and hypotheses (Ferguson 2015). The absence of the child's voice in 'Robinscar' was also identified in the Ofsted inspection of the authority[5].

Relationships

Of particular significance was the difference in the value of relationships to social workers, with those working in mental health services having a much stronger awareness of the need for positive working relationships with both service users and their colleagues and the investment of themselves that was required in order for these relationships to work to their optimum.

The way children's workers talked about collaboration reflected their awareness of the challenges in their relationships with families. They felt that aligning themselves more closely with mental health workers may enhance their relationships with families as they saw that mental health workers appeared to have a more positive relationship with them – and that collaborating with professionals who had a more positive relationship with service users could impact upon their own relationships with them. Again there was a lack of recognition that relationships needed to be invested in for their own sake, built upon fundamental elements of trust, openness and respect (Darlington and Feeney 2008).
It was felt by children's social workers that stronger relationships with other professionals would increase the information they could get and if other professionals understood their service better they would share more appropriate information. This suggests that workers felt that other professionals needed to see their vision - there was no explicit awareness of the need for a 'shared vision', or of how relationships with other services needed to

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[5] To preserve anonymity details are not provided

improve in order for this to happen. This lack of awareness of the need to genuinely share through a joint enterprise is in itself a barrier.

Children's social workers in this study recognise the difficult relationship they have with families and see the barriers as families being resistant to engagement based on how they view them as professionals. A literature review carried out by the Kings College, London in March 2015 highlighted that there was a continuum of care and control (Moriarty et al 2015) which is largely defined by the ethos of the service. Children's participants in my study recognised that they have power and that the approach most commonly used in their service has been more 'control' than 'care', reflecting an approach designed to achieve social order rather than creating relationships with families with an effort to understand their perspectives (Cree, 2011). This reinforces the 'bullet firing' identity that they feel that they have. Whilst they wish to shed this identity and be seen as more supportive, current work practices remain rooted in power as per the expectation of professionals as demonstrated in this study.

One social worker had experienced being part of the family drug and alcohol court for a period of time and highlighted the comparative improved outcomes for families, identifying the success of this service relied upon a rebalancing of the power relationships between professionals and families and a collaborative approach to problem solving. This was reflected in formal evaluations of FDAC by Lancaster University prepared for the DfE children's social care innovation programme (Harwin et al, 2016).

Children's social workers very much saw their role as being specific to the child and whilst it was not overtly expressed, attitudes reflected an overall lack of appreciation of the significance of relationship dynamics, family history and community context. This reflects the work of the Adoption Enquiry in 2016, conveying the message that parents were "unimportant in their role in children's lives and as human beings… making the development of respectful and trusting relationships with the whole family more difficult" (Gupta and Featherstone, 2018, p4). Existing research studies have highlighted the need for understanding and engaging with families and developing skill sets that avoid taking sides

and understanding the needs of each family member simultaneously (Reupert and Maybery, 2014).

Mental health workers talked about fostering a positive relationship with the service user and their family members, with the service user having overall responsibility for determining what was important for them in their endeavours to achieving this. Family members are included in planning and value is placed on them as an informal network of ongoing support. This dispersal of power, combined with an overarching view of the client as the expert demonstrates the trust, openness and respect required for effective relationship building and enhances collaboration (Hornby and Atkins 2000). Whilst existing research involving service users is limited, a study carried out by Stanley et al in 1999 included in-depth interviews with mothers with severe mental health problems. The focus of the interviews was on the women's experiences of service responses to their needs, and found that children's social workers generally did not provide the availability and listening skills required for a working relationship. In contrast, they cited mental health social workers as being most helpful and "there" for them (Stanley et al, 2003).

Mental health social workers talked about how they discussed cases with multi-disciplinary team members from different professional backgrounds as a priority to enhance their understanding of a client, demonstrating a good understanding of how each role could contribute to recovery and highlighting the benefits of combined expertise, strengths and skills. This echoes the findings of Basic in his study of successful co-operation between professional actors in the Swedish child welfare system, who states that successful collaboration relies upon a shared vision (Basic 2015). They described working relationships with co-located colleagues in multi-disciplinary teams which intimated that familiarity and accessibility were helpful to them in getting their colleagues' perspectives on the service users they were working with. These characteristics demonstrate the ingredients for joint enterprise and shared repertoire for successful collaboration as identified in Wenger's Communities of Practice (Frost, 2005). In this way it was clear that social workers in mental health services experience positive collaborative relationships with both service users and the different professionals that they are employed alongside within their co-located teams. Interestingly, in my study mental health social workers felt skilled in being able to have

challenging conversations with their service users, the relationships that they created providing a base for this.

