



**PROMOTING MENTAL HEALTH AND PSYCHOLOGICAL
WELLBEING IN CHILDREN: A SOCIO-CULTURAL ACTIVITY
THEORY ANALYSIS OF PROFESSIONAL CONTRIBUTIONS AND
LEARNING IN A MULTIDISCIPLINARY TEAM.**

By

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ABSTRACT

This research explores professional contributions and learning in a multidisciplinary team whose purpose is to promote mental health and psychological well being in children within family and community settings. It brings together three current priorities of policy and practice, namely, promoting mental health and psychological wellbeing in children and young people, multidisciplinary teamwork, and professional learning and development. The study examined a multidisciplinary child behaviour team of educational psychologists, family support workers and primary mental health workers working within a culturally diverse urban community. Activity theory was used as a theoretical framework and methodology to examine the sociocultural processes involved in multidisciplinary work. Individual interviews, focus group discussion and developmental work research were employed to identify and compare activity systems, and to surface and then work on contradictions. The exploratory findings arising from the analysis of the activity systems are discussed against the cultural and historical background of professional and multidisciplinary work. The implications for professional practice, multidisciplinary work and future research are also considered. Conclusions drawn emphasise the complex multilayered nature of professionals' work within multidisciplinary teams and the value of sociocultural activity theory as a method for analysing work and promoting learning in multidisciplinary teams.

DEDICATION

I would like to dedicate this thesis to my late parents, Bernard and Julia Elizabeth Durbin (nee Jones), both of who believed in the value of education and inspired me to pursue a lifelong quest for learning and research.

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TABLE OF CONTENTS

List of figures and illustrations

List of tables

List of appendices

Glossary

PAGE

1. CHAPTER 1 INTRODUCTION

1

1.1. Introduction to thesis

1

1.2. Personal and professional interest

1

1.3. Background and rationale for study

4

1.4. Definition of terms

6

1.4.1. Mental health and psychological wellbeing

6

1.4.2. Multidisciplinary team

7

1.4.3. Professional learning

8

1.5. Contribution to knowledge

9

1.6. Research aims

10

1.7. Principal research questions

10

1.8. Overview of chapter

11

2. CHAPTER 2 LITERATURE REVIEW

12

2.1. Scope of literature review

12

2.2. Literature search strategy

12

2.3. Mental health & psychological wellbeing.

14

2.3.1. What is mental health and psychological wellbeing?

14

2.3.2. Evidence of increased mental health need

17

2.3.3. What is comprehensive CAMHS provision?

18

2.3.4. Paradigms in mental health

19

2.3.4.1. The medical model

19

2.3.4.2. The psychosocial model

21

2.3.4.3. The social model

22

2.3.5. Child mental health: The socio-political and policy context

23

2.3.6. Mental health promotion and prevention

26

2.3.7. Psychological wellbeing in children & young people

27

2.3.8. Evidence-based interventions and practice

29

2.3.9. Values-based practice

30

2.3.10. Summary of section

32

2.4. Professional roles and contributions	34
2.4.1. Family support worker	34
2.4.2. Primary mental health worker	38
2.4.3. Educational psychologist	43
2.4.3.1. Educational psychologists' role in child mental health	43
2.4.3.2. EPs as mental health practitioners	44
2.4.3.3. EPs as therapists	45
2.4.3.4. EPs as consultants	46
2.4.3.5. EPs as community psychologists	47
2.4.3.6. EPs as child psychologists	47
2.4.4. Summary of section	49
2.5. Multidisciplinary teams and professional learning	50
2.5.1. Introduction	50
2.5.2. Multidisciplinary teams in children's services	50
2.5.3. Professional learning and practice	55
2.5.4. Professional learning in multidisciplinary teams	58
2.5.5. Summary of section	63
2.6. Overview of literature review	64
3. CHAPTER 3 RESEARCH DESIGN AND METHODOLOGY	65
3.1. Introduction and overview of chapter	65
3.2. Rationale for research design	65
3.3. Research aims and rationale	67
3.4. Research questions	68
3.4.1. Principal research questions	68
3.4.2. Subsidiary exploratory questions	69
3.5. Methodological and design considerations	70
3.5.1. Introduction	70
3.5.2. Methodological considerations	70
3.5.3. Principal paradigms in human research	71
3.5.3.1. Positivism versus relativism	71
3.5.3.2. Pragmatic paradigm	72
3.5.3.3. Transformative paradigm	73
3.5.4. Research Methodology	74
3.5.4.1. Action research	74
3.5.4.2. Co-operative Inquiry	76
3.5.4.3. Sociocultural activity theory	77
3.5.5. Other design considerations	79
3.5.5.1. Fixed versus flexible design	79
3.5.5.2. Qualitative versus quantitative	80
3.5.5.3. Single or multiple case study design	80
3.5.5.4. Evaluative, exploratory and transformative research	81
3.5.6. Summary of section	82

3.5.7. Sociocultural activity theory	83
3.5.7.1. Theoretical underpinnings	89
3.5.7.2. First generation activity theory	91
3.5.7.3. Second generation activity theory	92
3.5.7.4. Third generation activity theory	93
3.5.8. What is expansive learning?	94
3.5.8.1. The expansive learning cycle	95
3.5.8.2. Expansive learning and contradictions	96
3.5.8.3. How is expansive learning identified?	97
3.5.8.4. Expansive learning theory and intervention research	98
3.5.9. Criticisms and potential limitations of activity theory	100
3.5.10 Strengths of the activity theoretical approach	101
3.5.11 Development of the theory and its methods	102
3.5.12 Applications of activity theory in work settings	104
3.5.13 Summary of section	104
3.6. Research methods	106
3.6.1. Introduction and overview of chapter	106
3.6.2. Interviews as a sociocultural process	106
3.6.2.1. Advantages and disadvantages of interviews	107
3.6.2.2. Types of interview	108
3.6.3. Focus group discussion	112
3.6.4. Developmental work research	113
3.6.5. Double or dual stimulation	116
3.6.6. Double stimulation as an intervention	117
3.6.7. Summary of section	119
3.7. Methods of data analysis	120
3.7.1. Qualitative data analysis	120
3.7.2. Thematic analysis	124
3.8. Research context	127
3.8.1. Selecting a research site	127
3.8.2. Research sample	127
3.8.3. Research context	128
3.8.4. Multidisciplinary team history	129
3.8.5. Current multidisciplinary workforce and practice	131
3.8.6. Work and culture of team	135
3.8.7. Obtaining informed consent	137
3.8.8. Limitations of the study	137
3.9. Ethical and practical considerations	139
3.9.1. Informed consent	139
3.9.2. Maintaining confidentiality	139
3.9.3. Data ownership and accessibility	140
3.9.4. Terms of involvement and right of withdrawal	140
3.9.5. Status relationship	140

3.10.	The Research process and procedure	142
3.10.1.	The phases of research	142
3.10.2.	Phase one - negotiating an entry	142
3.10.3.	Phase two - interviewing individual service members	145
3.10.4.	Phase three - feedback to professions and team	152
3.10.4.1.	Developmental work research	152
3.10.4.2.	Records of the DWR	153
3.10.4	Phase four - Detailed thematic analysis	159
3.11	Addressing threats to credibility	163
3.11.1	Credibility of research	163
3.11.2	Transferability	166
3.11.3	Dependability and confirmability	167
3.11.4	Authenticity	168
3.11.5	Other considerations	168
3.11.6	Summary of section	170
4	CHAPTER 4 RESEARCH FINDINGS	172
4.1	Introduction an overview of chapter	172
4.2	Educational psychology findings	172
4.2.1	Subjects	172
4.2.2	Objects	173
4.2.3	Outcomes	173
4.2.4	Community	176
4.2.5	Rules	178
4.2.6	Division of labour	180
4.2.7	Tools	182
4.2.8	Contradictions	188
4.3	Primary mental health worker findings	194
4.3.1	Subjects	194
4.3.2	Objects	194
4.3.3	Rules	195
4.3.4	Outcomes	197
4.3.5	Community	201
4.3.6	Division of labour	202
4.3.7	Tools	203
4.3.8	Contradictions	205
4.4	Family support worker findings	210
4.4.1	Subjects	210
4.4.2	Objects	212
4.4.3	Outcomes	212
4.4.4	Rules	214
4.4.5	Community	218
4.4.6	Division of labour	218
4.4.7	Tools	221
4.4.8	Contradictions	222

4.5 Multidisciplinary team findings	228
4.5.1 Subjects	228
4.5.2 Objects	231
4.5.3 Outcomes	234
4.5.4 Tools	236
4.5.5 Rules	240
4.5.6 Community	242
4.5.7 Division of labour	244
4.5.8 Contradictions	247
4.6 Professional learning findings	254
4.6.1 Individual professional activity systems	254
4.6.1.1 What learning took place?	254
4.6.1.2 How was learning supported?	255
4.6.2 Professional group activity systems	258
4.6.2.1 PMHW group	259
4.6.2.2 FSW group	260
4.6.2.3 EP group	263
4.6.3 Multidisciplinary team activity system	264
4.6.3.1 Use of double stimulation with team	268
4.6.4 Small group work on team's objects and activity systems	272
4.6.4.1 Direct work.	273
4.6.4.2 Training	274
4.6.4.3 Team processes	275
4.6.5 Overview of developmental work research session	276
4.6.5.1 Team member's evaluative comments on the DWR	277
4.6.6 Summary of section	278
5 CHAPTER 5 DISCUSSION	283
5.1 Introduction to chapter	283
5.2 Educational psychologists' contribution	283
5.2.1 Outcomes	283
5.2.2 Rules	287
5.2.3 Tools	290
5.2.4 Contradictions	293
5.3 Primary mental health worker contributions	295
5.3.1 Outcomes	295
5.3.2 Rules	297
5.3.3 Tools	298
5.3.4 Contradictions	299
5.4 Family support worker contribution	303
5.4.1 Outcomes	303
5.4.2 Rules	304
5.4.3 Tools	305
5.4.4 Contradictions	307

5.5 Multidisciplinary team contribution	309
5.5.1 Outcomes	309
5.5.2 Rules	312
5.5.3 Tools	315
5.5.4 Contradictions	319
5.6 Professional Learning within multidisciplinary teams	324
5.6.1 Professional learning within individual interviews	324
5.6.2 Professional Learning in developmental work research	326
5.6.3 Evidence of expansive learning activity	329
5.6.3.1 Socio-spatial dimension	330
5.6.3.2 Anticipatory-temporal dimension	331
5.6.3.3 Moral-ideological dimension	332
5.6.3.4 Systemic-developmental dimension	333
5.6.4 Summary of section	334
5.7 Methodological considerations and learning	335
5.7.1 SCAT research: A mediated process	335
5.7.2 SCAT as an intervention	337
5.7.3 SCAT: A multilevel and multilayered approach	338
5.7.4 SCAT: A holistic and detailed approach	339
5.7.5 SCAT: A collaborative or contradictory process	341
5.8 Overview of chapter	342
6 CHAPTER 6 CONCLUSIONS	343
6.1 Overview of chapter	343
6.2 Summary of main findings	343
6.3 EP contributions	343
6.4 PMHW contributions	345
6.5 FSW contributions	347
6.6 Professional learning	349
6.7 Methodological learning	350
6.8 Multidisciplinary team contribution	352
6.9 Overview of research's contribution to knowledge	354
REFERENCES	356
APPENDICES	371

LIST OF APPENDICES.	PAGE
APPENDIX 1i. Research briefing	371
1ii. Activity triangle	375
1iii. Participant consent form	376
APPENDIX 2 Team business plan	377
APPENDIX 3 Interview transcript extract	389
APPENDIX 4 Extract from the researcher's diary	390
APPENDIX 5i. Letter accompanying e-mail feedback	391
5ii. An example e-mail response	392
5iii. Researcher's log after DWR	392
APPENDIX 6i. Professional group record form	393
6ii. Whole team activity discussion record form	394
6iii. MDT Group 2 feedback on activity system	395
6iv. EP Group feedback on activity system	396
6v. Developmental work research record	398
APPENDIX 7i. Thematic grid of comments on activity system	406
7ii. Thematic analysis of comments within DWR	411
7iii. Thematic grid of e-mail responses	414
APPENDIX 8 FSW individual activity triangles	416
8i. Senior FSW	417
8ii. FSW	418
8iii. Team Manager (FSW)	419
8iv. FSW	420
8v. FSW	421
8vi. FSW	422
8vii. FSW	423
8viii. Senior FSW	424
8ix. FSW	425
8x. Senior FSW	426
8xi. FSW	427
APPENDIX 9 PMHW Individual activity triangles	428
9i. PMHW	429
9ii. PMHW	430
9iii. SPMHW	431
9iv. Temp PMHW	432
APPENDIX 10 EP individual activity triangles	433
10i. EP	434
10ii. Senior EP	435

10iii. EP	436
10iv Principal EP	437
10v Assistant EP	438
10vi EP	439
10vii EP	440
10viii Senior EP	441
APPENDIX 11 Support staff activity triangles	442
11i. Service Office Manager	443
11ii. Support Officer	444
APPENDIX 12 PMHW group thematic grids	445
12i. Subjects	445
12ii Objects	445
12iii Community	447
12iv Division of labour	446
12v Rules	447
12vi Tools	448
12vii Outcomes	450
12viii Contradictions	451
APPENDIX 13 EP professional group thematic grids	452
13i. Subjects	452
13ii. Objects	452
13iii. Community	453
13iv. Division of Labour	454
13v Rules	457
13vi Outcomes	459
13vii Tools	461
13viii Contradictions	464
APPENDIX 14 FSW group thematic grids	467
14i. Subjects	467
14ii. Objects	467
14iii. Community	468
14iv. Division of labour	469
14v. Rules	472
14vi. Outcomes	474
14vii Tools	476
14viii Contradictions	480

LIST OF FIGURES OR ILLUSTRATIONS

FIGURE	PAGE
2.1 PMHW model of service delivery from Gale & Vostanis(2003)	40
3.1 Engestrom's (1987) second generation activity theory	87
3.2 Model of first generation activity theory	91
3.3 Model of second generation activity theory	92
3.4 Third generation activity theory model (Engestrom, 1999b)	93
3.5 Cycle of expansive learning (after Engestrom, 1999b)	95
3.6 Activity theory triangle framework with interview questions	146
3.7 An example of an individual family support worker triangle generated from an individual interview	148
3.8 An Example of the Primary Mental Health Worker Triangle generated in the DWR in phase 3	156
3.9 Photograph of the data display used in phase 3 prior to coding and identification of themes.	159
3.10 An example of a thematic map display	160:
4.1 Initial activity theory analysis of the educational psychology group activity system	174
4.2 Thematic map of EP outcomes	175
4.3 An example of the outcomes identified by an EP whose object was transition group work with children in Year 6	176
4.5 Thematic map of EP rules	179
4.6 An example of the rules that an EP identified as supporting and constraining their casework with a child and family.	180
4.7 An example of the division of labour within an activity system of an EP undertaking casework	181
4.8 Thematic map of EP tools	183
4.9 An example of tools used by an EP in an activity whose object was contributing to the development and delivery of mental health training.	184
4.10 An activity triangle illustrating the work of an EP in support of child	186
4.11 Thematic map of EP contradictions	188
4.12 Detailed thematic analysis of EP group activity system	190
4.13 Thematic map of PMHW rules	195
4.14 Example of the Rules identified within the activity triangle of a Senior PMHW whose object was to participate in a multiagency case allocation meeting.	196
4.15 Thematic map of PMHW outcomes	197
4.16 An example of the outcomes sought by a SPMHW attending a case allocation meeting	198
4.17 The activity system of a PMHW in case allocation meeting	199
4.18 Initial thematic analysis of PMHW group activity system	200
4.19 An extract from a PMHW triangle showing how labour was divided in an activity whose object was to allocate case to an appropriate professional.	203

4.20	Thematic map of PMHW tools	204
4.21	Thematic Map of PMHW contradictions	205
4.22	Detailed thematic analyses of Primary Mental Health Worker activity system	209
4.23	Initial thematic analysis of FSW activity system	211
4.24	Thematic map of FSW outcomes	213
4.25	An example extract showing the identified outcomes of a FSW whose object was the provision of a first response visit to a family in need.	213
4.26	Thematic map of FSW rules	214
4.27	An example extract of the rules of a FSW whose object was the delivery of a multiagency mental health training	215
4.28	An example activity theory analysis of a FSW activity system	216
4.29	An example of an analysis of senior FSW activity system	217
4.30	An example extract of the division of labour from a FSW activity triangle whose object was working with the family of a 5-year-old boy with behavioural problems	220
4.31	Thematic map of FSW tools	221
4.32	Thematic map of FSW contradictions	223
4.33	A detailed thematic analyses of FSW group activity system	226
4.34	Initial activity theory analysis of Multidisciplinary team activity system	227
4.35	Thematic map of the MDT outcomes	234
4.36	Thematic map of MDT tools	237
4.37	Thematic map of MDT rules	240
4.38	Detailed Activity Theory Analysis of the Multidisciplinary Team Activity System	246
4.39	Thematic map of the MDT contradictions	247
4.40	Thematic Analysis of the professional learning coming from Activity Theory Analysis of individual professional's work	256
4.41	An illustration of Stimulus material and responses mediated by dual stimulation using activity theory model	268
4.42	Mirror data 2 - Direct work	270
4.43	Mirror data 3 - Indirect work	271
4.44	Thematic map of evaluative comments given in the DWR	277
4.45	An activity theory analysis of team's training activity system	280
4.46	An activity theory analysis of fortnightly team meetings	281
4.47	An activity theory analysis of the team's direct casework	282
5.1	Thematic map of MDT outcomes or object motives	309
5.2	Thematic map of MDT rules	312
5.3	Thematic map of MDT tools	315
5.4	Thematic map of the MDT contractions	319
5.5	Thematic map of professional learning in Phase 1	324
5.6	Thematic map of professional learning in developmental work research	327

LIST OF TABLES

TABLE	PAGE
2.1 Thematic Analysis of PMHW work from Bradley et al (2009)	43
3.1 Kvale's interview stages linked to the approach used in study	110
3.2 Stages of interview process by Robson (2002) linked to research	111
3.3 Levels of data collection, analysis and display used in research to aid data analysis and interpretation.	122
3.4 Data analysis methods recommended by Miles & Huberman (1994) linked to those used in this study	124
3.5 Ethnic backgrounds of team members from service plan	131
3.6 Team activities with percentage targets from service plan	133
3.7 A summary of the phases of research in this study	143
3.8 A matrix illustrating the thematic analysis of rules and the linked data extracts taken from the individual sociocultural activity theory triangle interviews	161
3.9 A thematic matrix linking each professional group outcome theme to the multidisciplinary team outcomes.	163
3.10 Timeline for research	165
4.2 A table to show the frequency of community links mentioned by EPs	177
4.3 A table to show the frequency of community links mentioned by PMHWs.	201
4.4 A table to show the frequency of community links mentioned by FSWs.	218
4.5 Table showing subjects by professional role and group	229
4.6a Table showing the type and number of individual objects identified by the team	230
4.6b Frequency of objects chosen by each professional group and the multidisciplinary team.	234
4.7 A table to show the outcomes themes for the overall multidisciplinary team with linked professional group themes	235
4.8 A table to show the tool themes for multidisciplinary team and professional group	239
4.9 A table to show the Rule Themes for the MDT and Professional Groups	241
4.10 A table to show the percentage of community links mentioned by each professional group during individual activity theory interviews	242
4.11 A table to show the division of labour themes for the multidisciplinary team with the linked themes for each professional group.	245
4.12 A table to show the contradiction themes for the multidisciplinary team and professional group.	253
4.13 Excerpt from Individual interview illustrating professional Learning	256

4.14	Table to show a summary of PMHW responses to focus group discussion of activity theory analysis during Development Work Research	259
4.15	Record of FSW group discussion of the Initial Analysis of FSW Activity System	262
4.16	Multidisciplinary group discussion of the MDT activity system	266

GLOSSARY OF TERMS

AEP	Assistant Educational Psychologist
APA	American Psychiatric Association
BST	Behaviour Support Teacher
CAMHS	Child and Adolescent Mental Health Service
CAM	Case Allocation Meeting
CHAT	Cultural Historical Activity Theory
CORC	CAMHS Outcome Research Consortium
CP	Clinical Psychologist
DCSF	Department for Children, Schools and Families
DfES	Department for Education and Skills
DOH	Department of Health
DSM	Diagnostic and Statistical Manual
DWR	Developmental Work Research
EBPU	Evidence-Based Practice Unit
ECM	Every Child Matters
EP	Educational Psychologist
ERIC	Education Research International Citation
FSW	Family Support Worker
HAS	Health Advisory Service
IALS	Information and Advice Line
LD	Learning Difficulty
MDT	Multidisciplinary Team
MHF	Mental Health Foundation
NSF	National Services Framework

ONS	Office of National Statistics
PEP	Principal Educational Psychologist
PMHW	Primary Mental Health Worker
SCAT	Sociocultural Activity Theory
SEAL	Social and Emotional Aspects of Learning
SEN	Special Educational Needs
SENCO	Special Educational Needs Co-ordinator
SPEP	Senior Practitioner Educational Psychologist
SEP	Senior Educational Psychologist
SFBT	Solution Focused Brief Therapy
SFSW	Senior Family Support Worker
SPMHW	Senior Primary Mental Health Worker
TA	Thematic Analysis
TAMHS	Targeted Mental Health Services
VBP	Values-Based Practice
WHO	World Health Organisation
ZPD	Zone of Proximal Development

CHAPTER 1 INTRODUCTION

1.1. Introduction to thesis

This thesis will explore the sociocultural aspects of multidisciplinary work in support of mental health and psychological wellbeing in children and young people. In doing so, it will consider three current priorities of policy and practice at national, regional and local government level. These are:

- to promote positive mental health and psychological wellbeing in children and young people and prevent increases in child mental health problems;
- to develop multidisciplinary team working and integrated policies, processes and practices; and
- to support the development and learning of the children's workforce.

Using sociocultural activity theory (SCAT, Engestrom, 1987) the research aims to explicate the sociocultural factors within an activity system whose object is to work collaboratively across disciplines to promote positive mental health and psychological wellbeing. The research draws from, and builds on, previously submitted assignments on a sociocultural analysis of educational psychologists' work on school improvement (Durbin, 2007), and an examination of educational psychologists' contribution to promoting mental health and wellbeing in children and young people in schools (Durbin, 2008).

1.2. Personal and professional interest

Like many parents, I have a personal interest in doing all I can to support and prepare my own children to cope with life in the 21st century, to deal with life's

'ups and downs' and maintain good health including mental health and psychological wellbeing. As a teacher, I was also concerned to ensure that those children for whom I had responsibility developed positive relationships with each other and a sense of self-confidence and enthusiasm for learning. I was also keen to know what I might do to engender this, and to ensure the teaching approaches I used had a positive impact on children and their sense of wellbeing in my class. As a psychologist, my interest has been in understanding how to promote mental health and psychological wellbeing in children and young people in schools. I was struck by how children's psychological wellbeing and mental health outcomes could be heavily influenced by the different schools and family contexts. This led to an interest in the systemic influences on psychological wellbeing and mental health and to an understanding of the factors that supported positive outcomes for children.

In recent years, working in both specialist and managerial roles, I experienced working within and managing multidisciplinary teams who supported some of the most vulnerable young people and families in the community. This provided me with some insight into the challenges of multidisciplinary work and the value that collaborative working can bring. In addition, I was a member of the local child adolescent mental health services (CAMHS) partnership board whose responsibility it was to develop the local CAMHS strategy. This meant I had an understanding of the influence that strategic planning had on CAMHS service development and delivery. I was able to use this position to work with others to develop a more co-ordinated, cohesive and

comprehensive CAMHS within our local area. It led me to propose, develop and ultimately manage a multidisciplinary mental health team whose role was to fill a gap in service provision that had been identified as part of a consultation on the local CAMHS strategy with schools and other users. I subsequently became involved in establishing the joint commissioning, governance, development, management, and delivery of the service. This enhanced my interest in understanding the contribution that different professions make within a multidisciplinary team to the promotion of psychological wellbeing and mental health in children and young people.

It can be seen from this short biography, that my interest in both the topic and methodology of this research has been mediated by a number of different artefacts and communities I have worked with during with my professional past. My initial reason for pursuing doctoral study was in trying to understand how different school cultures influence outcomes for children and young people. I was also interested to explore the influence of teacher culture (see Miller, 2003) and how the attributions made by teachers, parents and other professionals influence the outcomes for children (e.g. Miller, 1999).

However, my recent work and experiences have enabled these ideas to evolve into an interest in understanding how team and professional cultures develop and work to support the mental health and psychological wellbeing of children and young people. I am interested to explore what different disciplines contribute and how they work and learn together to effect positive outcomes for children and young people.

1.3. Background and rationale for study

Child mental health and psychological wellbeing has been of concern and a national priority for well over a decade (see Health Advisory Service, 1995). In recent years it has become the focus of great concern because of the apparent increases in child mental health problems, with figures cited as high as 1 in 10 children reported to be experiencing mental health problems (Office of National Statistics, 2005). Alongside this, is the United Kingdom's relatively poor performance in promoting children's psychological wellbeing in comparison with other countries (Children's Society, 2008). This has created a political imperative for action to be taken in an attempt to ease these problems.

One aspect of government action has been to seek new ways to organise and deliver integrated services to ensure that they improved outcomes for children and young people. The process of the reform of local authority services, bringing together services for children, was initiated by the Every Child Matters (ECM) Green Paper (Department for Education and Skills (DfES), 2004) and subsequently legislated for within The Children Act (2007). ECM's work aimed at improving outcomes for children was paralleled by the development of the National Services Framework (NSF) for Children, Young People and Maternity Services (Department of Health/DfES, 2004). Standard nine of the framework offered standards of practice for child and adolescent mental health services including benchmark performance indicators and

models of good practice. This, in effect, created a blueprint with which the performance and effectiveness of CAMH services could be evaluated.

However, despite the increased priority and additional investment given by national, regional and local government, improvements in child mental health and psychological wellbeing have proved difficult to achieve. As a consequence, the government initiated an independent review of Child and Adolescent Mental Health Services (CAMHS Review, 2008). The review examined the services whose purpose was to improve the mental health and psychological wellbeing of children and young people and made recommendations as to how these might be improved.

How professionals and services are organised and work together within multidisciplinary teams and comprehensive CAMHS is of key importance to meeting the perceived increases in mental health need and managing the demand for advice, support and provision. The recent CAMHS Review (2008) suggests that the delivery of comprehensive CAMHS, where every professional knows the extent and limits of their role, and how to access appropriate support and services for children and young people, remains a largely unfulfilled vision in many areas. The entire children's workforce is encouraged both to acknowledge their contribution to promoting psychological wellbeing and mental health of children and young people and to see children and young people's mental health as being 'everybody's business.' (CAMHS Review, 2008). This has led different disciplines, such as educational psychologists (see Farrell et al, 2006) to review the contribution they make to

outcomes for children and to consider how their contribution is distinctive and/or complements the work of other professionals.

In addition, some local authorities have attempted to draw professionals together combining the knowledge and skills of different disciplines within multidisciplinary teams in order to support joint working and co-ordinated services aimed at promoting child mental health and psychological wellbeing (see for example Warrington BC, 2006 and Northants, 2007). The proposed research therefore aims to examine the work of one of these multidisciplinary teams in a local authority and to explore the sociocultural influences on the work and practice of individuals and groups of professionals within that team.

1.4. Definition of terms

Having outlined the background to my study and the reasons for my interest in the present study, it is important to define at an early stage some key terms used within the title of my thesis. i.e. mental health and psychological wellbeing, multidisciplinary team, professional learning and sociocultural activity theory.

1.4.1. Mental health and psychological wellbeing

It should be acknowledged from the outset that mental health and psychological wellbeing are both evolving and contested terms. The professional culture from which a term emanates heavily influences its definition and use. Weare (2002) suggested the multiplicity of terms and language used to describe mental health by different professionals and

agencies creates a barrier to joint working in itself. As a consequence, many of the terms used to describe mental health and psychological wellbeing mean different things to different professionals (Weare, 2002) which can hinder collaboration between professionals within CAMHS.

For the purposes of this study, mental health is considered to be on a continuum, with 'good' mental health at one end and severe mental illness at the other (Dogra et al, 2002). Mental health is used in this thesis in its positive sense. It is considered to be a state of psychological wellbeing supported by effective interpersonal and social relationships, and context-appropriate behaviour, cognition and emotion that enable a person to respond appropriately to the demands of their environment and culture (see Health Advisory Service, 1995). The term psychological wellbeing is used to describe the intra-personal state, which both generates and is generated by good mental health and interpersonal relationships (see Mental Health Foundation, 1999). It suggests that a person's behaviour, cognition, emotions and social interactions are all congruent and in line with what might be expected for their age, experience and circumstances. I discuss these, and other definitions in more detail in the literature review in Chapter 2.

1.4.2. Multidisciplinary team

Different configurations of multidisciplinary teams exist within CAMHS and Children's Services. The term is used to describe very different team compositions and working practices. The term multidisciplinary team is often used to describe interprofessional working, including actual, virtual and

networked teams such as those proposed within the ECM: Change for Children agenda (see Department for Education and Skills, 2004). This can make it difficult to compare one team's work and outcomes with another. For the purposes of this study a multidisciplinary team (MDT) is taken to mean a team with a composition of three or more professional disciplines working together in different roles and with different training, knowledge bases and skills. The precise team composition is often dependent on local circumstances, needs and interpretations of this need. What is important for this, and for other studies, is that a detailed description is given about the precise nature and make up of the team and its work, in order that similarities and differences can be observed, understood and explained. This study will examine the work of a multidisciplinary child behaviour team working in family and community settings in a culturally diverse urban community team. The team is composed of three professions: educational psychologists (EPs), family support workers (FSW) and primary mental health workers (PMHW). A more detailed outline of the team and its context is given later in Chapters 3 and 4 of the thesis.

1.4.3. Professional learning

Professional learning and development activities vary considerably and can include course attendance, workshops, reading and reflections on work practice. For the purposes of this study, professional learning is taken to mean the learning that comes from individual and group reflection on a work activity or practice that leads to the development of that work or practice and the knowledge, skills and confidence of the professionals involved.

Professional contributions and learning in this study are examined through a sociocultural lens drawing on the work of Engestrom (1987, 1999b). This involves an analysis of the multidisciplinary activity system and consideration of the potential contradictions that exist within the system, as a way of promoting innovation and change in the work practice and behaviour of the professionals and team. Engestrom (1999b) proposed a term 'expansive learning' to describe learning that occurs as a result of an analysis of an activity system and the social and cultural practices in particular teams, work groups or communities. He suggests:

“the process of expansive learning should be understood as the construction and resolution of successively evolving tensions or contradictions in a complex system that includes the object or objects, the mediating artefacts and the perspectives of participants.”
(Engestrom, 1999b, p. 384.)

A fuller discussion of professional learning and sociocultural activity theory is included in Chapter 2 and 3 of this thesis.

1.5. Contribution to knowledge

A full review of the literature will be presented later in this thesis. However, an initial analysis of the relevant literature suggested that this study is the first in-depth sociocultural analysis of the work of a multidisciplinary team whose specific purpose is promoting mental health and psychological wellbeing in children and young people in family and community settings. The research extends the application of Engestrom's (1987) theories into a different context and setting i.e. the work of a multidisciplinary team whose principal focus is promoting psychological wellbeing in children and young people.

The research further complements work undertaken by Daniels (2001a) who applied sociocultural activity theory to professional practices associated with children with emotional and behavioural difficulties and at risk of exclusion. It also builds on work undertaken by Leadbetter (2005) and Leadbetter (2006a) who applied Engestrom's (1987) theoretical framework to aspects of educational psychology practice. This study aims to extend the understandings generated about the sociocultural influences on professional practice and multidisciplinary team work in studies conducted by Anning et al (2006). It further aims to build on the Learning in and for Interagency Working (LiW) Project, whose approach is detailed in Leadbetter et al (2007) and Daniels et al, (2007) and whose findings have recently been outlined by Edwards et al (2009).

1.6. Research aims

It is against the above background and research context that the present study involving a sociocultural analysis of professional learning and contributions to promoting mental health and psychological wellbeing in children and young people within a multidisciplinary team is undertaken. The analysis will examine the professional contributions of educational psychologists, family support workers and primary mental health workers. The study aims to contribute to the development of knowledge and learning by exploring and answering the following research questions in respect of these professions:

1.7. Principal research questions

- What and how do professionals contribute to the process of promoting mental health and psychological wellbeing in children and young people whilst working within a multidisciplinary team?
- What are the sociocultural processes that mediate professional contributions within multidisciplinary teamwork?
- What contradictions and opportunities for innovation exist within the activity system whose object is to promote mental health and psychological wellbeing in children and young people through multidisciplinary teamwork?
- What professional learning comes from a collaborative sociocultural activity theory analysis of individual professional and multidisciplinary teamwork aimed at promoting psychological wellbeing in children and young people?

1.8. Overview of chapter

This introductory chapter has given a broad overview of the research thesis and outlined the background and rationale to the current study. It has also described how my interest in the topic has evolved through personal experience, professional practice and study. It has further provided some definitions of some key terms within the title of the thesis and highlighted how the study aims to make an original contribution to knowledge and research. It concluded with an outline of the aims of the study and the study's principal research questions. The chapters that follow develop these introductory comments in more detail.

CHAPTER 2 LITERATURE REVIEW

2.1 Scope of literature review

This chapter of the thesis considers what is already known about promoting mental health and psychological wellbeing through multidisciplinary working, drawing on published literature and research studies. The scope of the literature reviewed for this study covers consideration of:

- What is known about promoting mental health and psychological wellbeing in children and young people;
- What is known about the processes that support professional practice and multidisciplinary working within comprehensive CAMHS delivery; and
- What is known about the use of sociocultural activity theory as a methodology and method to analyse professional practice and to promote professional learning in applied work based settings?

2.2. Literature search strategy

In order to identify an appropriate body of literature against which to locate and position this study, I have adopted a semi-systematic search strategy using key search terms, their synonyms and combinations of terms. As has been previously discussed, terms used to describe mental health can vary quite considerably and can be influenced by the paradigm the author or authors of an article subscribe to. This necessitates the use of a search strategy using a range of terms and their synonyms.

Therefore, in order to find relevant articles I undertook a search using University of Birmingham MetLab facility of the databases including OVID

(including Psychinfo), ERIC (including the British Education Research Index) and Medline. Initially I used the title, key word and abstract search and then widened the search to the whole text of the article where insufficient articles were highlighted. The terms and synonyms used to search were as follows:

- 1) Psychological wellbeing; emotional wellbeing; emotional health and wellbeing; emotional resilience; emotional literacy and mental health.
- 2) Children; young people; children and young people.
- 3) Multidisciplinary team; multiagency team; inter-disciplinary and inter-agency team; multidisciplinary work, multiagency work, interdisciplinary work and interagency work.
- 4) Professional learning, professional development, continuing professional development.
- 5) Activity theory, cultural historical activity theory, sociocultural activity theory, sociocultural psychology.

These terms were used in combinations of two, three, four and all five terms. The latter two produced no articles, which appeared to support the notion that this research, if successful, should make an original contribution to knowledge. However, combinations of two or three terms generated sufficient articles (50 or fewer for each combination) to allow the titles and abstracts to be reviewed and those of relevance were then chosen and included within the literature review of this study. In addition, specific searches were made for each professional group's contribution to child and adolescent mental health. Further electronic searches were also made of e-books, e-journals,

government publications and newspaper articles, using Nexus. Finally, hand searches were made of all recent articles in 'Educational Psychology in Practice' and 'Educational and Child Psychology' for articles of relevance to this research.

2.3. MENTAL HEALTH AND PSYCHOLOGICAL WELLBEING

This aspect of the literature review starts with consideration of the multiplicity of terms used to describe mental health and psychological wellbeing and discusses the contested nature of the term, mental health. This is followed by consideration of the epidemiological evidence of mental health problems in children and young people. It then considers some of the key theoretical and research articles from the literature whose focus was promoting mental health in children and young people. This includes literature covering mental health. The Section ends with consideration of the principal paradigms used to explain mental health and psychological wellbeing, and the ontological and epistemological bases underpinning their evidence and claims to knowledge.

2.3.1. What is mental health and psychological wellbeing?

Practitioners use differing terms, explanations and language to describe the psychological wellbeing and mental health needs of children and young people. This can lead to confusion in parents and professionals themselves. A huge variety of terms are used to describe children's psychological wellbeing and mental health. Weare (2004) highlighted the range of terms used to describe mental health including emotional literacy, emotional intelligence, emotional health and wellbeing, psychological wellbeing and distress, emotional and behavioural difficulties, mental health problems and mental

health disorders (see Weare, 2004). The term chosen by practitioners often depends on the predominant paradigm of the professional discipline from which they originate (see Weare, 2004). It is therefore important, for the purposes of this literature review, to define what psychological wellbeing and mental health means.

The Health Advisory Service Report (1995) defined mental health in children and young people as:

- 'a capacity to enter into and sustain mutually satisfying personal relationships;
- continuing progression of psychological development;
- an ability to play and learn so that attainments are appropriate for age and intellectual level;
- developing a moral sense of right and wrong;
- not necessarily present when psychological distress or maladaptive behaviour are; and
- is appropriate given a child's age or context.' (p.6)

This definition appears at first inspection to be fairly comprehensive, however it could be criticised for its circularity and use of terms that are open to differing interpretations. How does someone define what is appropriate for a child's age and context? The Mental Health Foundation (1999) similarly offered a definition of emotional health that suggests that children who are emotionally healthy will have the ability to:

- 'develop psychologically, emotionally, creatively, intellectually and spiritually;
- initiate, develop and sustain mutually satisfying personal relationships
- use and enjoy solitude;
- become aware of others and empathise with them;
- play and learn;
- develop a sense of right and wrong; and
- resolve (face) problems and setbacks and learn from them.' (p.4)

Both definitions acknowledge the importance of mutually satisfying personal relationships, play and learning and psychological development. However, they require interpretation about what are 'mutually satisfying relationships' and what is a sense of 'right' and 'wrong.' The interpretations made very much depend on the social and cultural context in which the behaviour occurs.

Dogra et al (2002) suggested that the concept of 'mental health' should be considered to be on a continuum between mental (or psychological) wellbeing, at one end, and mental illness, on the other. The continuum ranges from normal human emotional experience to extreme psychological distress and mental ill health. The precise threshold determining where someone moves from mental health to mental ill health cannot be clearly defined, as behaviours that are considered normal and healthy in one context and culture might be considered abnormal in another (Dogra et al, 2002). This definition might be criticised by those who use a diagnostic approach such as Scott (2002), for not attempting to define and detail the thresholds of behaviour, cognition and emotion that underpin mental health and psychological wellbeing and those typical of mental health problems, disorders or illness. Nevertheless, the definition does recognise the breadth of potential mental health needs and the reciprocal interaction between a child or young person, their social context and culture in determining mental health needs and, as such, will be adopted in this thesis.

2.3.2. Evidence of increased mental health need

Beyond definitions, the apparent increase in the mental health problems of children and young people has been subject to considerable media interest, political discourse, and regional and national developments in recent years (see Rees, 2007, for example). Popular discourse within press reports indicated that children and young people in the UK are amongst some of the unhappiest in the world (Times Online, 2007). Official statistics also suggested that 1 in 10 children experienced mental health problems (see Green et al, 2005) at sometime in their childhood, and as many as 1 in 4 adults experienced mental health difficulties in their lifetime (Department of Health, 2004). As a consequence, one of the government's current priorities is improving the mental health of children and young people. Emphasis has been placed on improving the accessibility of mental health services and developing preventative community based provision to complement the specialist CAMHS provision.

It should be noted that the increases reported in mental health problems may be due to real changes in the mental health of the child population but could also be explained by changes in the sociocultural context and the way mental health needs are viewed. The changes in the level of need reported could be due to:

- changes in the identification, screening and assessment of children and young people considered to have mental health problems;
- broader and varying conceptions of mental health held by different professional disciplines; and/or

- the willingness of some professionals to employ a diagnostic–categorical approach to defining children’s mental health problems and needs.

2.3.3. What is comprehensive CAMHS?

Traditionally, provision within the CAMHS services has been delivered via four tiers of support. Organising mental health support and provision in this way was first proposed by the Health Advisory Service (HAS, 1995). HAS (1995) suggested that support should be provided to children and young people via a comprehensive CAMHS provision across four linked tiers of professional support and service provision. These are

- Tier 1- frontline professionals who work with children and families, this would typically be teachers, social workers, GPs and health visitors.
- Tier 2 - professionals who have some general knowledge of mental health such as EPs and PMHWs working together as part of a co-ordinated network in support of children’s mental health in family, community, primary health and education settings.
- Tier 3 - specialist multidisciplinary CAMHS teams working in clinical and hospital settings, providing outpatient support to children with mental health problems; and
- Tier 4 - specialist hospital or unit provision provided to support children and young people with acute and severe mental health problems such that they require inpatient care (adapted from HAS, 1995).

Consideration has been given to what different services contributed to comprehensive CAMHS (Department of Health/DfES, 2004) across these tiers

and to supporting children and young people's mental health needs and development in schools and other settings (Department for Education and Skills, 2001a). Moreover, the Every Child Matters (Department for Education and Skills, 2004) agenda has proposed the introduction and development of information sharing protocols, common assessment frameworks and multidisciplinary teamwork in order to overcome some of the barriers that exist between different agencies and professions. It has also led to consideration of what different professionals contribute to multidisciplinary work and how they might work together to support improved outcomes for children's and young people's mental health and wellbeing.

I will return to the issue of professionals' roles and contributions to CAMHS later in this chapter. Prior to this it is important to consider the principal paradigms underpinning professional practice in the area of mental health.

2.3.4. Paradigms in mental health

2.3.4.1. The medical model

Mental health needs are considered by those taking a medical perspective as being definable by an array of symptoms. These symptoms can be categorised into particular conditions, problems, disorders and illnesses through the use of diagnostic frameworks such as the Diagnostic and Statistical Manual of Mental Health Disorders (DSM- IV) (American Psychiatric Association, 2003) and the International Classification of Disorders (ICD) 10 (World Health Organisation, 1994). Professional groups, notably the psychiatric profession, have attempted to classify particular types of mental

health problems as disorders or conditions and offer diagnoses using the DSM-IV and ICD-10 frameworks. These diagnoses are determined by reference to a number of dimensions, factors and the presence and absence of particular symptoms. The approach stems from a 'medical' tradition of 'diagnosis, treatment and cure' of the individual. However, it could be argued that such frameworks take insufficient account of the sociocultural context in which the mental health concern occurs (Tew, 2005).

Writing in support of a diagnostic-categorical approach, Scott (2002) defended the use of the approach as a sensible way of classifying the mental health problems of children and young people which enables understanding of children with similar emotional, social and behavioural needs to be developed. He further argued that diagnostic classifications allow for the effectiveness of particular treatments and interventions to be developed and evaluated for children with similar symptoms. Scott (2002) concluded that such an approach helped to create an evidence base for practice and ultimately improved outcomes for children with particular mental health needs.

The 'medical' model of classification, diagnosis, and treatment of children's mental health needs is the dominant paradigm used by those who advocate an evidence-based approach to mental health intervention (see Carr, 2000 and Wolpert et al, 2006). The treatment or intervention of choice depends on the appropriate diagnosis and classification of a child's needs to a particular disorder or condition. As Tew (2005) pointed out, 'part of the attraction of the biomedical model has been that it seems to provide answers, meanings and

certainties.’ (Tew, 2005, p.9) However, the evidence-based approach might be criticised for adopting a rather ‘one size fits all’ approach and not accounting for differences in individual children, context and culture suggested within the definition of mental health provided by Dogra et al (2002), discussed earlier in this chapter.

2.3.4.2. The psychosocial model

Psychosocial paradigms are evident in the work of many community, social care and education professionals such as educational psychologists (see Miller, 2003). These professionals typically aim to understand and address children’s individual needs within naturalistic settings such as home, school or community. The aim is to understand and support change in the interactions between the individual, the system around them and the context, often using consultative approaches (see Wagner, 2000). The emphasis of the psychosocial model is in understanding the interaction between the child and their context, and examining the systemic and environmental influences on the child’s mental health and psychological wellbeing.

Professionals adopting a psychosocial approach draw on ecosystemic (Bronfenbrenner, 1979), social interactionist and constructionist theories (see Wagner, 2000) in an attempt to understand and support change in the interaction between an individual child with mental health needs, the significant adults and the wider context and system. The approach is criticised by Scott (2002) and others for giving insufficient recognition of the disposition and child based factors and not providing sufficient evidence of the

effectiveness of the approaches used. The challenge for professionals who employ such approaches is to demonstrate the outcomes generated by the approach, so that they may be seen as an alternative to the diagnostic approach or, at the very least, complement the traditional clinical interventions.

2.3.4.3. The social model.

Tew (2005) suggested that there are certain core values that stem from taking a social perspective. These included:

- mental distress being seen as situated within a continuum of everyday human experience;
- a holistic approach being taken so that an integrated understanding of a person (both their 'inner' and 'outer' experience) occurs within its social and cultural context;
- a person's, who has experienced mental distress, voice being listened to and taken seriously; and finally,
- practitioners adopting the principles of empowerment and anti-oppressive practice.

Tew (2005) observed that within mental health practice:

'biomedical perspectives remain dominant – and a concern with the overall complexity of a situation can become lost in an over-emphasis on diagnosing and treating individual 'pathology.'(p.216)

Social perspectives on mental health draw from a range of disciplines including sociological and psychological thinking on issues such as the impact of trauma, socio-economic disadvantage, discrimination, stigmatisation and anti-oppressive practice on mental distress (Tew, 2005). They provide the

‘pegs’ on which those who have experienced mental distress, and the practitioners who support them, can ‘hang’ aspects of their experience in order that they may begin to make sense of what can be a confusing and problematic experience (Tew, 2005).