Impact of discourses and narratives

Some of the social workers in the study recounted negative experiences when trying to work with colleagues from the other service, each reflecting an absence of at least one of the essential ingredients for collaboration. Many examples were provided by mental health social workers of poor experiences of attending child-focussed meetings, a lack of information sharing by children's social workers and a failure to communicate their decision making. Similar experiences were reported by practitioners in Webber et al (2011) in their survey of practitioner experiences of interagency work.

In my study, mental health social workers had experienced decisions being made by children's social workers in the absence of any discussion with them about the mental health and presentation of the parent. This meant that such decisions were not what they would have recommended given their knowledge of the parent. Mental health workers found children's workers made decisions around what services the parent should access, or placed expectations upon parents that were essentially unachievable, leading to an overall mistrust of the professional judgement of children's social workers. This echoes findings from a study carried out by Darlington et al (2005b), where some of the views expressed reflected experiences of children's social workers seeing themselves as experts and trying to take over. Powell (2005) in Fitzgerald and Kay (2008) argues that the developing hierarchy between professionals impacts upon the strength of each voice in the group, with some not being heard at all, leading to a failure to reach a consensus (Fitzgerald and Kay 2008). Further to this, the analysis of inter-professional communication carried out by LiPP found that all agencies were not given equal weight in child protection conference decision-making. The reasons suggested for this were that professionals from outside children's social care did not challenge decision-making and that there was a professional hierarchy in deference to social care decisions (LiPP, 2016).

Reder and Duncan argue that interagency communication would improve if professionals were to develop a 'communication mind set' (White and Featherstone, 2004). However this

study has found that there are other potentially greater forces at play. Negative experiences of working across service boundaries such as those recounted by participants, outlined above, are shared within co-located teams. Whilst individual experiences themselves influence whether professionals make further attempts to collaborate, the stories they share of experiences have a reinforcing and perpetuating effect. Generally, these perspectives are not complimentary and narratives hold negativity and blame.

A study carried out by White and Featherstone highlighted the influence of professional identity upon dominant perspectives within organisations that apportion blame and hold a moral stance that maintains their service and approach is right (White and Featherstone, 2004). Social workers are inevitably drawn to areas of specialism which resonate with them, driven by their passion for the cause. These are further sustained by the narratives within the service. They empathise with, and advocate, for their service user, acting in what they feel are their best interests. Difficulties arise when the perceived needs of one member of the family conflict with another, leading to narratives within services that reflect a conflict of interests, which polarise services rather than encourage collaborative ways of working (Weir and Douglas, 1999).

Narratives within organisations influence and dominate a way of thinking which enhances belongingness and team identity, reassures professionals that they are on the right 'side', but this in essence is exacerbating the divide between services, perpetuating and reinforcing barriers to communication. This is reflected in the work of Hardy et al, exploring the relationship between discourse and collaboration (Hardy et al, 2005). This was evident in the way that social workers in my study spoke about each other's service. Interestingly, in my study, professionals with different skills backgrounds were able to collaborate effectively when co-located within adult mental health services, suggesting that professional identities, linked to skill backgrounds and job titles, become less important when there is a team identity and joint enterprise which encourages a sense of belonging that is supported by a narrative which serves to reinforce this.

Themes emerged particularly from mental health social workers in relation to the practice of social workers for children. Mental health workers referred to children's social workers

generally making decisions without explaining their reasoning, being unpredictable and inconsistent in their work with families, and being unprepared for meetings. These views have led to a narrative reflecting a lack of trust and respect for children's social workers, elements which are critical for collaborative relationships to work (Darlington and Feeney 2008). In turn, children's social workers felt that mental health workers didn't want to damage their relationships with service users and felt that these relationships were prioritised over the sharing of information needed for making decisions in respect of children. These themes were not expressed by any of the mental health workers in my study. However, Rouf et al's (2012) study with mental health workers found that participants did express fear of damaging the therapeutic relationship and this impacted upon their assessment of risk. Maybery and Reupert's review of barriers and issues identified by mental health professionals for working with families and children found many believed the therapeutic alliance with the adult as being at risk if they addressed issues of parenting (Maybery and Reupert, 2009). Similarly, Slack and Webber (2008) explored adult mental health professionals' attitudes towards supporting service users' children and found, that whilst practitioners were in favour of supporting children, they did not feel it was their role and that it was incompatible with their therapeutic role with the parent (Slack and Webber, 2008). The focus upon an individual as the service user, whether this be the adult or the child, has been seen in this study to reinforce narratives held by each service which enhance and perpetuate their divided nature.