Tew (2005) argued for plural perspectives within multidisciplinary teams to enable them to respond to the diverse and complex range of experiences of mental distress. Furthermore, he suggested that:

‘within many conventional medical, psychological and social approaches, there has been a tendency to impose frameworks upon people in ways that deny their own knowledge and expertise.’
(Tew, 2005, p17).

Finally, Tew (2005) argued that a move away from the traditional paradigm of evidence based practice, toward a partnership approach requires the active engagement of service users and that:

‘a holistic approach which helps to make links between what may seem bewildering thoughts, feelings and behaviours, and the realities of people’s social and personal experience may be more helpful...’
(Tew, 2005, p27)

2.3.5. Child mental health: The socio-political and policy context

A recent large scale survey of 8,000 children conducted by the Children’s Society (2008) called the ‘Good Childhood Inquiry’ indicated that 27% of young people agreed with the statement ‘I often feel depressed.’ The validity of this statistic could be questioned as the definition of ‘depression’ was not made clear and young people answering this question may have heard many and various interpretations of what ‘depression’ means. Furthermore, it could be argued the enquiry team represents the vested interest of the Children’s

Society, as a charitable organisation, and therefore the study might be considered biased. Nevertheless the enquiry highlighted the mounting concern about 'children's mental health and wellbeing' (Children's Society, 2008) and concluded that:

'There is growing concern and recognition of the true cost of neglecting children's mental health and well being. Too often mental health and well being have been dismissed as being of little importance but there is now an understanding that if we want to give children a better childhood these matters must be addressed. We now need to translate this growing concern into action and investment in the necessary support services' (Children's Society, 2008, p16).

A recent independent review of CAMHS commissioned by the Department of Health and Department for Children, Schools and Families undertook a contemporary review of the state of children's psychological wellbeing and mental health services in England and made recommendations as to how services might be improved (CAMHS Review, 2008). The independent review used a literature review, focused group discussions with children and parents, and a call for evidence from interested parties and local site visits to evaluate the effectiveness of services. Although the review is not a research study, it did aim to gather evidence and make recommendations based on its findings to both local, regional and national government on CAMHS provision and service delivery.

The review's evidence could be criticised in that it did not demand the same rigour and quality of evidence required of empirical research. Amongst the methods used to gather information from stakeholders was a 'call for evidence from those in the third sector, professional groups and organisations and the public' (CAMHS, 2008 p.105). The study sought to identify the key issues,

practical solutions and highlight examples of good practice in promoting the psychological wellbeing and mental health of children. Its sampling methods, however, could be criticised, as it is not clear how site visits were chosen and how representative the views collected through its call for evidence were.

The review team followed its call for evidence with two focus groups of children and young people and parents/carers. Again, it is not made clear how these parents and children were selected to ensure they were fully representative of the spectrum of mental health need outlined by Dogra et al (2002) and of the full social and cultural diversity of the UK population.

Among the other things the review considered and discussed, was the language used to describe mental health and psychological wellbeing and the epidemiological evidence in respect of child and mental health problems. In addition, it considered the different models of mental health and argued that attempts to distinguish between the social and medical models were unhelpful (CAMHS, 2008). The review argued for the adoption of the biopsychosocial model that draws on elements of each paradigm but, as Tew (2005) pointed out, this model does not 'fully take account issues of power, differences in value base and potentially fundamental differences in approaches to knowledge.' (p.216). As the CAMHS review (2008) stated:

'Another key barrier is the difference in the professional cultures of health, education and social care, and also those of some professional groups. We are aware that some individual professionals continue to adopt a very rigid approach to practice, which they might attribute to the demands of their professional and ethical frameworks. At the same time, we have seen many examples of high-quality professional practice provided in a more flexible, child and family-centred way.'

(Independent CAMHS Review, 2008, p.61)

The review further highlighted considerable variations in the support and provision made for children and young people in different areas and concluded that:

‘Although there have been considerable service improvements and much progress in the collaboration between agencies across the country, unacceptable variations and gaps still need to be addressed. Children, young people and families are still waiting too long for interventions from more specialised children’s services, including CAMHS. The documented differences between services at both local and regional level cannot be explained solely on the basis of differing levels of need, and the resulting inequalities in provision must be tackled at all levels and across the full spectrum of children’s services.’ (CAMHS Review, 2008 p.26)

Finally, the review pointed to the challenges of achieving a fully comprehensive CAMHS and co-ordinated provision, in particular, through the development of multiagency teams:

‘While there is an increasing amount of research to show multiagency arrangements work well, we think it is important to sound a note of caution. We have seen examples where multiagency working is vital, but we have also seen that some arrangements can be time-consuming and expensive.’(p.62).

It is therefore proposed in the present study to examine the sociocultural factors that mediate the work of professionals within a multiagency team with a track record of successful practice in promoting the mental health and wellbeing of children and young people.

2.3.6. Mental health promotion and prevention

McDonald and O’Hara (1996) offered a useful theoretical framework as a tool for planning mental health promotion at a national, regional or local level.

They argued that for mental health promotion to be comprehensive it needs to address five main areas that are known to support positive mental health outcomes as well as tackling the five contrast poles which hinder mental

health. The areas they identify are environmental quality versus environmental deprivation; self esteem versus emotional abuse; emotional processing versus emotional negligence; self-management versus stress; and social participation versus social alienation.

McDonald and O'Hara (1996) further suggested, drawing on the work of Bronfenbrenner (1979), that for mental health promotion to be truly comprehensive it needs to address each of these elements at the levels of the macro-system, meso-system and micro-system. For example, government policies and reviews of mental health in young people could be considered to be working at the macro level. Local interpretations and delivery of these policies within a community or organisation might be considered work at the meso-systemic level; and the work of a particular service with a client or family would be considered as work at the micro-systemic level. McDonald and O'Hara's (1996) theoretical framework offered a useful way to conceptualise mental health promotion activity and consider the ecosystemic influences on the mental health and psychological wellbeing in children and young people. It could, however, be criticised for not giving sufficient consideration to the sociocultural and historical influences on mental health promotion.

2.3.7. Psychological wellbeing in children and young people

A significant development in terms of promoting psychological wellbeing of children and young people has been the introduction of Social Emotional Aspects of Learning (SEAL) (Department for Children, Schools and Families, 2006) in both primary and secondary schools. Drawing from the emotional

literacy and intelligence movement and an eclectic range of theories and approaches, including solution focused brief therapy (DeShazer, 1988), SEAL aimed to build the social and emotional competencies of children and to integrate the development of these within the curriculum of children. This curriculum has been developed at a national policy level but its implementation has been optional at a local and school level. SEAL provided guidance not only on what social emotional aspects should be taught but also how they should be taught through a combination of whole school, small group and targeted interventions. Approaches have been developed for primary and more recently secondary schools (Department for Children, Schools and Families, 2006), drawing on what is known to promote social and emotional competence in children and research undertaken by Weare and Gray (2000). In addition, materials have been developed to help schools to support parents with the Social and Emotional Aspects of Learning at home. (See Department for Children, Schools and Families, 2007)

The psycho-educational approach promoted by SEAL stressed the importance of laying the foundations of emotional and social competence and then creating the environments to support positive mental health and psychological wellbeing. The approach could be criticised for focusing on building children's competencies rather than seeking changes in the environment or context and for not sufficiently considering the sociocultural influences of family, home school and local community on the social and emotional outcomes for children. Nevertheless, the National Healthy Schools (2007) initiative has encouraged schools to create emotionally healthy

environments by adopting the SEAL approach. Furthermore, emotional wellbeing has been used as one of the core themes to determine whether a school can be considered to have achieved the healthy school standard.

2.3.8. Evidence-based interventions and practice

Wolpert et al (2006) undertook a meta-review of studies whose aim was to improve mental health in children and drew together information about the evidence-base for particular interventions and treatments of mental health problems. As a consequence, they made recommendations about the treatments of choice for a range of mental health needs and provided guidance for professionals (see Wolpert et al, 2006), and parents and children and young people (see Evidence Based Practice Unit (EBPU), 2007). The review summarised the evidence in support of particular treatments of child mental health problems as well as highlighting those interventions that were not recommended. Guidance was offered for conditions such as attention deficit hyperactive disorder, depression, anxiety and phobias, and post traumatic stress disorder. The review suggested that interventions should be targeted at children whose needs they are most likely to meet.

It should be noted that Wolpert et al (2006) adopted a medical – diagnostic model which assumes the validity of diagnostic approach in appropriately categorising and classifying children's mental health problems based on the symptoms displayed. Wolpert et al's (2006) report has subsequently been converted into a guidance document for children and young people offering a star rating and simplified explanation of why particular interventions or

treatments are recommended or not (see EBPU, 2007). The approach offered professionals, parents and children and young people an opportunity to make an apparently informed choice about a particular intervention. However, the approach might be criticised for offering an over-simplistic and reductionist view of child mental health, which focuses too heavily on factors within the child, and relies on the classification of children into pre-ordained conditions and disorders. It could be argued that the approach also gives insufficient recognition to the influence that the system, context, and culture have on the mental health needs of young people.

2.3.9. Values-based practice

Recently criticism of the evidence –based approach has come from within the medical and psychiatric profession itself. Williams and Fulford (2007), in a theoretical review of practice, advocated that Value-Based Practice (VBP) is required when considering children and young people’s mental health. They argued that ethical concern about children and young people’s welfare, and their long-term development, needs to be considered alongside the available evidence. Moreover, they also highlighted the importance of children and young people being given the opportunity to make informed choices. They suggested that:

“how people make decisions or come to judgements and exercise choice (about the evidence base and treatment choice)....reminds us forcefully that our values and our views of other peoples’ preferences are at the centre of these processes” Williams and Fulford (2007) p 237.

Williams and Fulford (2007) also pointed out that as scientific evidence and a pre-occupation with measurement have grown, so has the need for clarity

about our own and others' values and ethics. They argued that differing values are highly visible and evident in the practices of professional groups and staff who work with children.

Values Based Practice (VBP) starts from the premise that there may not be a single answer to many problems (Williams and Fulford, 2007). In direct contrast to Scott (2002), Carr (2000) and Wolpert et al (2006), Williams and Fulford (2007) suggest that decisions involving diagnostic labelling of children's mental health problems is as heavily influenced by professional values as by facts. In recommending a VBP approach, they indicated that the first call for information should always be the perspective of the child or young person themselves. Williams and Fulford (2007) further suggested that the VBP approach allowed for a balance of legitimately different perspectives within, for example, multidisciplinary teams. Professional awareness and knowledge of different values, ethical practices, language use and communication skills are important principles that influence professional practice in multidisciplinary teams. Williams and Fulford (2007) argued that VBP, whilst working within codes of ethics and laws, puts decision making back where it belongs with service users, professionals and managers of services.

Those from a more positivist and modernist tradition however still strive to find an evidence-base to support their working practices through such things as the CAMHS Outcome Research Consortium (CORC) (Wolpert et al, 2007). In addition, attempts have been made to answer the question 'What treatment

works to promote child and adolescent mental health? (see Carr, 2000, for example). This contrasts with those from a post-modern tradition like Williams and Fulford (2007) who offered a more social constructivist view of child mental health and its treatment. It could be argued that the evidence-based approach does not give sufficient recognition to the sociocultural influences on child mental health and professional practices. Whilst the value-based approach recognises the importance of values in mediating professional decision making, it does not fully recognise the wider sociocultural influences on professional practice.

2.3.10. Summary of section

This section of the thesis has considered what mental health and psychological wellbeing is and pointed to the difficulty of defining the terms precisely because of the influence of social context and culture. It has considered the epidemiological evidence and argued that due to difficulty of definition and variations in professional practices it is difficult to be precise about the nature and size of the problem in the child population. In addition, it has reviewed the principal paradigms used to explain mental health and considered how these paradigms influence practice and research into mental health. In particular it has discussed the tension that exists between the more positivist approaches of evidence-based practitioners and those who recognise the importance of values and culture in professional decision making and practice around child mental health. The chapter concluded by arguing that greater understanding was needed about the sociocultural influences on children's mental health and psychological wellbeing as well as

the professional practices that promote this through multidisciplinary work and comprehensive CAMHS provision.

2.4. PROFESSIONAL ROLES AND CONTRIBUTIONS

This aspect of the review examines what is known about the different professional roles and their contribution to promoting mental health and psychological wellbeing. It is limited to consideration of the three disciplines comprising the multidisciplinary team who are the focus of this study, These are the primary mental health workers, family support workers and educational psychologists.

2.4.1. Family support worker

Family support workers (FSW) are typically employed to provide outreach services for children and families in their own homes providing support and advice on childcare and parenting. Gray (2002) suggested that FSWs deal with the specific needs of families, as they arise in the family home, and refer them on to other health and social services as appropriate to the need. Many who occupy the family support worker role come from a childcare background and are typically trained nursery nurses. This appears due to the fact that the role evolved out of social services childcare, nursery and family centre provision.

The growth of the FSW role in the UK appears to have its origins in the implementation of the Children Act (1989) which emphasised the need for social care services to ensure a range of provision and services were available for 'children in need' in any local authority area. The emphasis within the Act was on social care services developing, supporting and providing a full range of services for 'children in need'. Many social services departments,

however, gave priority to child protection and services for “looked after” children for their social work. This meant that children with less severe and chronic needs had to be supported by paraprofessionals such as family support workers. Furthermore, the ‘Quality Protects’ framework (Department of Health, 1999) reinforced the importance of a thorough assessment of children and families in need, in order that their support needs could be identified and appropriate provision made such as parenting support.

More recently, the government outlined its plans for the children’s services workforce for 2020 (Department for Children, Schools and Families, 2008) among its aspirations are that workers not only think of individual children but families too, through what it calls its ‘think family’ initiative. The workforce plan further indicated that the government would make available funding to ensure family support workers receive appropriate training at the local authority employer level.

In an evaluation of a family support service, Vostanis et al (2006) highlighted the important role that family support workers play in providing support for parents, parent training and work at the interface between CAMHS and child protection services. Vostanis et al (2006) further outlined the variety of objectives toward which family support can be directed. These included befriending, helping families to meet basic needs, responding to child protection concerns, preventing child maltreatment and providing therapeutic interventions for parents and children.

Moreover, Gray (2002, 2008), drawing on an ethnographic case study of the family support worker role in Tower Hamlet, identified important features of the role undertaken by family support workers (FSW). In particular, the emotional support which FSWs offered to families. Further aspects of the role emphasised, included interpersonal support, shared ethnicity, befriending and bringing families to together and emotional engagement with child protection cases. Gray (2002) pointed out that FSWs often befriend families and win their trust, engaging, at a practical and emotional level, with mothers and children. Gray (2002) further observed that:

‘because FSWs befriend and engage emotions, families felt comfortable to disclose. This elicited rich narratives on the nature of social exclusion, poverty, child welfare and racism in the borough of Tower Hamlets’. More understanding of social care was the result (Department of Health 2000). ...The work of the FSS [Family Support Service] helps to break down barriers that ethnic minorities experience in the United Kingdom. FSWs shared the cultural knowledge and the first language of families. Families from ethnic minorities had an advocate who was able to listen to and understand the family’s point of view, then communicate the family’s specific health and social care needs to other agencies.’ (Gray, 2002, p20)

Moreover, Chaffin et al (2001) emphasised the preventative nature of the family support worker role and its importance in promoting parental competence, child nurturing and facilitating parents’ access to resources and networks of social support. Furthermore, Walker (2003), using an evaluative case study design, observed that:

‘ Family Support Teams intervene early, over a short period, with an eclectic mix of practical/therapeutic/activity-based help and advice.’ (p.224)

Vostanis et al (2006) found, in an evaluation of parenting support, that the support provided by family support workers achieved better outcomes

compared to those outcomes achieved for children receiving a parallel specialist CAMHS service. In particular, they found that FSWs' support was more accessible and responsive (i.e. had shorter waiting list times). They concluded that a Family Support Service established through social services achieved significantly more positive outcomes for children's behaviour and family life than the provision made through specialist CAMHS and that:

'In a 'real world service', children with behavioural problems are more likely to complete with positive outcomes [following] an intervention at a level 2 service [tier 2] rather than a specialist service [tier 3] predominantly targeting more severe disorders' (Vostanis et al, 2006, p. 525).

It should be noted that research into the family support worker role and its effectiveness is limited and the studies cited here also have limitations. Both Gray (2002 and 2008) and Vostanis et al (2006) were case studies, the former involving a detailed analysis of the processes involved in providing family support and the latter involving an evaluation of the outcomes of a specific team. This limits the generalisation of these findings. However, Gray (2002) argued that, in qualitative research, one should consider the applicability and transferability of findings rather than more positivist concepts of generalisation, reliability and validity, typically found in quantitative studies. In addition, as Walker (2003) citing Robbins (1998) pointed out:

'Trying to isolate the effectiveness of this specific new [family support] service located in a mosaic of statutory and voluntary community provision is difficult. Quantifying the impact of preventive family support work is complex and it is notoriously difficult to achieve systematic results (Robbins, 1998).' (p.224)

Nevertheless, despite the limitations of the research, Vostanis et al (2006) concluded that family support workers have a vital role to play within comprehensive CAMHS provision and that functional links between family

support workers and specialist CAMHS are essential (Vostanis et al, 2006). They further suggest that primary mental health workers (PMHWs) could fulfil a key role linking and working with FSWs. It is to the primary mental health worker role that the review turns next.

2.4.2. Primary mental health worker

The primary mental health worker (PMHW) is a relatively new role and profession. The role was first conceived by the Health Advisory Service (HAS) (1995) within its seminal paper 'Together We Stand.' HAS (1995) highlighted a gap in provision for children with mental health problems including those with emotional and behavioural problems. The gap in provision highlighted was between primary care (tier 1) and the specialist multidisciplinary CAMHS (or tier 3) provision. As a consequence HAS (1995) suggested that health authorities consider the creation of the PMHW role in order to bridge this gap.

The PMHW role and practices have subsequently evolved quickly in different localities. HAS (1995) suggested that PMHWs could emanate from a range of disciplines including nursing, social work and child psychology. Lacey (1999) found, in a survey of a variety of professionals including PMHWs within 169 primary care trusts, that 40% of those surveyed reported that the role was undertaken by specialist nurses, 5% child psychologists, 5% social workers and 50% of the returns indicated the role shared between disciplines.

Furthermore, Gale and Vostanis (2003), using a case study design to examine the PMHW service in Leicestershire, found that workers in the PMHW role were mainly from mental health nursing and social work background.

However, Gale and Vostanis (2003) argued that those from professional groups such as psychology and education are still central to the provision of a primary mental health service

Examining PMHW time use, Lacey (1999) further found that the median percentage of time spent by PMHW working in primary care services was 35%. Interestingly, Gale and Vostanis (2003) also found the PMHW service reduced the specialist CAMHS waiting list but there were as a result a high numbers of referrals for case related work for the PMHW service. This hindered the PMHWs' ability to perform the preventive functions recommended by HAS (1995). Lacey (1999) further asked respondents to outline the roles that PMHWs undertook in fulfilling their duties and the time they spent on each activity. Lacey found that respondents reported that 30% PMHW time use was for consultation, 18% training, 10% joint assessment and 20% direct work. This leads Lacey (1999) to conclude that qualitative research is required, in order to examine the factors behind these findings.

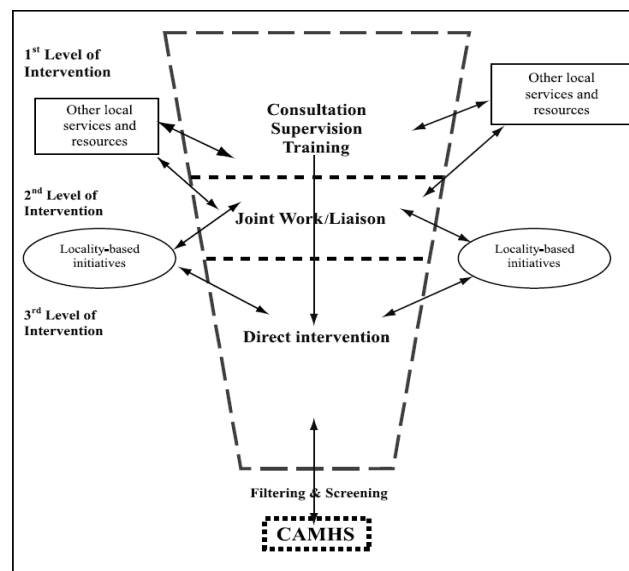
Subsequent studies by Gale and Vostanis (2003), MacDonald et al (2004) and Bradley et al (2009) examined the core competencies of the PMHW in more detail. Gale and Vostanis (2003) suggested the core attributes of the PMHWs are that they have:

- 'specialist knowledge of child and mental health;
- experience of working in a community setting with children, adolescents and their families;
- a senior level within their profession;
- comprehensive mental health assessment skills;
- an ability to provide clinical supervision and consultation to other professionals;
- an ability to design and deliver training;

- excellent communication and networking skills; and
- a range of direct work and therapeutic skills.’ (Gale and Vostanis, 2003, p.229)

Gale and Vostanis (2003) further proposed that an integrative approach to PMH work was required, drawing on biological, psychological and sociological theories. They outline a model of PMHW service delivery based on this approach (see Figure 2.1 below).

Figure 2.1. PMHW model of service delivery from Gale and Vostanis, (2003)



They proposed a three-level model of service delivery beginning with consultation, supervision and training for frontline professionals, followed by a liaison role involving collaboration and joint working between professionals (based on a team approach) and finally, work entailing direct intervention with children and families.

A further study by MacDonald et al (2004), using a multiple case study design and employing a thematic analysis identified two main themes in respect of PMH work. These were 1) the organisation of PMHWs in relation to their management, location and relationship to tier 3 [specialist CAMHS]; and 2) the role of PMHW i.e. their direct clinical versus consultation role. They also found three main types of organisation of PMHW services. These were:

- 1) as an outreach service of a specialist tier 3;
- 2) based in primary care; or
- 3) working as teams at tier 2. The latter being the organisation found in the team that is the focus of the present study.

In terms of PMHW role, MacDonald et al (2004) concluded there are two further dimensions to the role:

- 1) the degree to which PMHW provide direct care; and
- 2) the amount of support they provide to primary care.

They further highlighted a tension in the PMHW role between providing direct care versus consultation. Direct clinical work was often expected by many tier 1 staff but consultation-liaison was favoured by PMHWs (MacDonald et al, 2004). These differences in perspective and perception are highlighted as a major barrier to effective liaison-consultation work with tier 1. Furthermore, MacDonald et al, (2004) argued that PMHWs need different skills and levels of confidence to perform a consultation role successfully when compared with their other, traditional, clinical roles. In addition, they highlighted a further tension that exists in the role:

‘between the desire to increase access to specialist tiers, and to ensure the demand is appropriate and targeted at those in greatest need.’
(p.85)

MacDonald et al (2004) suggested a cost-benefit analysis was required between PMHWs’ collaboration with tier 1 staff and maintaining close liaison with tier 3 professionals. MacDonald et al (2004) concluded that further research is required into the PMHW role in order to identify the factors that facilitate effective working at the interface between tier 1 and tier 3. It should be noted that MacDonald et al’s (2004) study involved analysis of interview scripts some 2 years after the interviews had taken place which may affect the validity of the data and transferability of the conclusion to the present time and context. The sample taken was also largely from those within a health profession background introducing some potential bias in the sample taken.

In a development of the MacDonald et al(2004) study, and using the same data set, Bradley et al (2009) asked the question ‘what makes a good CAMHS primary mental health worker?’ Using a thematic analysis of responses, they highlighted the importance of the interpersonal attributes of accessibility, flexibility and self-motivation, as important aspects of PMHWs’ competencies, in addition to their clinical skills. In addition, Bradley et al (2009), using thematic analysis of data collected in 2001, asked the question ‘What are the most significant attributes needed for the role of PMHW?’ They identified attributes under four themes that related to skills, knowledge, working style and personal characteristics (See Table 2.1 below).

Skills	Knowledge	Working style	Personal Characteristics
Clinical Skills Listening Building relationships Managing the internal politics	Child mental and adolescent health services Development psychopathology Treatment techniques Services available locally	Flexibility Being accessible Developing supportive relationships empowering Sensitivity to others Communication Diplomacy Team working	Enthusiasm Self-motivation Self belief Confidence Resilience Strong personality

Table 2.1. Thematic analysis of PMHW work from Bradley et al (2009)

Bradley et al (2009) argued that attributes identified by respondents in their study were broadly in line with those highlighted by Gale et al (2004). The present study aims to shed further light on the PMHW role and the sociocultural processes that mediate their contributions within multidisciplinary teams and comprehensive CAMHS when working alongside other professionals such as educational psychologists and it is to this role that this turns next.

2.4.3. Educational psychologist

2.4.3.1. Educational psychologists' role within child mental health

A review of the professional literature indicated a variety of historical role constructions for the educational psychologists' (EP) profession around mental health and how it might contribute to comprehensive CAMHS provision. The roles identified include EPs working as mental health practitioners, therapists, consultants, and community and child psychologists.

2.4.3.2. EPs as mental health practitioners

The National Service Framework for Children and Maternity Service (Department of Health/DfES, 2004) recently highlighted the different contributions that professionals make to comprehensive Child and Adolescent Mental Health Service (CAMHS) delivery. It suggests that EPs, alongside others, provide support as 'tier 2' professionals (i.e. single agency professionals who work with others in a network to support the emotional, psychological and mental health needs of children and young people). In this role there is an implicit assumption that EPs contribute to the diagnosis and treatment of children with mental health needs as 'tier 2 mental health practitioners'. Tier 2' professionals are expected to provide support for a certain level of mental health need and offer consultation to tier 1 professionals (teachers, GPs, social workers etc) to help them meet some of the identified mental health needs of children and young people. They are also expected to seek to consult or involve specialist tier 3 CAMHS services when they do not feel they have the skills, knowledge, competence and

confidence to address the particular type and level of mental health need identified (Department of Health/DfES, 2004).

2.4.3.3. EPs as therapists

The historical roots of the EP role in child guidance, sees some in the profession keen to adopt a 'child therapist' role, working with children with psychological problems or mental health needs and undertaking work with individual children of a more intensive, in-depth and therapeutic kind. Jones (2003), in a review of EP involvement in child guidance clinics, highlighted the recent re-emergence of the child guidance practices amongst EPs including use of therapeutic interventions. Moreover, MacKay (2007) has suggested that EPs are a key therapeutic resource for children and young people and can help them to achieve positive outcomes.

Great interest has been shown in evidence-based therapeutic interventions such as Cognitive Behavioural Therapy (see for example, Greig, 2007) in supporting improved outcomes for children with mental health difficulties such as depression (Greig, 2004a and 2004b). Therapeutic approaches appear to have been attractive to an EP profession that was unsure about its current identity within comprehensive CAMHS and which wanted to make a distinctive, effective and evidence-based contribution. However, it is arguable whether EPs performing individual therapeutic approaches would complement what other professions offer and promote long-term systemic change and improvements in overall child mental health and psychological wellbeing.

2.4.3.4. EPs as consultants

EPs role in offering consultation emerged as a major force in educational psychology practice in the 1990s (see Wagner, 1995 for example) in the belief that it helped them to facilitate change in the system as well as the child.

Although, consultation has been interpreted in as many ways as there are contexts (Hanko, 1990). Conoley and Conoley (1982), for example defined it as:

‘a voluntary, non-supervisory, relationship between professionals from differing fields established to aid one on his or her professional concern.’(p.2)

Wagner (1990,1995) led the way in suggesting that consultative approaches using symbolic interactionism, social constructivism and systemic psychology were best suited to the role and practice of EPs. Consultation subsequently became an accepted methodology of choice within many educational psychology services and many different variations of the approach were developed (see Munro, (2000), Dickinson, (2000), and Gillies, (2000)).

However, Leadbetter (2006b), among others, questioned the way in which the concept of consultation had been interpreted and applied by EPs and EP services. She suggested that in fact EPs have three main uses for the term ‘consultation’. Consultation as applied in EP practice could be seen as either an overall model of service delivery, a defined task with agreed characteristics or as specific skill or activity (Leadbetter, 2006b). In addition, how EPs use consultation to promote psychological wellbeing and mental health in children and young people is less clear.

2.4.3.5. EPs as community psychologists

The constraints of working with school and educational legislation have led Stringer et al (2006), among others, to question whether EPs should shift the focus of their work to the community. Moreover, MacKay (2006) observed that the increase in social inequalities and mental health problems emphasised the need for EPs to adopt a community psychology focus. The view that EPs should be community psychologists sees the profession serving the needs of children and families in the community rather than needs of staff, schools and local authorities (Stringer et al, 2006). Stringer et al (2006), taking a critical perspective of EP work, argued that:

‘A Community Educational Psychology orientation provides a sound basis forthe effective application of psychology to improve the circumstances of children, parents and carers and others in the community. (p.67)

In supporting the idea of a community orientation to EPs’ work, MacKay (2006) points out that schools are still an important part of the community. He argued that it was time for the EP profession:

‘to claim its natural heartland of holistic services to children and young people across settings of home, school and community.’ (MacKay, 2006, p.14.)

2.4.3.6. EPs as child psychologists

The introduction of Children’s Services Authorities (CSA) outlined earlier has led some in the EP profession to re-examine the title, role and functions of the educational psychology profession. The re-emergence of arguments in favour of educational psychologists becoming ‘child psychologists’ has occurred.

MacKay (2007), for example, argued that:

‘educational psychologists are the most thoroughly embedded in educational systems; they have the widest training in child and adolescent psychology are therefore best poised to be generic child psychologists.’ (MacKay, 2007, p16.)

However, it is not clear whether the profession in adopting a ‘child psychology’ role would inadvertently reinforce the assumption of many parents, teachers and other professionals, that it is an EP’s role to diagnose and treat individual children’s mental health problems.

In the recent review of the functions of educational psychologists in light of the Every Child Matters (2004), Farrell et al (2006) argued that moves should be made toward creating a unified training for a child psychology profession. They argued that aspects of the role of clinical child psychologists (CP) and educational psychologists (EP) were very similar and that aspects of the training could be merged. This would form the basis from which a generic child psychology profession could be created. However, the evidence-base on which the Farrell et al (2006) assertion is made is less clear. It did not, for example, provide a detailed analysis of the roles and functions of child clinical psychologist’s, or sample clinical psychologists’ views about their role and how these contrasted with those of educational psychologists. This suggests that a detailed examination of the educational psychology profession’s contribution to promoting mental health and psychological wellbeing in children and young people would be beneficial, including an examination of the sociocultural processes that mediate their work. This would support improved understanding of how EPs work with, and alongside, other professions, including child clinical psychologists and other child mental health

professions, to promote children and young people's mental health and psychological wellbeing.

2.4.4. Summary of section

The role that EPs, FSWs and to a lesser extent PMHWs play in promoting positive mental health and psychological wellbeing in children and young people appears poorly understood. Furthermore, the sociocultural influences on EPs', FSWs' and PMHWs' practice also seem to be under researched.

The present study seeks to further understanding of the sociocultural processes that mediate EP, FSW and PMHW contributions to promoting mental health and psychological wellbeing in children and young people within a multidisciplinary team. So, the review now turns to what is known about how professions work and learn together in multidisciplinary teams.

2.5. MULTIDISCIPLINARY TEAMS AND PROFESSIONAL LEARNING

2.5.1 Introduction

The development of the Children's Service workforce and multidisciplinary teams (MDT) using integrated processes have been identified as priorities in the UK government's agenda for change (Department for Children, Schools and Families, 2004). How professionals contribute to MDTs and are trained, developed and supported to meet the new agenda and support positive outcomes for children, is a key part of this strategy (Department for Children, Schools and Families, 2004). Moreover, priorities have been set to ensure the workforce have the necessary knowledge, skills and confidence to fulfil their changing roles (Department for Children, Schools and Families, 2008). Consideration has also been given to how individual professionals, professional groups and inter-disciplinary teams develop and learn in the workplace and how these processes can be supported (see Anning et al, 2006; Edwards et al, 2009). This section of the thesis examines what is known about multidisciplinary work, professional learning in the workplace and in particular within multidisciplinary contexts.

2.5.2. Multidisciplinary teams in children's services

The enquiry and report into the death of Victoria Climbié undertaken by Lord Laming (Laming, 2002) highlighted failures in the communication between different professionals. The changes proposed in response to the report were first outlined in Every Child Matters (ECM) (Department for Education and Skills, 2004) and subsequently enacted and brought into law through the Children Act (2005). This acted as the stimulus for the development of

Children's Services including the use of integrated multidisciplinary teams and processes. Indeed, a study undertaken McCombie and Chilver (2005), on behalf of National Institute of Mental Health (NIMHE), highlighted that overcoming barriers to multiagency collaborative working was amongst the top priorities identified by CAMHS managers and professionals as needing further work and research.

Some early research by Anning et al (2006) attempted to understand the impact of ECM on multiprofessional teamwork and the professionals and teams involved. Their study aimed to understand how five different multidisciplinary teams developed and functioned following the introduction of ECM (Department for Education and Skills, 2004). Using principally an ethnographic approach, the researchers collected a range of data by gathering existing documents, observations of team meetings, one to one interviews and asking participants to complete critical incident diaries and dilemmas. Drawing on Wenger's (1998) 'community of practice' theory and, to a lesser extent, Engestrom's (1987) activity theory framework, they studied the relation between the documented rules of the team and individuals' actual work in the team (Anning et al, 2006). The five teams selected included a youth crime team, a young people's team (community CAMHS team), a nursery team, a head injury team and a child disability team.

Anning et al (2006) described three phases of their research activity which included collecting documents and making observations, use of interviews and participant critical incident diaries and, finally, use of focussed groups to

pose typical scenarios derived from their previous research to each team. The approach used relied on a qualitative methodology and involved action-orientated research, and attempted to intervene and promote reflection, expansive learning and development in the teams studied.

In reporting their findings, Anning et al (2006) drew on the work of Ovretviet (1996) who had proposed that there were five main types of multidisciplinary team namely a fully managed team, a co-ordinated team, a core and extended team, a joint accountability team and finally a network association team. However, as a consequence of their analysis Anning et al (2006) concluded that 'there is probably no correct organisational structure for multiprofessional teams.' (p.59) They did, however, suggest that successful practice was supported by teams where all team members:

- were line managed and had their work co-ordinated by other team members;
- have appropriate personal and professional support; and
- have absolute clarity about who is performing each of these tasks for themselves and others.

Anning et al (2006) also analysed the predominant and complementary models or paradigms held in MDTs by examining the discourse within each team. They then categorised these as systemic, medical, social and needs-based models. On the basis of this they concluded that:

'the existence of internal variations in explanatory models suggests there are dilemmas for our teams in achieving cohesion, through negotiated shared practice models, while at the same time embracing and celebrating complexity and diversity.' (p.59)

They further argued that multiprofessional teams ‘socially construct’ problems and interventions through a particular combination of professional perspectives or ‘gazes.’ Moreover, they suggested that shared expertise was frequently required in the work of multidisciplinary teams. However, they point out that the challenge for professionals was how to reflect on their practices together with service users.

Anning et al (2006) considered the learning that comes for the individual within multidisciplinary teamwork and argued that all teams carry the sociocultural histories of both individual workers and of the institution of which they are a part. They observed that there may be a tension between a desire in a team to reach a consensus (through a Wenger’s community of practice model) and to confront (through for example Engestrom’s knot-working model) (Anning et al, 2006). Finally, they concluded that:

‘Service providers and users can learn from each other in cycles of expansive learning to understand and refine workplace activities.’
(Anning et al 2006, p.86)

A further study by Walker (2003) described a 2-year evaluation study of a Multidisciplinary Family Support Team working at tier 2 CAMHS. The team was described as having representatives of each main agency and a co-ordinator. Unfortunately, the author does not describe the precise composition of the team, so direct comparison with the Anning et al (2006) study cannot be completed. Nevertheless, Walker (2003) interviewed professionals and undertook focus group discussions with a range of stakeholders including children, parents, families, other professionals and service users to evaluate

the appropriateness, acceptability and accessibility of the service. He collected data on service impact, the degree of integration of working or closeness of working, the way a team demonstrated collective responsibility and finally how the team was led and managed. He suggested the degree and pattern of integration was evident by the enthusiasm, consolidation, strengthening of new relationships, streamlining of administrative and procedural matters and an appetite for training and innovation.

However, the Walker (2003) study did not give details of how data was analysed, preventing full scrutiny of the methodology used. Nevertheless, a number of themes emerged that illustrated the work and effectiveness of the team. These included recognition of the importance of:

- the context in which the work of team was placed i.e. its connection with other formal and informal support;
- the capacity of the service to meet individual needs from diverse backgrounds;
- service flexibility including a willingness to modify work, respond to queries and negotiate other support; and
- the positive impact of the service.

The analysis of child focus group responses highlighted the positive benefits of children's involvement in evaluation and of the support they received, which was reported to be appropriate, accessible and acceptable to them. The children particularly valued the individual support and choices they were offered about the type of support they received. Also, interviews with families,

both at the time of involvement and twelve months later, indicated that of the ten families visited twelve months later, six had had no further contact with the service, of which three reported positive change and three no major change in the problem. All the families who had had further contact with the tier 2 service were referred on to tier 3 CAMHS suggesting that their needs were beyond the tier 2 team. This led Walker (2003) to conclude that trying to isolate the effectiveness of a specific service within the complex network of other services was very difficult. Nevertheless, he concluded that a qualitative methodology serves to complement more traditional outcome measures used in CAMHS services.

This study aims to examine and explore the aspects of multidisciplinary work and build on the work of Walker (2003) and Anning et al (2006) by illuminating how different disciplines work with and alongside one another and learn from each other within multidisciplinary teams. Moreover, it aims to consider the sociocultural influences on professional contributions and learning within a multidisciplinary team setting.

2.5.3. Professional learning and practice:

For Eraut (2007) professional learning and development can be viewed from both individual and social-cultural perspectives. He suggested that professional learning and the related concepts of professional knowledge, skills and competence can be both individually and socially situated. Eraut (2004) argued that by using the individual perspective the researcher can explore what and how people learn and differences in the interpretation of

what they learn. Moreover, he suggested that use of a social perspective allowed the researcher to consider the social construction of knowledge, learning and its context. However, he cautioned against assuming that by accepting the sociocultural origin of knowledge this also implies that all individuals in a work group, undertaking practices with a similar object, have a similar knowledge base and fine tune their practices for clients in similar ways (Eraut, 2004).

Eraut (2003) discussed the relationship between theory and practice development in the workplace and highlighted the different forms of knowledge used in workplace learning. He suggested that more attention needed to be given to those things that support 'tacit' or informal learning in the workplace and that those responsible for supporting professional learning and development should focus their efforts on creating work environments and contexts which maximise a professional's performance, capability and competence to practice. This, he suggested, includes consideration of what an individual brings to their practice, the evidence from empirical research about what is effective and information about the particular client and their context. Through consideration of all of these factors effective professional performance, development and learning will be supported.

In a theoretical overview of workplace learning, Eraut (2007) further highlighted the socio-political influences on a profession's practice and learning. He noted that many professions define themselves by their professional standards, frameworks of competence and qualifications. In

contrast, national and local government frequently define professional knowledge and practice quite differently and seek evidence of the demonstrable outcomes and impact of a profession's work (Eraut, 2007). Moreover, Eraut (2003) suggested there are many sources of theory about professional practice including academic, professional, lay and personal theories. He argued that a profession is best understood as an applied field rather than a discipline 'because its rationale derives from its social purpose and not from any distinctive form of knowledge.' (p.62).

Examining professionals work, Eraut (2003) posited that there are two forms of professional practice

- the observable, socially constructed and approved practice (possibly evidence based); and
- the only partly observable, describable experience-based practice of the practitioner.

'A person's theoretical capability will depend not only on the range of theories which they 'know and understand', or even on the range of theories they have used, but also on the range of contexts in which they have used them'. (Eraut, 2003, p63)

In addition, taking a critical perspective on Wenger's (1998) notion of 'communities of practice', Eraut (2003) suggested that, even in a relatively stable community, shared practices could be jeopardised by micropolitics, factionalism or practitioners who zealously guard their personal autonomy. He argued that professionals:

'contributions of their practice of knowledge acquired from their diverse previous contexts of work and formal training are bound to have a significant effect.' (Eraut, 2003, p.64)

and that:

‘the effectiveness of a team is highly dependent on the interactions embedded in the performances of its members, which cannot be judged in isolation from each other.’ (Eraut, 2003, p64).

2.5.4. Professional learning in multidisciplinary teams

Edwards et al (2009) described a Teaching and Learning Research Project (TLRP) examining the importance of learning in, and for, multiagency working. Using an activity theory framework the research indicated that a sociocultural analysis of inter-professional working was an effective way of understanding how professional collaboration supports social inclusion and how the latter both shapes the work of professionals and is shaped by them.

Edwards et al (2009) further pointed out that supporting professionals to examine the contradictions in their work provides a way of stimulating ‘expansive’ learning and development of their work and practice within multiagency teams. In addition, their study highlighted a number of factors within the interaction between individual professionals, professional groups and the work context that supported and constrained the development of individual and inter-professional practice.

They further suggested that professional learning involves professionals acquiring mental schema of professional knowledge which they can draw on and use when appropriate (Edwards et al, 2009). The ability to interpret the setting or sociocultural context of their activity and know when to draw and apply their professional knowledge and learning were seen as equally important. This appears to relate to Eraut’s (2004) ideas that professional

learning is both individually and socially situated and that professionals use their professional and experiential knowledge in determining an appropriate course of action. Edwards et al (2009) argued that professional learning from a sociocultural perspective is not:

“simply a matter of acquiring concepts that are simultaneously stored and then used when needed, though it does involve internalisation. Neither is learning simply a matter of being swept up by social practices of what Lave and Wenger (1991) have called a ‘community of practice’.” (Edwards et al, 2009, p.27).

This resonates with a similar observation made by Eraut (2004) highlighted earlier in this chapter. However, Edwards et al (2009) argued that professionals are knowledgeable and active decision-makers who work within existing social practices, which in turn shapes the sources of knowledge they use and the possible courses of action they take in any given situation (Edwards et al, 2009). Moreover, they suggested that professional knowledge and identities were bound up with the expectations held of them by others. Furthermore, Edwards et al (2009) pointed out that the sociocultural view of learning does not make a distinction between what is learnt by individuals, on the one hand, and how they act in and on their world, on the other. They suggested that individuals both shape, and are shaped by their context. There is a reciprocal interaction or dialectic between an individual and their world.

Edwards et al (2009) applied their sociocultural view of learning to a study of interagency work whose focus was the prevention of social exclusion, in an attempt to understand what professionals think and do when working within multiagency teams. This research led the team to see professional learning as involving:

‘both intellectual and emotional change and as intertwined with the histories, practices and intentions of the practitioners’ organisations’. (Edwards et al, 2009, p.27).

The study used a multiple case study approach and application of Engestrom’s Developmental Work Research (see Engestrom, 1999b) with multidisciplinary teams representing five different local authorities from across the country with varying demographics and different professional disciplines within these teams. The study involved three main sites and two sites which acted as pilots. Offering an institutional analysis, they suggested that how expertise and specialist knowledge is claimed, owned and shared, are both important and problematic. The study drew on Bernstein’s (2000) theories of the representational power of discourse within organisations and particularly his concepts of boundary strength (classification) and control (framing) to interpret how labour was divided horizontally and vertically between professionals. Edwards et al (2009) concluded that Bernstein’s (2000) framework provides a useful way of understanding practices that cut across organisational and professional boundaries.

On the basis of their Developmental Work Research (DWR) sessions and analyses, Edwards et al (2009) posed two principal questions. First, what are professionals learning whilst doing multiagency work? Second, how and where are they learning? In response to the first question, what are professionals learning within interprofessional work, they identified some key concepts including:

- ‘focusing on the whole child in the wider context;
- being responsive to others – both professionals and clients;
- clarifying the purpose of work and being open to alternatives;

- knowing how and knowing who (can help);
- rule-bending and risk-taking;
- creating and developing better tools;
- developing processes for knowledge sharing and pathways for practice;
- understanding one's self and professional values;
- taking a pedagogic stance to work'. (Edwards et al, 2009, p.66)

Edwards et al (2009) concluded that these emergent concepts reflect informed and responsible professional practice. However, they observed that professional status needs to be earned in negotiation with other professionals and service users. As a consequence, they argued that professionals 'need to be clear about what they can contribute to local systems of distributed expertise.' (p.84)

In terms of their second question, how professionals are learning? Edwards et al (2009) highlighted the importance of working and learning at the boundaries of professional practice in what they conceive as 'neutral zones'. They suggested these spaces are where inter-professional learning can take place and professional identity negotiated. Furthermore, they suggested the tools developed outside of a local setting through, for example professional training, cannot in themselves determine professional practice. How, and in what ways, tools and resources are used and applied in practice needs to be carefully considered. Finally, drawing on Engestrom's (2001) theory of expansive learning they pointed to the inextricable link between individual and organisational learning.

Edwards et al (2009) further examined the challenges that were faced by those working within inter-professional teams and systems. Using an activity

theoretical approach they highlighted the contradictions faced and worked on by professionals in institutional systems undergoing change. They posited that recognising and working on these contradictions and tensions supported an activity system to change and meet new demands. They also stressed the importance of values-led, responsible individual action within organisations, which may not have responded to changes in demand so quickly. This has links with Williams and Fulford (2007) ideas about values-based practice within CAMHS work and Tew's (2005) ideas on the importance of values in mental health work, discussed earlier in this chapter. However, taking a critical perspective, one could argue that the power imbalances highlighted between the individual and institution or organisation are insufficiently recognised within this approach. In addition, it could be argued that issues of professional health and wellbeing were not specifically addressed through the periods of considerable conflict and change highlighted within the Edwards et al (2009) approach and analysis.

Nevertheless, Edwards et al (2009) suggested that their analysis stressed the importance of some key aspects for individual professional contributions and learning. These included the impact of:

- values on inter-professional work;
- having a sense of the short and long term in professional work;
- helping others to recognising your expertise;
- having an outward looking stance;
- having discrete areas of knowledge in professional groups; and
- respecting the expertise of families. (Edwards et al, 2009)

It is interesting to note that the expertise of 'children and young people' is subsumed here under the expertise of families, and this list could be criticised for not fully emphasising the importance of children's voice or perspective in professional practice, development and learning. This is a point highlighted within the values-based practice approach proposed by Williams and Fulford (2007) and further emphasised by Tew (2005).