Policy and procedure

Despite the recommendations from Ofsted's 2013 thematic analysis "What about the Children?", there is no organised way of working together in 'Robinscar' that goes deeper than sharing information within the framework of the service, and whilst local procedures may refer to or encourage a need for collaborative practice, the absence of structure or management demand for this leaves social workers unequipped for the task. This reflects the work of Coates (2015), where participants identified silo ways of thinking with policies and procedures individual to each service, defined by their own goals and priorities.

As a profession we are bound by protocol and procedure, which we have seen reviewed following serious case reviews in attempts by successive Governments to be seen to be

making attempts to make children safer. Recommendations frequently reflect the need for updated protocols, with an overarching assumption that this will make people practice differently. Within 'Robinscar' we have procedures[6] relative to safeguarding children at risk when parents have a mental health problem, and specific criteria for considering children at greatest risk of significant harm. However, the procedural guidance is somewhat limited beyond considering the risk of significant harm and specific features to look out for when children's social workers are working with a family affected by parental mental health difficulties. The procedure manual states that children are at greatest risk when either 1) the child features in parental delusions or 2) the child becomes the focus of the parent's aggression - also reflected in RCPSYCH's advice for professionals in adult mental health services. Within the procedures manual there is a list of recommended considerations for assessing the impact of parental mental health, however, this fails to substitute for collaborative work and is prescriptive in nature which leads to a 'tick box' approach and an absence of analysing all the information known about a family.

A study by Webber et al (2011) determined that joint protocols between the two services had improved inter-agency working but that they should not be seen as a panacea for poor inter-agency collaboration. Equally important were positive interpersonal relationships between practitioners from different services and confident communication beyond their own service boundaries (Webber et al 2011).

Wellbeing

For both mental health and children's social workers, there are issues around their wellbeing which may impact upon the quality of collaborative work. Mental health workers identified not feeling 'owned' by the authority, and whilst children's social workers alluded to the improvement journey that they were on as a result of the OFSTED inspection result, it is only as a result of my own experiences within the service that I am aware of the full impact of recent service developments upon individual workers.

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[6] To preserve anonymity details are not provided

According to Glisson and Hemmelgarn (1997), organisational climate is the main predictor of positive service outcomes, with social workers feeling positive about their work and supported by their organisation being more productive with regard to the objectives of the organisation. Further to this, they found that social workers who felt valued by their employers have greater success with regard to what the organisation was trying to achieve, resulting in improved experiences and outcomes for service users (Glisson and Hemmelgarn, 1997). It would make sense then, for social workers from both services to experience more positive working environments, with the local authority taking responsibility for the wellbeing of the staff they employ.

Suggestions for overcoming barriers in order to improve mutual engagement, shared repertoire and joint enterprise

There were three broad areas where social workers identified a need for improvement in order to enhance cross boundary collaboration. An improved understanding of each other's services, roles, responsibilities and procedures was identified by all, with some workers identifying that the other service was a complete unknown to them. It was felt that some increased familiarity and face-to-face contact with colleagues from the other service would be helpful, with a focus upon social work values for mental health social workers within their everyday practice.

All three areas will be enhanced by improving the relationship between professionals and families. Relationships are critical and this has already been recognised in 'Robinscar' and restorative practice is currently being taught, exemplified and encouraged in children's social care. Whilst children's social workers initially related collaboration as being with professionals, the restorative model is being introduced with a focus upon improving relationships with families.

Although the restorative approach is welcomed as potentially underpinning some of the principles of collaborative practice, there needs to be an acknowledgement that "culture eats strategy for breakfast" (Gartman et al, 2018) and that the overarching narratives and discourses need to reflect more positive experiences of working across organisational boundaries. We need to find some way of increasing trust between professionals from

mental health and children's services, and making positive experiences of collaboration more frequent. We need to increase joined up work, make it normal practice and have this reflected as a priority in the day to day work of social workers, supported by managers.

We need to work towards having a joint enterprise, where agreed analysis and hypothesis will include discussions around risk and ascertain an agreed level of risk which can then be addressed in a shared way. This can lead to joint plans where everyone understands their role within this – resulting in power being equalised, everyone working to the same end, and ultimately having better outcomes for families.

Conclusion

My interest lies in how, as an authority, we can draw upon what this study has found, supported by contemporary research and other relevant knowledge sources, in order to influence collaborative practice and complement the improvement journey in children's services. Specialist services are certainly the current method of delivery, with their associated frameworks and procedures. Reassuringly, there is a developing awareness of the problems that exist in spanning the boundaries between these services, with varied attempts, both nationally and internationally, at finding ways to bridge them. As I have explored, one way of bridging the gap is to improve collaboration between the specialisms, and with the understanding that we now have in 'Robinscar', we are better equipped to support practitioners with this.

Many of the features required for successful collaboration are lacking between adult mental health services and children's social care in 'Robinscar'. Narratives need to be more positive with regard to the way that each service speaks about the other, and as these are perpetuated by poor experiences of collaboration, more positive experiences need to be encouraged and disseminated. This means finding ways of improving mutual engagement, joint enterprise and shared repertoire. Opportunities need to be increased for improving trust and professional respect which can be enhanced by increasing familiarity between workers and opportunities for informal communication and interaction. Key to the process needs to be an improved understanding of each other, the services, roles and responsibilities.

Contribution to existing knowledge

Findings from this study have enabled a deeper understanding of how two specific services in 'Robinscar' collaborate with each other. As a result, my team are able to respond to these barriers and positively influence the way that services are able to work together and with adults and children for the ultimate benefit of families in our local communities. This benefits the services we work between in saving time and money by making improvements from the inside (Costley et al, 2010, p4).

This study demonstrates that in order for collaborative practices to be enhanced, barriers need to be understood in the context of local organisations. Whilst there are commonalities between cultures in similar organisations, the influence of the current context of those organisations and how it feels for individual workers to work there has a significant impact upon practice.

We are fortunate as a local authority to be in a period of improvement and have employed an overarching approach that ultimately embeds collaborative practice, making the findings from this study all the more relevant and practical in real terms. The readiness for change and improvement within 'Robinscar' means that practice can be influenced positively, using the proven principles of successful collaboration for our own work as a team and to encourage in the practice of those we are working alongside.

The intention is to embed improved collaborative approaches and practice between the two services based on my enhanced understanding of where each service and individual practitioners are 'at'. We can now be guided by what is required by professionals in order to enhance the support that they provide to the families they are working with.

This study has enhanced understanding of how each organisation's culture and narratives impact upon individual's approach to their work and the extent to which they recognise the need for establishing collaborative partnerships aside from the superficiality of information sharing, and the need for deeper understanding of each other's services in order to develop a shared, agreed way of working with families.

The issues are clearly complex, with many factors which need to be addressed concurrently. The complexity of the issue, the size of the organisations and the ongoing barriers means that there is a need for negotiating the interface to support all the above, by people who recognise and understand the services and are able to work to enhance collaboration across the service boundaries.

<center>**Recommendations**</center>

I have combined the findings from this study with existing research into improving mutual engagement, joint enterprise and shared repertoire to make recommendations which have been separated into areas of responsibility. It makes clear the value of the Mental Health in Families team as a boundary spanning team, able to support the interface between the services and concentrate on increasing mutual engagement, joint enterprise and shared repertoire.

As we have seen, whilst a collaborative approach is very much down to the individual and their motivation, people are also influenced by their individual organisational cultures. In order for front line staff to be open to working in a more collaborative way, the organisational fabric of each service needs to support collaboration and there needs to be working relationships at all levels of the service, reflected in their everyday priorities. Professionals from both services, from front line through to strategic management, need to embrace an ethos of collaboration outside their own service boundaries. In addition to this, relationships between colleagues across service boundaries need to be supported on an individual case-by-case level.

Within the restorative approach that has been adopted by children's social care, there is a focus on understanding of the family unit as a whole, on relationship building and taking the time to understand from the point of view of the service users. However, in order to implement this approach fully, social workers need to work towards reducing the power dynamics that families recognise and expect. The elements identified earlier in this study that are necessary for relationship building and creating mutual engagement need attention. These restorative principles then need fully transferring into collaboration with professional both inside and outside their own service boundaries.