2.5.5. Summary of section

This section of the thesis has considered multidisciplinary team work and, in particular, professional contributions and learning in the workplace. Drawing on Eraut's (2003, 2004) ethnographic studies of workplace learning and Edwards et al's (2009) sociocultural analysis of interprofessional team work, this aspect of the literature review has explored how individuals learn in workplace settings and how they acquire and apply different forms of knowledge and learning. Edwards et al (2009), using an activity theory approach, focused on the learning in, and for, interagency work and suggested there was an inextricable link between the individual and the organisational learning. It further highlighted the importance of using contradictions as stimuli for expansive learning in individual professionals and multiagency teams. The current study aims to build on the learning generated from these studies and to provide a detailed sociocultural analysis of professional practice and learning at the level of the individual professional, professional group and the multidisciplinary team in a tier 2 CAMHS team.

2.6 Overview of literature review

This literature review has considered what is known about mental health and psychological wellbeing in children and young people. It has highlighted the contested nature of terms and different theoretical perspectives used to describe and explain the concept of mental health. It further highlighted the socio-political and sociocultural context in which issues of psychological wellbeing and mental health are considered and addressed. The review discussed the contributions that different professional disciplines make to promoting mental health and psychological wellbeing and examined what is known about the three specific professional roles which are the focus of the study, namely family support workers, primary mental health workers and educational psychologists. The review discussed the historical evidence development and construction of the each profession's role and considered how this has contributed to their current role in promoting mental health and psychological wellbeing in children and young people.

Finally, the review considered what is known about professional contributions and learning within multidisciplinary team contexts. This emphasised the value of considering individual professionals' contributions in their sociocultural context and the importance of promoting professional learning by considering the contradictions that exist in multidisciplinary work. The use of activity theory and Engestrom's theories (1987, 1999a) was also mentioned briefly as providing a framework and methodology to support such analyses and learning and it is to consideration of methodology that the thesis moves next.

CHAPTER 3 RESEARCH DESIGN AND METHODOLOGY

3.1. Introduction and overview of chapter

This chapter provides an overview of the design and methodology used in the present study. It begins with an overview of the research design, aims and questions. It then moves on to outline the theoretical basis of the sociocultural activity theory approach including the epistemological and ontological assumptions underpinning the approach. It further discusses the methodology and methods used and consideration is given to the strengths and weaknesses of the approach. The chapter concludes with an outline of the procedures used and the context in which the research took place.

3.2. Rationale for research design

The literature review highlighted the fact that work on promoting psychological wellbeing is currently of prime concern. It also emphasised that multidisciplinary responses to children's mental health and psychological wellbeing have been a focus of recent research and much political attention. It suggested that an understanding of how professionals from different disciplines work and learn together within multidisciplinary teams was of key importance to supporting positive outcomes for children's mental health and psychological wellbeing. It also highlighted a number of studies that used activity theory research as a means of attempting to explore professional work and learning within multidisciplinary teams.

The current study aimed to build on previous research by using activity theory research with a multidisciplinary tier 2 team, whose purpose was to promote mental health and psychological wellbeing in children and young people in family and community settings. The study proposed that activity theory provides an appropriate theoretical and methodological framework from which to understand, analyse and illuminate the processes involved in professional and team activity in this area of work.

Using the sociocultural activity theory framework, the current study aimed to explore those aspects of professionals' work that contributed to promoting mental health and psychological wellbeing in children. It was hoped that an in-depth analysis of this activity system would support an improved understanding of the interrelationship between the individual professional, professional group and multidisciplinary team contributions.

A fuller discussion of the methodology used in this study and its rationale is given later in this chapter, however a brief overview is provided here to help frame the aims and research questions guiding the study.

The current study used Engestrom's (1987) second-generation activity theory, aspects of his third-generation theory (Engestrom, 1999a) and Developmental Work Research (DWR) techniques (Engestrom, 1999b). Using these methods to collect and analyse the data, it was hoped that the sociocultural processes illuminated would provide a stimulus for learning in

the professionals and team involved and fulfil the aims and answer the research questions set out for this study below.

3.3. Research aims and rationale

This research aimed to examine the professional contributions within a multidisciplinary team whose object is to promote psychological wellbeing in children and young people. The purpose being to explore the similarities and differences in the 'tools' or 'artefacts' that each professional used on this object, and to consider how professional and team culture mediated the work. Finally, the study aimed to explore the contradictions that exist in this area of work and to stimulate learning in the professionals and the multidisciplinary team involved.

The principal rationale for this research, as highlighted in Chapters 1 and 2, comes from the current emphasis on improving the mental health and psychological wellbeing in children and young people through multidisciplinary working. As discussed earlier, recent government policy suggests that the most effective way to support mental health and psychological wellbeing is via a comprehensive CAMHS service, and effective multidisciplinary team working using integrated processes such as unified care pathways, information sharing protocols, common assessment frameworks and interprofessional collaboration. Professional work within multidisciplinary teams is seen as vital to achieving successful outcomes for children. However, early work on the development of multi-professional teams by Anning et al (2006), following the introduction of Every Child Matters,

indicated that there is still a considerable amount of work to be done to achieve integrated processes and working in these newly formed children's services teams. More recently, the Independent CAMHS Review (2008) highlighted the considerable variations in the effectiveness of multidisciplinary teams in supporting successful outcomes for children and questioned whether multidisciplinary teamwork had always led to improvement. It is against this background that the following research questions are posed.

3.4. Research questions

3.4.1. Principal research questions

- What do professionals contribute to the process of promoting mental health and psychological wellbeing in children and young people whilst working within a multidisciplinary team?
- What are the sociocultural processes that mediate these professional contributions within multidisciplinary teamwork?
- What contradictions and opportunities for innovation exist within the activity system whose object is to promote mental health and psychological wellbeing in children and young people through multidisciplinary teamwork?
- What professional learning arises from a sociocultural activity theory analysis of individual professional, professional group and multidisciplinary teamwork in this area of work?

3.4.2. Subsidiary exploratory questions

Furthermore, when seeking to promote psychological wellbeing in children and young people in family and community settings through multidisciplinary team work:

- What are the objects that the different professionals' and the team's work is directed toward?
- What are the hoped for, and actual, outcomes of the different professionals and team's work?
- What knowledge bases, skills and experiences do the different professionals bring to this work?
- What are the tools or artefacts used by the different disciplines in the team?
- What are the rules that support or constrain the work of the different professionals in the team?
- What is the community with which the professionals and team work?
- How is labour divided between the different professional disciplines within and outside the team?

3.5. METHODOLOGICAL AND DESIGN CONSIDERATIONS

3.5.1 Introduction

This section of the thesis considers the principal paradigms in educational and psychological research and discusses how these have informed the current research methodology and design of this study. It discusses the range of methodologies considered for this research, before moving on to a more detailed discussion of the methodology chosen. The section ends by providing a summary of the rationale for the present research design and methodology.

3.5.2 Methodological considerations

The researcher considered the principal paradigms in research and the ontological and epistemological assumptions underpinning each to determine the nature of the research methodology adopted for the present study. These considerations were then used to inform the researcher's methodological and design decisions for the present study.

However, it should be acknowledged at the outset that when considering the appropriate design and methodology for this study, the researcher weighed a number of factors. First, the research topic and questions outlined above. Second, the researcher's experience of applied research and professional practice discussed in Chapter 1. Third, the context and site of the research detailed in Section 3.8 of this chapter. Finally, the research paradigms and methodologies discussed within the research literature. All of these aspects influenced the eventual choice of research methodology and design, and provide the rationale for the methodology adopted in the present study.

3.5.3 Principal paradigms in human research

3.5.3.1 Positivism versus relativism

Cohen, Manion and Morrison (2007) suggest that there are two principal paradigms that inform the nature of the human inquiry and research. Firstly, there is the positivist paradigm which posits that human behaviour, and social science, can be understood by the laws of natural science and the researcher is an observer of social realities and facts, whose observations and analyses are expressed in general laws. The approach stresses the importance of quantitative methodologies using clear rules and procedures to identify empirical regularities and, in particular, causal relationships between two or more things (Robson, 2002).

In contrast, the relativist and interpretative paradigm considers that reality is represented through the eyes of the researcher and participants. Different approaches to research are merely different ways of viewing the world (Robson, 2002) The world is interpreted and constructed through different theories or concepts. The meaning of experience, behaviour and language are used to interpret and attempt to understand the complexity of human behaviour. The research process generates working hypotheses rather than facts. The approach stresses the importance of qualitative methodology and the emergence of concepts and theories from the data (Robson, 2002).

More recently, however, alternative research traditions have developed in response to criticisms of both positivism and relativism. Post-positivist

research, for example, recognises that the knowledge and values of the researcher can influence what is observed. Whilst the post-positivist researcher still contends that reality does exist, they also recognise that it can only be known imperfectly and by statistical probability (Robson, 2002). Constructivism, on the other hand, argues that reality is socially constructed and the task of the researcher is to understand and interpret the different constructions and meanings (see Burr, 1995, for example). In this way, constructivists tend to draw on multiple perspectives in order to understand multiple realities. Within constructivism, participants and researchers work together to construct a view of 'reality.'

3.5.3.2 Pragmatic paradigm

A further paradigm in research is the pragmatic paradigm which forms the basis for realist theory, perspectives and approaches (Robson, 2002). A detailed examination of realist approaches is beyond the scope of this paper (see Robson, 2002 for a detailed discussion). Suffice it to say, a realist adopts a pragmatic stance to research and chooses a design and methodology from across the full range of methodologies available. They adopt research that is 'fit for purpose' and the real world context in which it is being undertaken. This paradigm provides a theoretical framework which allows the researcher to choose a design and methodology most suited to the real world situation and the research question under investigation, and to draw from either quantitative, qualitative or mixed methodologies (Robson, 2002).

3.5.3.3 Transformative paradigm

Another paradigm described by Mertens, (2005) as the transformative paradigm includes, for example, critical theory and other emancipatory approaches (Cohen, Manion and Morrison, 2007). Those adopting a transformative paradigm contend that issues of power and control are not sufficiently accounted for in, for example, constructivist approaches to research (Mertens, 2005). Transformative research recognises the importance of multiple perspectives in the construction of reality and posits that what seems to be real may just be a 'reified structure' borne out of the historical situation (Mertens, 2005). Within this paradigm are feminist, cross-cultural, Marxist and collaborative action approaches to research (Mertens, 2005).

The ontological assumptions of a researcher adopting a transformative paradigm is that 'reality' is best uncovered by examining the social, political, cultural, historical, economic, ethnic and gender influences on 'reality'. The underpinning epistemology of the approach stresses the importance of understanding knowledge 'in situ' or 'situated knowledge' and recognising the social, political and historical influences on the 'knower' and the known. Within this paradigm the relationship between the researcher and the researched is seen as interactive and depends on the reflective and reflexive consideration of power and control issues within research.

'Objectivity in this paradigm is achieved by reflectively examining the influence of the values and social position of the researcher on the problems identified as appropriate for research, hypotheses formulated, and key concepts defined.' (Mertens, 2005, p.25)

The present research is located broadly within the transformative paradigm. The researcher, as a professional research-practitioner, wished to adopt an approach that created a link between research activity and learning and development in practice.

3.5.4 Research methodology

The researcher considered a number of different methodologies that could be considered to be broadly within the transformative paradigm. The approaches considered included Action Research (see McNiff (2002) Co-operative Inquiry (see Heron and Reason, 1996) and Sociocultural Activity Theory Research (Engestrom, 1987). Each of these methodologies is briefly outlined below, and their ontology and epistemology discussed. This list is not exhaustive and there are numerous other methodologies including critical ethnography, ethnomethodology and other transformational approaches that could have been discussed. A further discussion of these approaches is beyond the scope of this thesis and can be found in Cohen, Manion and Morrison (2007) and Mertens (2005).

3.5.4.1 Action research

Action Research believes that there is a vision of the future that is better than the present situation (McNiff, 2002). Furthermore, Action Researchers aim to understand present realities as a way of promoting a future that is more akin to their own values and vision of the future. Their approach is frequently based on the notions of truth, social justice, compassion and respect held by the researcher. They seek to recognise and critique their own and other's practice in order to identify which aspects of practice are good or in need of

improvement. Furthermore, action researchers believe that learning will transform into purposeful personal action through the research process.

Action Researchers see knowledge as something they do, a living process rooted in experience. (McNiff, 2002). Knowledge is seen as dynamic and ever changing, sometimes in unforeseen ways. Action Research involves reflecting on experience, contrasting this with a vision of the future based on researcher's values, and then determining and taking action in order to move from the present to the future reality. Traditional epistemologies see research as being separate from practice but in action research they are seen as interrelated. Furthermore, in collaborative action research these things are done in negotiation with others and involve a process of encounter, dialogue and relationship with others. It is these processes that provide the opportunity for growth and development and social transformation (Mertens, 2005).

Action Research depends on an open dialogue with participants and research can be problematic where this does not occur. Another potential weakness of the approach is a tendency of those involved to rely on the researcher as an expert. The practitioner-researcher can also have a tendency to focus on operational and efficiency issues rather than on research and development and strategic thinking (Cohen, Manion and Morrison, 2007). Furthermore, concern has been expressed about the incompatibility of action and research. Research values the concepts of precision, control, replication and attempts to generalise from a specific situation (Cohen et al, 2007). Whereas action, on the other hand, focuses on translating generalisations into some kind of

specific action. Finally, it is argued that whilst action research has a methodology for creating data, it does not have a specific methodology for interpreting it (Cohen, Manion and Morrison, 2007). This represents a fundamental criticism of the approach, and one this research aimed to overcome by adopting a theoretical framework to support the analysis and interpretation of its research findings.

3.5.4.2 Co-operative Inquiry

Co-operative Inquiry is a form of action research that draws on humanistic principles. It stresses the importance of the participation of all involved in the research process as co-researchers and co-subjects and uses the humanistic principle of self-determination. In other words, it sees participants as active agents in the research process and emphasises the need to do 'research with people, rather than on them.' (Heron and Reason, 1996, p.2). It asks participants to work collaboratively to make sense of their world and practice, and to take creative action to address matters of importance. Heron and Reason (1996) outline the defining features of co-operative inquiry as:

- all the active subjects are involved as co-researchers;
- the validity of approach is maintained through agreed procedures and cycles of inquiry;
- there is an interplay between reflection, making sense and action; and
- there are different forms of knowing including experiential, presentational, propositional and practical forms of knowledge (Heron and Reason, 2006).

Heron and Reason (1996) outline a number of pre-requisite skills and research procedures in order to maintain the validity of the approach (see Heron and Reason, 1996, for a fuller discussion). Furthermore, they suggest that:

‘ knowing is grounded in our experience [experiential knowledge], expressed through our stories and images [presentational knowledge], understood through our theories which make sense to us [propositional knowledge] and expressed in worthwhile action in our lives [practical knowledge] (Heron and Reason, 1996, p.12).

Participants contribute to research by ‘generating ideas, designing and managing the project, and drawing conclusions from the experience, and they are also co-subjects, participating in the activity being researched’ (Reason, 1994, p.326.) Moreover, the approach depends on free expression, co-operation and empowering relationships between those involved. However, ‘Co-operative inquiry does not explicitly address power relations and the potential transformative effects of the research’ (Mertens, 2005, p.243). Furthermore, the approach appears to place an emphasis on the pragmatism and the personal interpretation of data rather than the use of an existing theory to support this analysis and interpretation. Moreover, the approach does not explicitly consider the ‘situated’ nature of knowledge (Mertens, 2005) and the influence of social, cultural and historical factors on knowledge and its acquisition (Edwards, 2000)

3.5.4.3 Sociocultural activity theory

A developing research tradition within the broad transformative paradigm is activity theory research, which has its origins clearly within Marxist philosophy and dialectics (Engestrom and Sannino, in press). The approach was

developed through the early work of Russian cultural psychologists, in particular, the work Vygotsky (1978), and Leont'ev (1978). Activity theorists reject the dualism, outlined earlier, between the experimental-positivist and constructivist-interpretative approaches to understanding and researching human being, learning and development (Engestrom, 1999a). As Engestrom (1999a) points out the traditional:

‘division between the social sciences and psychology’ has led to separate notions that ‘humans are controlled either from the outside by society or from the inside by themselves.’ (Engestrom, 1999a, p.29).

Sociocultural activity theory (SCAT), therefore, provides a means by which the interaction between the individual (with their thoughts, feelings, behaviours and constructs) and society (with its dynamic social, cultural and historical features) can be researched and understood (Engestrom, 1999a).

Engestrom (1999a) further contends that the Vygotsky’s notion of the cultural mediation of action suggests that:

‘the individual could no longer be understood without his or her cultural means; and the society could no longer be understood without the agency of individuals who use and produce artefacts.’(Engestrom, 1999a, p2).

Sociocultural and activity theory, therefore, calls for an approach to research which attempts to understand human activity within a systemic context, and by reference to the mediating influence of social, cultural and historical factors.

Edwards (2000) contrasted the activity theoretical approach with action research and suggested that if action research was concerned with facilitating systemic change, then sociocultural activity theory (SCAT) offered an analytical tool by which to promote informed action. SCAT provided a way for

the researcher to consider the influence of histories on current and future actions (Edwards, 2000). Given this, the researcher took the view that the research drawing on the transformative and sociocultural paradigm of activity theory was most suited to this research.

A further detailed consideration of Activity Theory and its methodology and methods used in this study are provided later in this chapter in Section 3.5.6 onwards. Prior to this the researcher's other design decisions are considered.

3.5.5 Other design considerations

3.5.5.1 Fixed versus flexible design

A fixed design typically involves a predetermined experiment on a group by manipulating variables and testing a priori hypotheses (Robson, 2002).

However, the present research aimed to be transformative in nature and therefore the precise path and direction of the research was not fully known.

The researcher needed to be responsive to the participants and context in which the research was taking place. The path and direction of the research is , in part, determined by the responses and learning of participants. For these reasons, a flexible research design was chosen in order that the researcher may respond to the exploratory and potentially transformative nature of the findings generated. The four phases of the research are described later in this chapter and illustrate the flexible and evolving nature of the design used (see Section 3.10). A flexible research design is very much in keeping with a central tenet of activity theory research and the idea that it promotes agency

in those whose subject perspective is under research (Engestrom and Sannino, in press).

3.5.5.2 Qualitative versus quantitative

Activity Theory allows for a mixed methodology in which qualitative and quantitative data can be drawn on and used. The stakeholders to the study were keen to ensure that the perspectives of as many members of the team were obtained as possible, and then used to create rich description of the team's activity system. It was therefore concluded that a largely qualitative approach and analysis would enable the researcher to capture the multiple perspectives within the team's activity system. The adoption of qualitative approaches drawing together these different perspectives within the activity systems fits with the idea that an activity system is multi-layered and multi-voiced (see Engestrom, 1999, for example). The exploration and understanding of all voices and interaction within the system was considered key to understanding and promoting transformation in the multidisciplinary team.

3.5.5.3 Single or multiple case study design

Consideration was given as to whether to use a single or multiple sites for the research. However, because of the many and different ways multiagency teams are constructed (Anning et al, 2006). It was felt that it would be more appropriate to adopt a single case design and to obtain the multiple voices and sources of information within this single case (see Yin, 2009). Indeed, it has been suggested that the activity theory approach is particularly suited to single case study design, as this allows an activity system to be considered

within a unique sociocultural and historical context and situation (Murphy and Rodriguez-Manzanares, 2008).

3.5.5.4 Evaluative, exploratory and transformative research

An additional consideration made the researcher, in collaboration with stakeholders, was the extent to which the study should seek to evaluate outcomes, explore processes and/or promote change. The commissioners of the research highlighted a considerable amount of internally and externally sponsored evaluation research that had taken place with the team and its immediate context. A number of the studies evaluated the efficacy and effectiveness of the team (see Window et al (2004) and Vostanis et al, (2006)). Indeed, the team itself had a considerable amount of outcome data demonstrating its effectiveness (see Appendix 2).

In addition, the team was facing a significant change in the scope and nature of its work. The managers of the service were keen to capture and draw on the culture and history of the existing tier 2 team and to use this as a basis for informing the future planning and development of the service. To this end, the stakeholders were keen to support research that aimed to explore the team's systems and processes and to use these as a basis to support change.

Employment of an activity theoretical approach enabled the researcher to explore and analyse the team's activity system and to use this as a basis to support transformations in the team's activity system (see Engestrom, 1987).

It was therefore agreed that the present research would adopt an activity

theoretical approach and to use this, where possible, as a basis to support individual, professional group and team learning and development.

3.5.6 Summary of section

Within the transformative paradigm a number of different approaches to research can be used to promote development and change in practice (Mertens, 2005). These can offer fundamentally different conceptions of how development and change are promoted through research. Action Research (McNiff, 2002) and Co-operative Inquiry (Heron and Reason, 2006) aims to work with participants collaboratively and co-operatively in their current context to facilitate or empower them to make changes. The approaches depend on building collaborative and co-operative effort in research and subsequent actions. Both of these approaches has an appeal to an applied psychologist seeking to work with, and alongside others, to make changes to a situation and to reduce any perceived power differentials between the researcher and participants. However, neither approach explicitly considers the transformational power of history and culture on learning and development in research and practice (Mertens, 2005). Indeed, the stakeholders and team involved in the present research were particularly keen to learn from the culture and history of the team, as a way of informing future team and service development.

The activity theory approach, with its emphasis on sociocultural and historical development of an activity system, was felt to be most suited the aims of this research. It enables the researcher to explicitly consider historical and cultural

influences on participants' learning actions and activity systems. Furthermore, Engestrom's (1987, 1999b) activity theory approach offers a theoretical framework and methodology through which the researcher can explore and analyse, and potentially transform, the contributions and learning of professionals working within a multidisciplinary team context. So the thesis now moves back to consider sociocultural activity theory, and its associated methodology and methods in more detail.

3.5.7. Sociocultural activity theory

'How do human beings – how can they – come to know anything about the world?' (Toulmin, 1999 p.53)

As highlighted above, the principal paradigms and theories in psychology and psychological research offer quite different theoretical frameworks for understanding human behaviour and learning. There are those that stress the importance of instrumental behaviour in determining human learning and development (for example, Skinner, 1962). Whilst others still emphasise the importance of cognition and emotion in determining behaviour i.e. Ellis (1962) and Beck (1976). Furthermore, for traditional psychology knowledge is situated in the consciousness of individuals (Davydov, 1995).

Vygotsky's (1978), on the other hand, emphasised the importance of culture on human development and learning. As Davydov (1995) suggested:

'the ideal [knowledge] cannot be discovered or understood at the level of consciousness of a single person; the ideal is an aspect of culture'. (Davydov, 1995, p.15)

Vygotsky (1978) further recognised that social, historical and cultural practices and learning were promoted by tool mediated action. Such tools or artefacts

were considered to be imbued with cultural, historical and social information of the society or culture to which they belonged. He also considered that these tools or artefacts could be used to support learning through a process of mediation. It was presumed that through mediation the cultural, historical and social aspects of learning and development are passed on from one person to another in a culture. Vygotsky (1978) further proposed that in order to promote learning and development in a person, it was important to identify their 'Zone of Proximal Development (ZPD)'. The ZPD represented the difference between what a person could do with, and without, mediation.

It was further assumed, within the Vygotskian tradition, that human learning and behaviour were sociocultural processes. Furthermore, those adopting a Vygotskian approach would expect that intra-psychological processes (or a "process of internalisation" as Engestrom (1999a) refers to it) would be promoted by inter-psychological processes i.e. interaction between people within a social, cultural and historical context (through what Engestrom (1999a) calls a "process of externalisation"). It was assumed within this approach that cognitive development and learning is promoted by tool mediated activity.

The sociocultural approach also assumes that knowledge, learning and development are culturally embedded and that human behaviour or activity cannot be understood without reference to the culture within which it is situated. Furthermore, culture, itself, cannot be understood without recourse to individual perspectives. Research stemming from the sociocultural tradition

therefore needs to consider the individual and their culture, and reciprocal interaction between the two.

Activity theory offers a theoretical and systemic framework through which the interaction between the individual and their sociocultural historical context can begin to be explicated. For activity theorists it is:

“First, collective activity, then culture, the ideal [knowledge], sign or symbol, and finally individual consciousness.” (Toulmin, 1999, p. 16)

Moreover,

‘The goal of the sociocultural approach is to explicate the relationship between human action, on the one hand, and the cultural, institutional, and historical situations in which this action occurs, on the other.’ (Wertsch et al, 1996, p. 11)

Furthermore, Engestrom (1999a) suggested that the traditional ‘division between the social sciences and psychology’ had led to the separate notions that ‘humans are controlled either from the outside by society or from the inside by themselves.’ (p.29). Sociocultural activity theory (SCAT) provides a means by which the interaction between the individual (with their thoughts, feelings, behaviours and constructs) and society (with its dynamic social, cultural and historical features) can be understood.

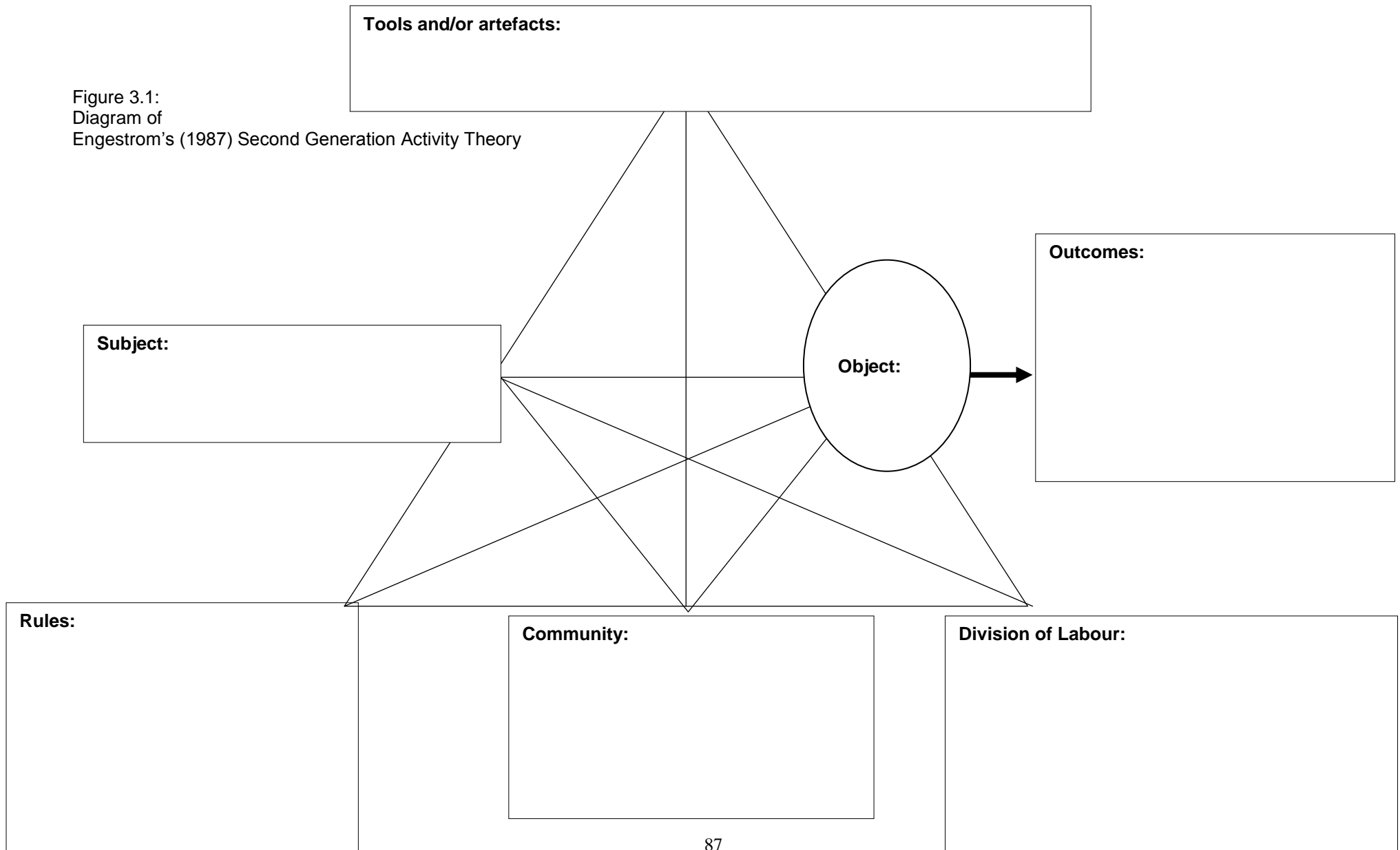
‘Humans can control their own behaviour – not “from the inside”, on the basis of biological urges, but from “from the outside” using and creating artefacts’ (Engestrom, 1999a, p.29).

However, Engestrom (1999a) argued that the problem with a simple triadic representation of action, involving subject – mediating artefacts – object, such as that proposed by cultural psychologists like Vygotsky (1978), is that it does not fully explain the societal and collaborative nature of action (Engestrom et al, 1999). Engestrom (1999a) further suggested that a more complex model of an activity system is required. He proposed a model in which subject – object

were not only mediated by artefacts/tools but also by the rules or conventions that exist, the community (i.e. others working on the same object) and the division of labour (i.e. how that work on the object is shared). This, Engestrom (1999a) contended, provides the social, collaborative and cultural context in which individual actions take place (see Figure 3.1 below).

It is also important for the purposes of the study to define what 'subject' in activity theory means. 'Subject' refers to the individual or group whose agency is being used as the point of view of analysis' (www.edu.helsinki.fi), accessed on 3/11/2006). Object is defined as the 'thing' (or problem space) that the activity is directed toward. Tools are considered the mediating instruments that are used on that object and can be either concrete or conceptual. Community refers to the individuals or group who share a common object. Division of labour refers to how tasks, power and status are shared between members of the community within an activity. Rules, on the other hand, are the implicit and explicit regulations, norms and conventions that constrain and promote action and interaction (Russell, 1997).

Figure 3.1:
Diagram of
Engestrom's (1987) Second Generation Activity Theory



Sociocultural activity theory (SCAT) and Cultural – Historical Activity Theory (CHAT), therefore, offer a conceptual or theoretical framework by which the activity and work of professionals can be analysed. This can help the researcher to understand the social, cultural and historical influences on professionals' practice and, in particular, their work within multidisciplinary teams.

The approach also enables the points of contradiction to be brought to the surface and 'worked on', so change, development and learning can take place (Leadbetter, 2005).

'Using activity theory analysis enables specific elements to be drawn out and the relationships and conflicts and contradictions to be considered'and..... 'through analysis of activity systems, often in conjunction with the participants, it is possible to consider the contradictions between the different elements....' (Leadbetter 2005 p.24)

Leadbetter (2005) further suggested that "activity theory becomes not only a tool for analysis but also part of a structured and coherent developmental process." p.26. This involves what Engestrom (1999a) referred to as the process of 'expansive learning', which underpinned his 'developmental work research' techniques, both of which will be discussed in more detail later in this chapter.

'Change can be seen as expanding the potential for learning (or expansive learning)" and "opening up possibilities for changing work practices within the context that the system is operating in.' (Engestrom, 1987, p.24-25).

Engestrom (1999a) further argued that it could be useful to move from the analysis of individual actions to an analysis of their broader context and back again. He further suggested that:

‘actions involve failures, disruptions, and unexpected innovations ... analysis of the activity system may illuminate the underlying contradictions that give rise to those failures and innovations.’ (p.32).

In this study, Engestrom’s (1987) social cultural activity theory framework is therefore used to enable the exploration of the complex dialectal influence of culture on the individual and the individual on the culture within a multidisciplinary team.

3.5.7.1. Theoretical underpinnings

‘Species do not adapt to environments: they construct them.’ (Lewontin, 1982, p.163 cited at www.edu.helsinki.fi/activity/pages/chatanddwr/activitysystem/ accessed on 3/11/2006).

As briefly discussed earlier, Sociocultural Activity Theory (SCAT) or Cultural Historical Activity Theory (CHAT) has its roots within a Marxist philosophy. Working from this tradition, Vygotsky (1978) was the first to suggest the idea that human action was mediated by tools and signs and that collaboration with others created the potential for learning (or a zone of proximal development). Building on this, Leont’ev (1978) proposed that an activity was a collective system driven by both its object and motive. He further suggested that to understand development and learning one needed to study complete activity systems including their objects and motives. Other theorists such as Luria (1976) and Il’enkov (1977) developed activity theory to suggest that cognition was culturally mediated and that activity systems could be analysed and understood by examining their internal contradictions.

Moreover, Engestrom (1987) suggested that analysis of the many interacting relations within an activity system (depicted by the lines in Figure 3.1.) can provide insights into those things that mediate between a subject and the object of their work and its motive. Engestrom (1987) further suggested that an activity system is heterogeneous and multi-voiced, and that there is constant negotiation, construction and re-construction within an activity system. An activity system is constantly working through contradictions within, and between, its elements. An activity system produces change and development through analysis of these contradictions.

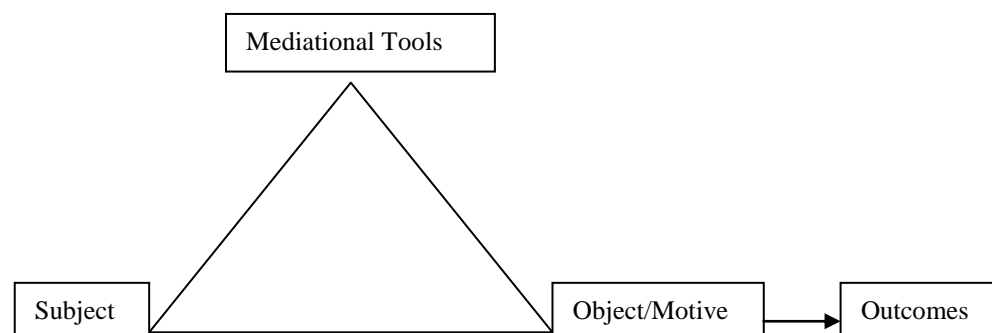
Engestrom (1987) further suggested that four different types of contradictions could be identified within activity systems. Primary contradictions are those that occur within particular internal aspects of an activity system, for example, in the tools used. Secondary contradictions occur between the different internal elements of the activity system indicated by the lines, for example between the tools and the community. He further proposed tertiary contradictions occur when a new object and motive are formed and migrate away from original object and motive. Finally, he suggested that quaternary contradictions emerge from the interaction between an activity system and other related activity systems (for example, where the activity system of one service contradicts another). It is the analysis of these contradictions within, and between, activity systems that promotes development and learning.

3.5.7.2. First generation activity theory

Activity theories are considered by Engestrom (1987) to be based on understanding of the triadic relationship between subject (individual or group), mediating artefacts or tools, and object (the thing being worked on) and its motive. This approach, Daniels (2001a) pointed out, stemmed from very early developments of Vygotskian theory. A methodology based on Vygotskian theory aimed to understand the tools/artefacts that mediate between the subject and the object of their activity and its outcome. The assumption being that the signs, symbols and tools used are imbued with previous cultural and historical tradition of the activity. It further assumes that experienced ‘actors’ use these signs and symbols to mediate the learning of others new to the object of the activity. These are so-called first-generation activity theories and are represented by Figure 3.2 below.

Figure 3.2. Model of first generation activity theory

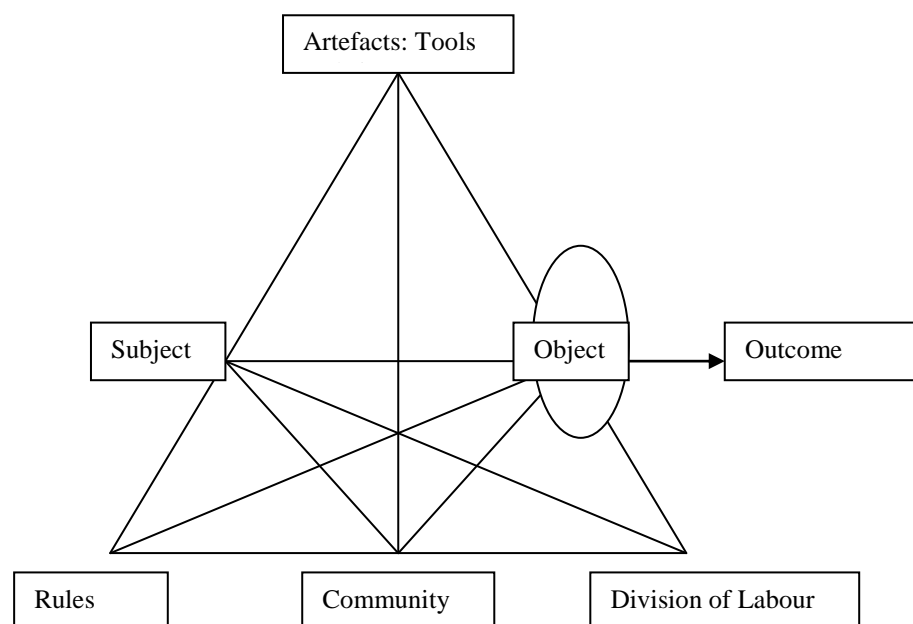
(Adapted from Daniels, 2001a)



3.5.7.3. Second generation activity theory

Engestrom (1987) proposed an expansion of this triadic relationship to take greater account of the community and social context in which an activity occurs. It introduced the idea that subject – object relationships were not just mediated by cultural-historical artefacts but by the sociocultural context and community within which and with whom they take place. This led Engestrom (1987) to propose a Second Generation Activity Theory which is represented in the activity triangle in Figure 3.3 showing the increased complexity of the interrelationships and interactions within an activity system.

Figure 3.3 Model of second-generation activity theory (Engestrom, 1987)

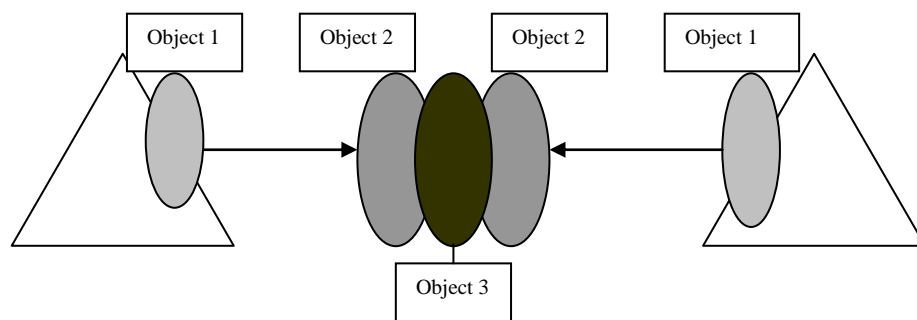


Engestrom (1987) highlighted the importance of understanding the interrelationships and dynamic interaction between the different elements of the activity system. Furthermore, he suggested that examination of the interactions within and between each of the elements of the activity triangle

may highlight contradictions. Contradictions for Engestrom are points of tension or potential for change that if worked on will enable an activity system to learn and evolve.

3.5.7.4. Third generation activity theory

Figure 3.4 Third-generation activity theory model (Engestrom, 1999b)



Engestrom (1999b) in an expansion of his second generation theory proposed that an activity system does not occur in isolation of other activity systems in the community and that there is not only a dialectic interaction within an activity system but also between activity systems (See Figure 3.4). It is this dialectic interaction that leads to the formation of new and evolving objects for people to work on. Engestrom (1999b) proposed that it is the contradictions between two interrelated activity systems that offer the space for development and growth. Furthermore, he pointed to the tension that can exist between existing and newly formed objects of an activity system that also creates further opportunity for development through expansive learning

3.5.8. What is expansive learning?

Drawing on Bateson's (1972) conceptual model of learning, Engestrom and Kerosuo (2007) suggested that the theory of expansive learning is a process occurring over time in which:

‘ participants of an activity system take specific learning actions to analyse inner contradictions in their activity, then design and implement a new model for their activity, that radically expands its object, opening up new possibilities for action and development.’
(Engestrom and Kerosuo, 2007, p339)

Bateson (1972) proposed that there were three levels of learning, Learning I, II and III. Learning I refers to any given response appropriate to its context. Learning II is where people learn the embedded rules and typical patterns of behaviour for the context. Finally, Learning III is where a person begins to question the meaning and sense of their context (Daniels, 2008). This creates dilemmas or double binds for the subject whose perspective is being considered.

Elaborating Bateson's (1972) model of learning III further, Engestrom (2001) argued that:

‘The object of the activity system is the entire activity system in which learners are engaged. Expansive learning at work produces culturally new patterns of activity. Expansive learning at work produces new forms of work activity’ (Engestrom, 2001, p139)

Furthermore, Daniels et al (2007) describes expansive learning as the:

‘capacity of participants in an activity to interpret and expand the definition of the object of the activity and to respond to it in increasingly enriched ways. (Daniels et al, 2007, p523)

Moreover, the theory of expansive learning is based on the dialectics of ascending from the abstract to concrete. Engestrom (2001) suggests that rather than just seeing learning as a vertical process in which humans

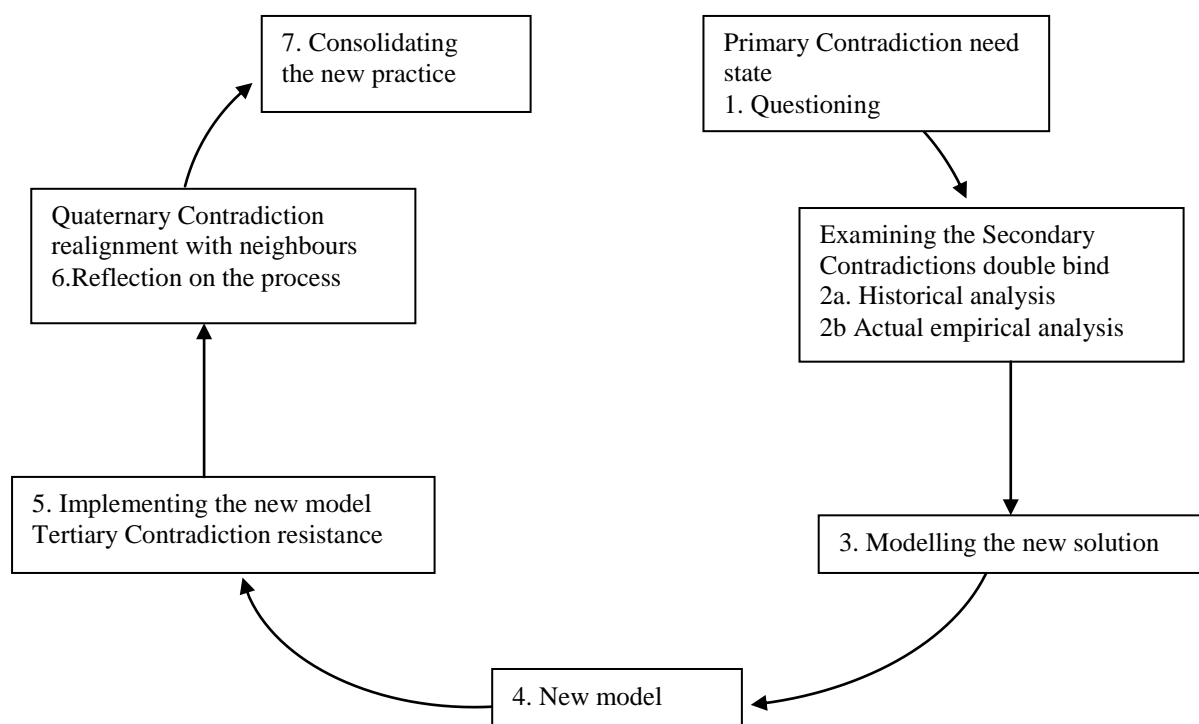
gradually acquire greater competence. We should also see learning as also occurring horizontally and sideways leading to the development of new patterns of activity. In expansive learning a simple idea develops from the more complicated object to a new form practice. Moreover, Engestrom and Sannino (in press) define expansive learning as the:

‘learning in which learners are involved in constructing and implementing a radically new, wider and more complex object and concept for their activity.’ (Engestrom and Sannino, in press, p2 of 24)

3.5.8.1 The expansive learning cycle

Engestrom (1999a) considered the points of contradictions, between and within an activity systems, as creating the space and opportunity for expansive learning. He suggested that expansive learning is a cyclical process that leads to constantly changing objects and activities. This process is illustrated in Figure 3.5. He argued by bringing contradictions to the surface and working on them created the potential for expansive learning in individuals, groups or communities of practice.

Figure 3.5 Cycle of expansive learning (after Engestrom 1999b)



Engestrom (2001) further argued that expansive learning is triggered by participants' 'conflictual questioning of existing standard practices' (Engestrom, 2001, p151). This, in turn, leads to a more in-depth analysis and questioning. The dual action of questioning and analysis are aimed at identifying and defining the tensions and the contradictions that are behind them (Engestrom, 2001). The third stage of the expansive learning cycle is that of modelling. Modelling involves the formulation of new framework as the result of the analysis of contradictions. When modelling reaches fruition it results in the development of a new solution and activity. The new model is examined and either accepted or rejected, and then may be implemented, which opens a whole new series of tensions and contradictions (Engestrom, 2001). However, as Engestrom and Sannino (in press) caution 'the cycle of expansive learning should not be seen as a universal formula of phases and stages of expansive learning.' (p. 8 of 24)

3.5.8.2 Expansive learning and contradictions

Contradictions are the driving force behind development, change and expansive learning in activity systems. Contradictions are viewed as

'historically evolving tensions that can be detected and dealt with in real activity systems.' (Engestrom and Sannino, in press, p.4 of 24)

Furthermore,

'Expansive learning requires articulation and practical engagement with inner contradictions of the learner's activity system.' (Engestrom and Sannino, in press, p.5 of 24).