Recommendations for the Local Authority as an organisation

-        For those social workers employed to work in adult mental health services, a demonstration of support and ownership. This should include access for social workers to all resources used by other council employees, including IT equipment, e-learning

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opportunities and classroom based training as well as access to local authority intranet. Further to this, a recognised point of contact for social workers to access any additional support required from the local authority in a straightforward, efficient way.

- Students and newly qualified social workers to be encouraged to experience social work in other services and from other perspectives.

- Children's and adults' services to work towards a shared repertoire of keeping families safe and building resilience.

- Supervision as a reflective space – for allowing social workers to explore their visceral experiences and how these shape their hypotheses, this being essential for collaborating with children, parents and professionals effectively

Children's social care:

- Social workers' focus upon sharing information to shift to understanding and analysis of information, what they still need to know in order to challenge their own hypotheses. Use frequent discussions with mental health workers to explore what they know and their understanding of the information they have, try to reach agreement with regard to their analysis and hypothesis to ascertain the level of risk and how best to address this.

- Managers to recognise the value of collaboration with families and professionals in casework, understand that this reflects restorative practice principles and enhances the analyses and hypotheses required for assessment and planning with families and encourage collaborative practice from social workers in their casework

Mental Health social workers:

- Engage with children's social workers to discuss families, consider circumstances and share information with children's workers regarding the presentation of the parent they are working with, their day to day functioning and how best to engage with them. Discuss what this means for the child, clarify risk and agreed how this needs to be addressed. Make use of consultations with Mental Health in Families team for this.

- To make efforts to maintain their value base as social workers and seek opportunities for this – the social work supervision groups being an ideal forum.

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Mental Health in Families team

As agents for change in our boundary spanning position, our commitment to bridging the gap and improving collaboration will continue. With an improved understanding of the barriers to collaboration in our area, through this study, we will adapt the way that we respond to the needs of practitioners in both services. We will endeavour to:

- Remain co-located as required on a mobile and agile basis with all teams across children's and adult mental health services

- Improve narratives within each service by challenging negative discourses, while also acknowledging negative experiences of working together and addressing these appropriately in order to avoid future repetition

- Be available for face-to-face case consultation with professionals from both children's and adult services. Case consultations to be reflective, share and explore information regarding the impact of parental mental health to encourage analysis and accurately identify levels of risk

- Encourage and, where needed, facilitate discussions between professionals in order for information to be fully shared and understood for assessments and planning to be as joined up as possible, encouraging a shared vision based on a thorough analysis of family circumstances involving families

- Use workshops with workers from children's services to improve understanding of mental health services based on what they feel they need as well as what the team see is required. This will include responsibilities, legal frameworks, roles, diagnoses

- Challenge myths, stereotypes and assumptions with regard to both children's social work and mental health to improve perspectives and understanding and reduce stigma within each service

- Ongoing training for the local safeguarding children's board on the impact of parental mental health to enhance learning and understanding with colleagues from across all services supporting families in 'Robinscar'

Recommendations for future research

- Evaluation of effectiveness of MHIF team in terms of improving collaboration between mental health and children's services in 'Robinscar'

- Similar exploration of collaborative work within other local authorities to identify local barriers to mutual engagement, joint enterprise and shared repertoire

- Larger study comparing social work approaches from different backgrounds

Limitations

The small sample size was determined by the amount of time and resource I was able to commit, given that the study was carried out on a part time basis alongside my usual work role and had a limited word count. As this is a small study, caution is required in extrapolating from it. Whilst it offers a snapshot of front line practice, further study would be required in order to test out the findings.

Whilst there was an equal number of social workers from each service, representativeness of the whole service cannot be assumed. In addition, due to the constraints of ethical requirements, my study only explored the perspectives of social workers and therefore does not take account of other professionals within the multi-disciplinary teams. This means it is not generalizable to reflect the perspectives of the mental health service as a whole.

While this was a small study and should be seen as exploratory, the key themes that emerged are reflected in the literature. Whilst findings are directly relevant to 'Robinscar' they are not generalizable to other areas or services, although future comparatives may be interesting in terms of gathering themes (Costley et al 2010 p3).

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