However, Engestrom and Sannino (in press) contend that there is a large difference between conflict experiences and developmentally significant contradictions. The first are associated with short-lived actions and the

second to evolving longer term activity systems. Moreover, Engestrom and Sannino (in press) argued that these conflicts, double binds or dilemmas, disturbances and local innovations may be analysed as manifestations of contradictions. Furthermore, Sannino (2005) proposed that the roots of conflicts can be explored by shifting from action level of conflict to activity level of contradiction' and back again. Engestrom and Sannino (in press) further contend that the larger scale expansive learning cycle contains within it smaller cycles of learning actions.

'Smaller cycles may take place within a few days or even hours of collaborative analysis and problem solving.' Engestrom and Sannino (in press, p.11).

Moreover, Engestrom (1999b) suggested that these 'Miniature cycles of innovative learning should be regarded as potentially expansive' (Engestrom 1999b, p.385), as a full expansive learning cycle is uncommon and requires considerable effort and supported intervention (Engestrom and Sannino, in press).

3.5.8.3 How is expansive learning identified?

In undertaking an activity theoretical approach Engestrom (1999b) proposed two main forms of analysis that can be used:

- 1) the historical-genetic, which seeks to explain the activity system by tracing its origin and evolution and
- 2) the actual-empirical, which seeks to explain the system by examining the inner relationships.

The present study adopted an actual-empirical approach rather than an explicitly historical-genetic approach.

Furthermore, Engestrom (2000) contends that there are four dimensions by which an object can be expanded. These are socio-spatial, anticipatory-temporal, moral-ideological and systemic-developmental. He highlights some key questions that might be used to indicate whether expansion has occurred on these dimensions or not. These are:

- Socio-spatial dimension - 'Who else should be included?'
- Anticipatory-temporal dimension - 'What previous and forthcoming steps should be considered?'
- Moral-ideological dimension - Who is responsible and who decides?
- Systemic – developmental dimension - How does this shape the future activity?

3.5.8.4 Expansive learning theory and Intervention research

Engestrom (1999b) used his theories to develop interventionist research methodologies such as the Developmental Work Research (DWR) (Engestrom, 1999b) and the Change Laboratory approach (Engestrom, 2007), in which a researcher supports work groups to explicitly consider contradictions in their activity systems (see Engestrom, 2007). Moreover, Engestrom and Sannino (in press) argued that the theory of expansive learning was helpful in the 'analysis of learning in non-traditional, hybrid and multi-organisational settings' (Engestrom and Sannino (in press), p.3), such as might be found in comprehensive CAMHS and the tier 2 multidisciplinary team within this study.

However, Engestrom and Sannino (in press) further contend that there is a distinction between the generalised object of a historically evolving activity

system and the specific object as it appears to a particular subject within any given action. The former is connected to societal meaning and the latter connected to personal sense making or meaning (Engestrom and Sannino, in press). They argued that the theory of expansive learning cannot be reduced to abstract learning within organisations without real human subjects. They suggest that the system's view is insufficient means of promoting expansive learning and

‘movements between the system's view and subject view is of crucial importance’ (p.6) and ‘changes must be initiated and nurtured by real, identifiable people, individual persons and groups’(p.6.)

Engestrom and Sannino (in press) also argued that expansive learning calls for formative interventions to be based on the Vygotskian principle of double stimulation (Vygotsky, 1978). They suggest that Vygotsky's (1978) concept of double stimulation creates the idea of formative interventions, which are very different from the linear notion of intervention embedded in the traditional idea of the controlled experiment (Engestrom and Sannino, in press). The concept of double stimulation is discussed later in Section 3.6.5.

Finally, Engestrom and Sannino (in press) contend that interventions using the change laboratory approach occupy an intermediate position between the mini-cycles of innovative learning actions and the macro-cycles of expansive learning. Formative interventions such as DWR (Engestrom, 1999b) and the Change Laboratory (Engestrom, 2007) attempt to accelerate and intensify the expansive learning process by introducing successive tasks that require specific learning actions. However, Engestrom and Sannino (in press) also observe that expansive learning cycles are quite rare and difficult to document

due their spatially and temporally distributed character. 'Researchers should not expect nicely linear results from their efforts.' Engestrom and Sannino (in press, p.15)

3.5.9. Criticisms and potential limitations of activity theory

Criticisms of activity theory in general and of Engestrom's theories in particular can be summarised as follows:

- Activity theory is not a unified theory but a set of overlapping articulations (Holzman, 2006).
- Activity theory does not sufficiently acknowledge the natural world and the wider biological and ecological systems in which human activities take place (McMurty, 2006).
- Activity as a unit of analysis is not sufficient in itself, as it does not take sufficient account of different psychological processes that can underpin very similar activities. Analysis of an activity cannot tell us why and how a person is engaged in an activity (Toomela, 2000).
- Activity theory is limited in its analysis of mental phenomena in particular emotions (Toomela, 2000) and does not consider sufficiently the influence of an individuals' affect, motivation and identity on an activity (Roth, 2007).
- Discourse and identity are underdeveloped in CHAT (Daniels, 2007).
- Engestrom's theories provide a conservative praxis and an overly technical approach that undermines the potential radical and transformational power of social conflict and social antagonism and does not give sufficient recognition to the socio-economic and political context in which activity and development takes place (Avis, 2007); and

- Engestrom's (1987, 1999a) theories and approaches are drifting away from activity theory's original concern with the social mediation of human consciousness through inter-subjective interaction (Thompson, 2004).
- Activity theory does not have clearly defined and specific research procedures and methods (Murphy and Rodriguez-Manzanares, 2008).

3.5.10. Strengths of the activity theoretical approach

Other researchers and theorists, however, have spoken in defence of activity theory (Ratner, 1997), and talk of reclaiming aspects of the approach from those with a more cognitive outlook (Stetsensko and Arieviditch, 2004).

Arguments put forward include that:

- cognition and culture are embedded within historically developing and culturally mediated activity systems and that activity theory provides a means towards a study of human thought within joint mediated activity (Lecusay et al, 2007);
- identity and discourse of individuals are best understood within 'the ensemble of societal relations' (Daniels, 2007, p.95) and concepts of identity need to be tied to concrete practical activity (Daniels, 2007);
- the use of 'subject' as a unit of analysis would help to overcome concerns about how to consider individual agency within an activity system (Blunden, 2007);
- understanding of the self and identity is embedded with sociocultural contexts and cultural mediated activity, which should be seen as the foundation of the self, and analysis of the self should be incorporated within the system of social relations (Stetsensko and Arieviditch, 2004); and

- flexibility and versatility of activity theory's research procedure and methods allows them to be applied across a wide range of settings (Murphy and Rodriguez-Manzanares, 2008).

3.5.11. Development of the theory and its methods

Daniels (2007) cautioned against the ' inappropriate incorporation of theoretically incompatible ideas' (p.97) within activity theory. He pointed to the importance of finding a ' language of description' for activity theory research. This he argued would help the researcher to capture the social principles which underpin the regulation of the 'the ensemble of societal relations' (Daniels, 2007 p.95), and support analyses of these relations in a way which allows for the parameters of power and control to be considered. Edwards et al (2009) and Daniels (2007) further proposed that Bernstein's (2000) work on conceptualising discourse in language might provide the activity theory researcher with this 'language of description.'

Boag-Munroe (2004) in an attempt to find a language of description combined the theoretical framework of activity theory with Critical Discourse Analysis (CDA). This provided a potential method to analyse language use within activity theoretical framework. Boag-Munroe (2004) suggested that:

'CDA can be used as both a analytical tool and theoretical approach, which can be combined with other theories and methods to interrogate text so that relationships and behaviours within and between communities can be better understood and explained.'
(Boag-Munroe, 2004 p.169.)

Boag-Munroe (2004) applied the CDA approach to three separate interviews with teacher mentors who had responsibility for initial teacher training. Mentor

language was contrasted with language in government policy using the support of Wordsmith, a computer programme to analyse the frequency of word use. However, she concluded that the CDA approach did not fully take account of the 'paralinguistic' features of an activity system but could offer some interesting insights into textual data and the dynamic of an activity system (Boag-Munroe, 2004).

Edwards (2000) contrasted the activity theoretical approach with action research and suggested that if action research was concerned with facilitating systemic change then sociocultural activity theory (SCAT) offered an analytical tool from which to promote informed action. SCAT provided a way for the researcher to consider the influence of histories on current and future actions (Edwards, 2000). Edwards (2000) further pointed out that:

'Systemic analyses are not seeking equilibrium. Instead, the contradictions and turbulence identified within the systems are characterised as points of systemic adaptation and expansive learning. As part of the process of expansive learning the analysis is fed back to participants in the system so that they might interrogate the evidence, and ultimately seek and test alternative ways of operating.'
(Edwards, 2000, p.201)

'SCAT research is multi-layered and consciously weaves together relationships between culture, mind and action' (Edwards, 2000, p.198) and 'knowledge is accordingly constructed dialectally in interaction with cultural tools that mediate the knowledge in use in that community.' (Edwards, 2000, p.198).

3.5.12. Applications of activity theory in work settings

Engestrom (1999b) has led the way in applying his theories to workplace activity systems and has illustrated the application of his theories and approaches to a range of different settings including medical practice (see Engestrom, 1996). The theory has since been applied to a number of different work settings by other researchers, for example, Roth and Lee (2007) have applied the approach to an in depth study of work on a fish farm. Daniels (2004) has applied the approach to consideration of the sociocultural influences on the activity that surrounds children with emotional and behavioural difficulties. Using sociocultural activity theory he explored the processes involved in the identification and provision of support for children with emotional and behavioural difficulties and highlighted how different school cultures and activity systems mediated different outcomes for children.

More recently, Daniels et al (2007) and Leadbetter et al (2007) outlined the application of the theory to multiagency teams working with children at risk of exclusion in children's service settings as part of the 'Learning in and for Interagency Work Project'. They have begun to explore the sociocultural influences on multiprofessional work as well as looking at ways that learning and development in and for teams can be promoted and enhanced through the use of Engestrom's (2007) developmental work research and change laboratories. This work has been recently outlined in Edwards et al (2009)

3.5.13. Summary of section

This section of the thesis provided an overview of sociocultural activity theory as the methodology of choice for the present study. This review suggests that

despite the limitations of the approach, activity theory offered an appropriate methodology from which a sociocultural analysis of a complex multi-voiced and multi-layered activity system can take place. This thesis further contends that the approach can support a thorough analysis of a multidisciplinary activity system whose object is to promote mental health and psychological wellbeing in children and young people within family and community settings. The study also aimed to build on previous applications of activity theory by combining a range of qualitative methods of data collection and analysis in an attempt to provide a description' of the 'ensemble of societal relations' (Daniels, 2007, p.95.) contained within a multidisciplinary team. It is therefore to the outline of these methods that the thesis now turns.

3.6 RESEARCH METHODS

3.6.1. Introduction and overview of chapter

In the present study, interviews, focus group discussion and Developmental Work Research (DWR) were employed with individuals, professional groups and the entire multidisciplinary team. DWR was further used to feedback and verify the findings for each professional group and the composite team.

This section of the thesis briefly reviews the methods used in the research. It attempts to relate the approaches suggested to the methods employed in this study. It begins with an outline of the principal method used in this study; an Interview based on activity triangle framework. It also discusses the use of interviews as a method of research, drawing on the ideas of Robson (2002) and Kvale (1996). It further discusses the use of focus groups and Developmental Work Research. It also looks at the ethical and practical considerations of study, the methods of qualitative data analysis used and any potential threats to validity of the findings. The section concludes by providing an outline of the different phases of the research and explaining the method and procedure used in each phase.

3.6.2. Interviews as a sociocultural process

Interviews were used as the main tool for collecting data in this research.

Interviews are defined as ‘an interchange of views between two or more individuals on a topic of mutual interest (Kvale, 1996, p.11).’ In that sense they provide an ideal medium for a researcher working within the sociocultural

paradigm and interested in how behaviour and learning is mediated by socially situated action. The use of interviews emphasises the importance of interaction and of ‘ the importance of knowledge being generated between individuals, often through conversations (Kvale, 1996, p.14).’

Within an interview situation, knowledge is generated and constructed not objectively or subjectively but inter-subjectively (Cohen, Manion and Morrison, 2007). Moreover, an interview is more than just a conversation between two or more subjects. It often has a particular purpose and involves a series of questions being asked of a person or persons by another. Kitwood, (1977) cited in Cohen, Manion and Morrison (2007) suggested that an interview’s purpose can be viewed as either for 1) information transfer; 2) interpersonal transaction; or 3) as an everyday social encounter. Cohen, Manion and Morrison (2007) further pointed out that interviews can have a variety of other purposes, for example, to assess, to select, to effect change, to sample opinion and to develop and test hypotheses. However, the principal purpose of the interview in this study was as a process to gather information and data to enable the research questions posed in this study to be answered.

3.6.2.1. Advantages and disadvantages of interviews

The interview as a research method has the following advantages.

- It is flexible;
- it can capture verbal and non-verbal information; and
- it addresses complex and deep issues.

However, interviews can have disadvantages as a research method, in that:

- they can be time costly;
- they are open to interviewer bias;
- they can cause interviewee fatigue;
- they can be inconvenient for respondents; and
- anonymity can also be difficult to maintain.

(Adapted from Cohen, Manion and Morrison, 2007).

Additionally the interviewer needs to consider issues of trust, closeness of relationship and the power and control exerted by the interviewer on the interviewee. However, as Barker and Johnson (1998), cited in Cohen, Manion and Morrison (2007), suggested 'interviews and questions are cultural media, which provide a means by which people make sense of the world and one another' (p.230). This view of interviews supports the idea that interviews are sociocultural processes and that 'interviewers and interviewees co-construct [knowledge and understanding] through the interview process'. (Walford, 2001, p.90).

3.6.2.2. Types of interview

Interviews can vary in their formality, structure, content and style. The approach taken within an interview is largely determined by the theoretical paradigm within which the researcher is operating. Kvale (1996) suggested that there are:

‘ several forms of interview and each can vary along several continua including the degree of openness about purpose, their degree of structure and whether they are exploratory or hypothesis testing (p.126-7).’

The qualitative approach to interviewing tends to be unstructured, ethnographic and illuminative. Kvale (1996) argued that an interview within the qualitative tradition should:

- 'Engage, understand and interpret;
- use natural language;
- reveal and explore nuances;
- elicit descriptions;
- be open to new data and phenomena;
- focus on specific ideas and themes;
- accept ambiguity and contradiction;
- accept that interview may provoke insight and change;
- regard interviews as an interpersonal encounter; and
- ensure they are positive and enriching experiences.' (Kvale, 1996, p.30.)

Kvale (1996) further suggested that using interviews in research involve seven stages including:

- 'Thematizing – broad theoretical considerations.
- Designing – questions and response.
- Interviewing –setting up and the way the interview is conducted.
- Transcribing – how data is recorded.
- Analysing – how data is interpreted.
- Verifying – checking validity.
- Reporting – how reported.' (p.88.)

These stages are linked to the approaches used in the present study in Table 3.1 below.

Table 3.1 Kvale's(1996) interview stages linked to the approach used in study.

Stage	Approach used in this Research
Thematizing	Themes were pre-determined by the Sociocultural Activity theory framework used
Designing	Questions and prompts were designed to help the participant describe the different aspects of the activity in detail
Interviewing	First interview involved Introducing the purpose, obtained consent, reviewed purpose and outlined method to be used
Transcribing	A written record of participants responses and back up tape recording were made
Analysing	The activity triangle in itself is a method of analysis but this was followed by a thematic analysis (which will be outlined in the next chapter)
Verifying	Each person's response was checked back with participants at an individual, group and whole team level
Reporting	Displayed and Reported outcomes using matrices and activity triangle.

Furthermore, Robson (2002) adapting King (1994) suggested that a qualitative interview is most suited to situations where an individuals' perceptions of processes of a social unit such as a work group are needed or

where historical accounts or exploratory work is required, as was the case in the present study.

Using the sequence suggested below by Robson (2002) interviews were conducted as a one to one. Each interview was prefaced by a preamble explaining the rationale for the research, a reminder of how confidentiality and other ethical issues would be addressed and by reviewing the activity triangle framework given in Figure 3.1. The interviews were conducted using the activity triangle headings and associated questions and prompts in order to maintain a consistency of approach. These are detailed later in this chapter in Figure 3.6, although it should be noted that the order and the type of questions asked varied. Once all the data was gathered, interviews were concluded with explanation of how the data would be analysed, used and fed back to participants.

Table 3.2 Stages of the interview process suggested by Robson (2002) linked to study

Framework for interview	Approach used in this research
Introductions	Outline of rationale and purpose of Interview
Warm up	Discussion of participant's 'subject perspective', training and experience.
Main body of interview	Interview based on activity triangle framework going around each node
Cool off	A two week period between the interview and receiving the written record of the interview.
Closure	The interview closed with an outline of next steps in the data analysis.

To summarise, interviews using a semi-structured format are particularly suited to the flexible, qualitative research design and methodology used in this research. The interviews were semi-structured by the use of a theoretical framework or schedule, which allowed considerable freedom in question order and wording, and in the time spent on each aspect (Robson, 2002). Semi-structured Interviews appear particularly suited to a sociocultural activity theory approach in that they support the co-construction of knowledge and understanding through socially situated and tool mediated interaction in the interview. However, data collected in this way may be open to criticism due to the potential for interviewer bias. In order to attempt to overcome this potential pitfall, the present study used an activity theory framework as a means of structuring questions and gathering data. In addition, data collected and recorded was fed back to participants to check its accuracy and validity.

3.6.3. Focus group discussion

A focus group is a form of group interview. They provide for a group view rather than a series of individual views. It is from this interaction and discussion that data emerges. Focus groups allow for a particular or specified group of people to come together to talk about a particular issue or theme. Their strength can be that they are less time costly, can produce a lot of group level data and can facilitate particular insights (Robson, 2002).

Some potential pitfalls of focus groups include the impact of group dynamics and ensuring that all participants feel confident and comfortable in the group. Issues of group dominance and participation need to be considered to ensure

that they do not unduly influence the outcomes. Other weaknesses of the approach include the fact that the data generated may not be wholly reliable and allow generalisation to other contexts (Robson, 2002).

Robson (2002) described the advantages of the focus groups and suggested they.

- are a highly efficient way of collecting qualitative data;
- create a natural quality control (checks and balances) by participants;
- create a focus, and a consistent and shared view;
- are a flexible, and an enjoyable and inexpensive approach; and
- participants are empowered and enabled to contribute (Robson, 2002).

Robson (2002) suggested that focus groups are useful for orientating research, developing themes, generating qualitative data, generating and then evaluating data and gathering feedback from previous studies. Focus groups also provide a useful method to triangulate with data collected by other techniques such as interviews. In this study focus group discussions were used as a way of obtaining feedback on the initial activity analysis made at the professional and whole team level.

3.6.4 Developmental work research

Kuutti (1999) proposed that activity theory is in itself transformational and interventionist in its approach. He further contended that humans are not just actors but creators of their activity contexts and that their purpose is to reconstruct these contexts. Kuutti (1999) further observed that accepting this

central tenet naturally leads to the use of developmental work research, as an application of activity theory to work in organisations.

Developmental Work Research (DWR) is an interventionist methodology developed by Engestrom (1987) as way of moving from activity theory analysis of work groups to a process that acts as a stimulus for expansive learning, change and development in work groups. DWR is defined by Edwards et al (2009) as an:

‘interventionist methodology where researchers work with research participants to reveal contradictions and to promote the use of the tools of activity theory to enable practitioners to work on the contradictions. (p.174)’

The DWR approach involves a ‘subject’, usually a group with a shared object and activity, presented with a problem situation in their work supported in their addressing the problem with tools or a means to make new tools. Daniels (2007) outlines six steps that are usually involved in developmental work research.

- ‘Drawing on ethnographic evidence to question existing practices
- Analysing historical origins of existing practices and bring these to bear in analysing current dynamics within and across services
- Modelling an alternative way of working
- Examining the model to understand its dynamics, strengths and pitfalls
- Implementing the model and monitoring processes and impact of implementation in the dispositions and actions of professionals’

Engestrom (1999) further suggests that his approaches provide a theoretical framework for the analysis of innovative learning at work. He posits that activity theory is deeply contextual and orientated toward understanding

historically specific local practice, and a dialectical view of knowledge and thinking. The approach is also developmental in that it seeks to explain and influence qualitative changes in human practices over time.

Engestrom (1999b) describes how by working alongside, and with, a work group a researcher can support the group to analyse their own activity systems and to highlight contradictions and then work on these over time. Such an approach helps a work group to come up with new and developmental solutions to their own work-based problems. This forms the basis of Developmental Work Research techniques.

Central to this process of change is identification of contradictions within activity systems and then working on these to affect change within an activity system. Clearly, a potential criticism of the approach is that it seeks to intervene and change a work context whilst at the same time trying to analyse and understand it, with the result that the research is on constantly shifting sands. The DWR approach is a relatively new and emergent method that has its roots in the sociocultural paradigm. Edwards et al (2009) argued that DWR is a:

‘research methodology that reflects the view that social science should enable people to make the world a better place, through enhancing their understandings of their actions and their implications.’ (p.173)

In other words, it is methodology that enables people to transform their lives by acting in, and on their world. DWR gives participants the tools or stimuli of activity theory to work on and understand their working lives, in order that they are better able to shape these the tasks they see as necessary (Edwards et

al, 2009); using the Vygotskian notion of “dual stimulation”. DWR is adopted and used in this study as a way of promoting development and learning in the professionals and multidisciplinary team.

3.6.5 Double or Dual stimulation

The concept of dual or double stimulation was first proposed in the writings of Vygotsky (1978), as a strategy that may be used to support learning and development in children. Vygotsky (1978) observed that when faced with a new task or problem to solve (first stimulus), pitched within their zone of proximal development, a child could be supported in learning by the introduction of a neutral stimulus (second stimulus). Vygotsky (op.cit) observed that when these two stimuli were presented simultaneously a child learned over time to use the second neutral stimulus as a tool to mediate their performance toward the first stimulus i.e. the new task or problem. In other words, through the process of double stimulation a child learned over time to use the neutral object as a tool to help them solve a problem (Vygotsky, 1978).

Vygotsky (1978) regarded the process of double stimulation as an important method of helping psychologists to objectify inner psychological processes. He went on to contend that the double stimulation method enabled a psychologist or researcher to study the way a person accomplished a task with the aid of specific auxiliary means (Vygotsky, 1978).

3.6.6 Double stimulation as an intervention

More recently, Engestrom (2007) argued that the concept of dual or double stimulation could be used as part of developmental work research and, in particular, within his Change Laboratory Approach (see Engestrom, 2007). He argued that in the workplace learning situation what was required was active sense making and reconfiguration of the tasks and contexts by participants in collective workgroups (Engestrom, 2007).

Moreover, Engestrom (2007) suggested that the Change Laboratory approach provided an intervention or method, employing the principles of double stimulation, which could promote dialogue, transformation and continuous development improvement in work groups. Engestrom (2007) further argued that the approach of double stimulation could be adapted and used to support the learning and development of groups of people working within a shared activity system. As such, a work-based problem (or first stimulus) could be presented alongside the activity theory framework (as the neutral, second stimulus). The workgroup, with the aid of a researcher or research team, are then encouraged to use the second stimulus to generate the thoughts and ideas about the work-based problem. The ideas and thoughts generated are noted and used as a basis to work on and resolve the problem.

In the Change Laboratory, Engestrom (2007) describes a process in which a set of three-by-three surfaces are used (see Daniels et al, 2007 and Edwards et al, 2009, for examples). The horizontal surfaces include so-called 'mirror' material or problem situations drawn from work practices of a group. A 'model'

surface is used for theoretical tools, for an example, the activity theory framework might be used. The model can then be used to get to the systemic roots of the problems and their inner contradictions. The middle surface is reserved for the ideas or other tools generated by participants during this process. In this way the Activity Theory framework is used to make sense of the work-based problem presented in metaphorical 'mirror' by the researcher. In this way the Vygotskian notion of double stimulation is used with a work group to help them to generate novel solutions to presenting problems. The vertical surface represents past, present and future, to support consideration of the historical development of the activity and its contradictions. Using this approach, problems are examined by modelling the past activity, and then moving onto the current activity system and its inner contradiction, before moving to create a future model.

Engestrom (2007) posits that the Change Laboratory approach works in three dimensions. That is:

- 1) through the gaze of participants moving from one surface to another;
- 2) over three layers of time (past, present and future); and
- 3) within the discourse and various voices in the system.

This leads Engestrom (2007) to suggest that:

'as systemic contradictions accumulate in the work activity, repeated dilemmatic problem situations and 'impossible' tasks emerge, confusion, stress and resistance grow and unpredictable 'irrational' actions are likely. By means of external cultural artefacts such as the Change Laboratory instrumentality, a collective effort may be taken to transform the situation by agentic actions. In the Change Laboratory, disturbances and dilemmatic situations, including practitioners' own irrational actions engendered by these situations are reproduced, observed and re-experienced as 'first stimuli.' Conceptual models are

employed as 'second stimuli' to facilitate specific agentive actions of analysis, design and implementation.' (Engestrom, 2007, p21)

Finally, Engestrom (2007) concludes that the application of dual or double stimulation provides a useful method to support expansive learning activity across a range of different work groups and settings. The approach has since been applied and used to support formative interventions and transformations across a range of work place settings. (see for example, Daniels et al, 2007 and Leadbetter et al, 2007). Early evidence from these studies in the UK and elsewhere suggests that the approach can be successful in supporting expansive learning in multi-agency teams working to support vulnerable children (Edwards et al, 2009).

3.6.7. Summary of section

A review of the methods used in this study indicates that interview and focus group discussions are consistent with, and can be used to support, the application of a sociocultural approach. Furthermore, Developmental Work Research (DWR) provides a method of stimulating professional learning and development in work groups through the use of double stimulation. The methods used in the present study included a semi-structured interviews based on Engestrom's (1987) second generation activity theory and triangle. It also included the use of focus group discussion (Robson, 2002), Developmental Work Research (DWR) (Engestrom, 1999b) and use of 'double stimulation' with the whole team (Engestrom, 2007). These methods and levels of intervention were combined in an attempt to support the learning actions, and potentially expansive learning activity in individual professionals, professional groups and the entire multidisciplinary team concerned.

3.7. METHODS OF DATA ANALYSIS

3.7.1. Qualitative data analysis

This section of the thesis discusses the methods of data analysis and reviews the strengths and weaknesses of the approach used. It outlines the process of data reduction, data display and drawing, and verifying, conclusions outlined by Miles and Huberman (1994). It further considers thematic analysis as a method, drawing on the ideas of Braun and Clarke (2006).

In qualitative research the researcher takes:

‘a wide angled lens to gather data, and then, by sifting, sorting, reviewing and reflecting on them, the salient features of the situation emerge.’
(Cohen, Manion and Morrison, 2007, p.462)

According to Miles and Huberman (1994) qualitative data have the following strengths. They are naturally occurring, local, case and context specific, offer holistic and rich descriptions, can be flexible and collected over time. In particular, they help to locate meanings of events, processes and structures as well as peoples’ perceptions and assumptions about their social world

The weakness of qualitative data analysis is that ‘there are frequently multiple interpretations to be made of qualitative data – that is their glory and their headache!’ (Cohen, Manion and Morrison, 2007, p.461). In addition, the sheer volume and complexity of the data generated can create difficulties for the researcher in their analysis.

‘Qualitative research rapidly amasses huge amounts of data, and early analysis reduces the problem of data overload by selecting out significant features for future focus.’ (Cohen, Manion and Morrison, 2007, p.462).

In the present study, the theoretical framework used to record the participants' responses provided for an initial analysis of the data collected (see Figure 3.6) Cohen, Manion and Morrison (2007) further suggested there were five ways to organise and present data in qualitative data analysis.

- By groups (of respondents).
- By individual (participants).
- By issue (identified).
- By research question.
- By instrument (of data collection).

These methods of presenting and organising data are helpful and can be applied to the present study (see Table 3.3 below). It is important to note that the different forms of analysis are not mutually exclusive and that different types of analysis can be made in an attempt to obtain a comprehensive and rich sociocultural picture of the data set.

Table 3.3: Levels of data collection, analysis and display used in research to aid data analysis and interpretation.

Analysis	Purpose	Data Collection	Data Analysis	Data Display
By Individual	To identify the sociocultural context within which an individual team member's work takes place and to highlight the points of contradiction and stimulate further learning.	Semi -structured Interview generating a jointly written record of activity triangle framework and back up tape recording.	Highlighting contradictions and tensions. Checking out accuracy of record and interpretation with participant.	Activity Triangle Framework with speech bubbles indicating contradictions and tensions. Verbatim extracts of individuals evaluation of their own learning and the process used.
By Professional Group (1)	To identify the sociocultural context within which each professional discipline's work takes place and to highlight the points of contradiction and tension in order to stimulate further learning.	Individual records of each professional group. By checking these themes out with each professional group using an iterative process, whole group discussion and a written record of the discussion.	By considering individual case examples of each professional group holistically and generating the key themes and highlighting the contradictions.	Activity Triangle Records summarising the individual responses and with contradictions and tensions highlighted. Written record of the group's response to this.
By Multidisciplinary Group(2)	To identify the sociocultural context within which the multidisciplinary team's work takes place and to highlight the points of contradiction and tension in order to stimulate further learning	Individual records of the whole team. By checking these themes out with the MDT group using an iterative process, whole group discussion and written record of the discussion.	By considering all individual case examples of the full MDT holistically and generating the key themes and highlighting the contradictions.	Activity Triangle Records summarising the whole team's responses and highlighted contradictions and tensions Written records of the team's response to this
By element of the activity triangle (Instrument)	To check the validity of the themes identified in earlier analysis and provide a thorough and detailed analysis to ensure data was not ignored or lost	Written record of all data extracts for each element of the activity triangle across each professional group	Detailed thematic analysis and identification of themes for each element of the triangle for each professional group.	Matrix Grids linking the data extracts to each theme identified within each element of the activity triangle.
By Research Question	To relate the data back to the primary and secondary research questions	All of the above and extracted transcription data about participants evaluative comments on the process and the learning that came from it	The themes highlighted from all the above are summarised compared and contrasted. Interview data is reviewed for emergent themes.	Matrix grids contrasting themes for each professional group and the whole team. Extracted verbatim individual and group comments on the learning and the usefulness of the process and approach used.

Miles and Huberman (1994) argued that qualitative analysis can be defined as involving three concurrent flows of activity, data reduction, data display and conclusion drawing and verification. These three types of analysis, along with data collection itself, form the interactive, cyclical process of qualitative data analysis.

Data Reduction is defined as ‘ a process of selecting, focussing, simplifying, abstracting and transforming data that appears in written field notes and transcriptions’ (Miles and Huberman, 1994). In the present study, data reduction occurred through using a written summary of the data collected from each participant, further reduction took place in combining and summarising the responses of individuals in to professional group summary and then reduced further to provide a whole team level of analysis. Data display is ‘ an organised, compressed assembly of information that permits conclusion drawing and action’ Miles and Huberman, 1994, p.11). The data displays used in the present study include activity theory triangle frameworks at the level of the individual, group and whole service as well as matrices or thematic grids to help make link between data extracts and themes are identified.

Drawing conclusions and verifying data, Miles and Huberman (1994) argued, starts with:

‘the qualitative analyst beginning to decide what things mean.... by noting irregularities, patterns, explanations, possible configurations, causal flows and propositions.’ (p.11)

They further suggested that the competent researcher holds conclusions at the same time as maintaining an openness and scepticism. The meaning

emerging from the data have to be tested for plausibility and confirmability (Miles and Huberman, 1994). To aid this process, the conclusions drawn in this study were fed back to participants at an individual, group and team level in order to verify their validity. Table 3.4 links the method of data analysis suggested by Miles and Huberman (1994) with the method of analysis used in this study

Table 3.4: Data analysis methods recommended by Miles and Huberman (1994) linked to those used in this study

Method of Analysis	Individual Professionals	Professional Group	Whole Team
Data Collection	Written record and back up tape	Professional groups' comments on the triangles	Whole team comments on the triangle
Data Reduction	Written summary of individual activity triangle and contradictions	Written summary of the professional groups' activity triangles and contradictions	Written summary of whole team activity triangle and contradictions
Data Display	Activity triangle with contradictions highlighted	Group activity triangle with contradictions highlighted	Team activity triangle with contradictions highlighted
Drawing and verifying Conclusions	Checked with participants for accuracy and validity	Summary checked with professional group for accuracy and validity	Summary checked with whole team for accuracy and validity

3.7.2. Thematic analysis

Braun and Clarke, (2006) defined thematic analysis as 'a method for identifying, reporting patterns (themes) within the data' (p.80). They further suggested that thematic analysis (TA) rather than being a passive account of emerging themes, is one in which research plays an active role in identifying, selecting and reporting themes (Braun and Clarke, 2006). TA offers an

accessible and theoretically flexible approach and method used across a range of disciplines (Braun and Clarke, 2006). It is also a key method and tool to be used flexibly within qualitative research. It offers a technique that can be considered independent of theory and can be applied across a range of theoretical and epistemological bases. Braun and Clarke (2006) observed that:

‘TA is not wedded to any pre-existing theoretical framework, and therefore it can be used within different theoretical frameworks’ (Braun and Clarke, 2006).

This suggests that thematic analysis may be applicable and can be used with sociocultural activity theory framework without it necessarily conflicting and contradicting the sociocultural paradigm. However, any theoretical framework carries assumptions about the nature of the data that it represents. So, within TA the researcher needs to make these assumptions transparent and show reflexivity.

Common to all types of TA is the search for and identification of themes or patterns across a complete data set. Braun and Clarke (2006) pointed out that what counts as a theme can vary and that ‘there is no hard-and-fast answer to the question of what proportion of your data set needs to display evidence of the theme’ p.82 and researcher judgement and flexibility is required. They further suggested that the ‘keyness’ of a theme is not necessarily dependent on quantifiable measures – but rather on whether it captures something important in relation to the overall research question (Braun and Clarke, 2006). Researchers can consider the prevalence of a theme - i.e. the number of occurrences across the whole data set or the number of participants who

articulated these. However, Braun and Clarke (2006) suggested that the most important aspect of a thematic analysis is the consistency in the researcher's approach to analysis and creating a link to the research questions.

TA can provide for a rich description of the whole data set or a detailed account of one or group of themes. Braun and Clarke (2006) suggested that TA can be performed inductively or deductively from theory. A deductive approach involves using an existing predetermined theoretical framework to support the thematic analysis, such as in this study. As Braun and Clarke (2006) suggest a 'theoretical' thematic analysis is determined in part by the theoretical standpoint and in part by the lens through which the researcher first views and then analyses the data.

Braun and Clarke (2006) suggested a good thematic analysis spells out its theoretical assumptions, and clarifies how and for what purpose it was undertaken. The research questions and theoretical assumptions should drive the method of analysis used. As Braun and Clarke (2006) argued that:

'a rigorous thematic approach can produce insightful analysis that answers particular research questions.' (p.97).

This review of thematic analysis suggests that, when properly conducted, TA can provide a flexible approach to analysis that can be used across a range of epistemologies and research questions. The present study uses a 'theoretical' thematic analysis drawing on a sociocultural activity theory perspective and lens through which the data was viewed, analysed and interpreted in order to answer the research questions outlined earlier in this chapter.

3.8 RESEARCH CONTEXT

3.8.1. Selecting a research site

In order to identify an appropriate research site and sample for the proposed study the researcher identified those authorities that were in receipt of additional funding from the government for Targeted Mental Health Services (TaMHS). The researcher then identified, from this sample, those authorities who had chosen to deliver services to children and young people through a multidisciplinary team approach and that were reported to have effective practice. The authorities practices were also reviewed to see if they had a tier 2 multidisciplinary team, those who did not were removed from the sample. Finally, the researcher selected from the sample left those authorities that were within the immediate geographical region he was working. As a consequence, one authority serving a diverse city community in terms of ethnicity, socio-economic status and levels of mental health need was identified and approached. Following discussion with the Principal Educational Psychologist, the service management team and steering group, the authority agreed to participate in the research and nominated their tier 2 Child Behaviour and Mental Health Team to participate in the research.

3.8.2. Research sample

The team selected comprised of 28 individual professionals involving representatives of disciplines from psychology, social care and health backgrounds and two different agencies, a Health Trust and Children's Services. The team included three service managers, two support staff, ten family support workers, six educational psychologists and four primary mental

health workers. The researcher aimed to interview 75% of the team to ensure a representative sample of the team's work and activity but in the end, twenty-five team members came forward to participate in the research. This represented nearly 90% of the sample available within the team. Three professionals did not participate in the individual interview phase of the research these included one EP, one AEP and one FSW. However, two of these, an EP and FSW joined the later Developmental Work Research session with the whole team. Participation in the research was voluntary. Therefore, the researcher did not feel it ethical or appropriate to pursue those team members for the reasons they did not participate. That said, those who did volunteer information indicated that it was due to their other work commitments at the time of the study.

3.8.3 Research context

In order to understand the cultural and historical development and context of the team involved in this research, the researcher gathered together a range of written artefacts of the team's current and past work during the initial phase of the research. In addition, the researcher met with the senior managers involved in the development and creation of the team over 10 years ago. The researcher also liaised with the manager responsible for children's services research development within the local authority area. This provided details of published and unpublished research that had taken place with, and about, the team. Finally, the researcher collected a range of promotional material, policies and procedures from the team. The size, volume and nature of the documentary evidence and issues of confidentiality meant that it is not

feasible to include all the documents gathered in this thesis. However, a recent anonymised service development plan is included as an overview of the current team practices and priorities (see Appendix 2).

3.8.4 Multidisciplinary team history.

The multidisciplinary team involved in this study was created in September 1999, and has successfully functioned as a child behaviour support team with responsibility for promoting the mental health of children and young people in family and community settings over the last ten years. The team was initially commissioned as a multiagency team by the local CAMHS partnership and funded via the mental health grant and other monies. The team was established to provide a city-wide early intervention service for children and their families who were considered vulnerable because of the children's behavioural, psychological or mental health needs. The team aimed to support children up to the age of 11 and their parents/carers in family and community settings.

The team combined the skills and knowledge of Family Support Workers, Educational Psychologists and Primary Mental Health Workers in support of children and their families mental health and psychological wellbeing in family and community settings. Despite originally being a temporary project and time -limited initiative, the team has managed to secure funding, and sustain itself and grow over the last 10 years. In addition, unpublished and published research by Window et al (2004) and Vostanis et al (2006) examining aspects of the team's work has provided further evaluative evidence of the

effectiveness of the team's work in promoting successful outcomes in children and, for example, supporting parents.

The service recently hosted a 10-year celebratory event (that the researcher attended), which provided further qualitative anecdotal case study evidence from service and other user perspectives as to the value of the team's work. The need to secure funding and to justify the team's work and existence meant that it had become historically and culturally important for the team to create an evidence base for the efficacy and effectiveness of its work and practices. The team has established a range of outcome indicators, which further evidenced the successful performance of the team.

The team was set up and managed by a Senior Educational Psychologist, whose vision was to create a multidisciplinary team with representatives of each of the three agencies or disciplines. As a consequence, the team was set to work at tier 2 of CAMHS, as a multidisciplinary team. Prior to this professionals worked in single discipline teams within their own agency. PMHWs worked in health services, FSWs in social care services and educational psychologists in education services. A discussion of the historical development of each professional role was given earlier in Chapter 2 and is discussed further in Chapter 5.

The numbers of staff were initially small but as the team attracted additional funding, and became known as an example of good practice, the team grew to its current size of 17 full time equivalent employees (which includes 28 full

and part-time staff). Moreover, the team's achievements have been celebrated at both a local and national level (see DfES, 2001) and a range of leading edge research activities (see for example, Window et al, 2004 and Vostanis et al, 2006) have been undertaken with the team and clients.

3.8.5 Current multidisciplinary workforce and practice

The team's workforce is ethnically diverse and as far as is possible reflects the community it is serving (see Table 3.5 below). The gender balance of the team is approximately 80% female 20% male. The age balance of the team was specified as 78% of staff were between age 30-51, 15% between age 20-30 and 7% age 51+.

Table 3.5 Ethnic backgrounds of team members from service plan

Ethnic Background	Numbers
White British	17
White Irish	1
White Black Caribbean	1
White Asian	0
Indian	2
Pakistani	1
Caribbean	1
British Sikh	2
African Asian	2

The team's work is overseen by a Multi-agency steering group that includes all members of the management group and other senior managers. (e.g. Principal Educational Psychologist). It also had representatives of the Primary Mental Health Service, Psychology Service, Family Support Service, Voluntary Sector Services, Service Users (parent), Primary Healthcare Trust (PCT), Children and Young People Services and Behaviour Support Services.

The majority of the team's work was supported by the funding streams from the Mental Health Grant, NHS Trust partnership and contributions from the Psychology Service. The team had a history of short-term funding through the use of the Children's and Innovations Fund. However, more recently 85% of the staff were funded through CAMHS grant, local authority and PCT funding. The team had had a history of uncertainty in its funding and periods of staff increases, reductions and vacancies. Despite this, the team and its staff have remained relatively stable with low staff turnover figures cited in the team's annual report (see Appendix 2).

The supervision and line management responsibilities for each professional group in the team were retained by each of the respective professions and agencies. For example, EPs were professionally supervised and managed by senior members of that profession. A similar arrangement was made for PMHWs and FSWs.

The team stated aims were to:

- 'promote the life chances of children at risk of underachievement, educational failure and social exclusion related to early indication of mental health need;
- provide locality based support to improve the skills and confidence of parents/carers and frontline professionals;
- encourage wider ownership of mental health issues across the city as they affect children and young people;

- ensure children and families have access to support in reducing behavioural disturbance;
- engage coherently with voluntary sector agencies; and
- ensure that issues affecting black and minority ethnic individuals, groups and communities are explicitly addressed within all work.'

The team delivered a range of different services in support of these aims. The table below demonstrates the range of work carried out by the team and the percentage time given to each area. The broad areas of work include direct work, training and consultation. Underpinning this was a commitment in the team and service to maintain service quality by monitoring and evaluating its effectiveness.

Table 3.6 Team activities with target percentages from service plan.

DIRECT WORK 70%	TRAINING 10%	CONSULTATION AND ADVICE 15% (10% of which is used for Advice Line)
Direct work with families and children	Training workshops in school	Telephone advice and information line
Direct Group work with parents	Solution focused training	Market stall
Direct group work with children in schools : SPARKS social growth programmes. Transition work with Year 6 children in school	CAMHS Information Event	Information leaflets written in a variety of community languages
First Response appointments	Child Mental Health Forums	Resource development
	Contribution to the CAMHS training strategy	Consultation with parents

Please see the Service's Development Plan for further details of its activity for the three years up to and including 2010.

The team's principal activities included offering direct work, training and consultation and advice. The team's most recent plan highlighted three main purposes to its activity; to provide direct work, emotional well-being and mental health training and to sustain service quality. Each of these purposes is outlined in more detail below.

Direct work.

The team aimed to provide direct work with children and families from diverse communities; to enhance parenting skills and capacity in managing common emotional and behavioural concerns and thereby promoting psychological/emotional well-being, and positive mental health.

Emotional wellbeing and mental health training, promotion & education.

The team aimed to raise awareness, and build skills, capacity and confidence of staff within universal services. It aimed to promote the importance of positive mental health and emotional wellbeing for all children and young people across the city, by enabling staff to develop a repertoire of universal, prevention and early intervention approaches.

Sustaining service quality.

The service aimed to ensure the team maintained an evaluated, effective, responsive and proactive service. In addition to the team's own evaluation a range of published and unpublished research had also been undertaken with the team.

3.8.6 Work and culture of the team.

The team had a strong culture of solution-orientated practice, undertaking evaluation of its effectiveness and collaboration between professionals at all levels. Table 3.6 above provides an overview of the principal activities undertaken by the team. In addition, the team had a policy and procedures file outlining the key protocols and procedures of the team.

Also, within its direct work the team used a range of multidisciplinary processes. These included:

1. Case allocation meetings, to consider all new referrals and to allocate them to an appropriate lead professional.
2. Undertaking 'First-Response' visits, to provide a quick (within a fortnight) response to families with lower levels of need.
3. Initial joint assessment visits involving two professionals from the team in a lead and support role.
4. A time limited 8-session programme of intervention visits.
5. A process of evaluation involving the use pre- and post-measures of parent's perceptions of children's behaviour and wellbeing.
6. Group work interventions in schools, to build children's pro-social skills and behavioural, emotional and social skills.

The activity undertaken by the team under the broad heading of consultation and advice were:

1. Developing and providing a range of resources, information and promotional work on issues of mental health and wellbeing.

2. Providing a telephone information and advice line for parents staffed by professionals from the team on a rotational basis.
3. Providing one-off consultation for parents of children whose needs were not deemed to warrant full team involvement.

Finally, the activity the team defined as training included the service contributions to:

1. Multidisciplinary mental health training.
2. Solution-focussed training for professionals.
3. Bespoke training events for schools and other organisations.

Underpinning all of these activities was a range of team and management processes. These include:

1. A multidisciplinary steering group to oversee the strategic management of the team.
2. A team management group to oversee the operational management of the team.
3. A team meeting to provide a forum for full team discussion, consultation, collaboration and where appropriate decision-making.
4. A professional group meeting to provide a forum for full team discussion, consultation, collaboration and where appropriate decision making.
5. A Case Allocation Meeting to discuss new or re-referrals and allocate to an appropriate professional group.

All of the above were supported by two support staff who worked and operated the team's budget and administrative procedures, including maintaining the team's electronic and other record keeping systems.

3.8.8. Obtaining informed consent

Following presentation of the research proposal to service managers and the steering group of the team and the multidisciplinary team itself, the service agreed to participate in the research. As outlined above the team provided details of the team, the service development plan, performance indicators and details of the other research undertaken with the team and authority (see Appendix 2, for example). The researcher subsequently attended a full team meeting to explain the research, and to seek informed consent of all team members.

3.8.9 Limitations of the study

The research took place within one local authority and with one multidisciplinary team. The team's work was focused on working to promote the mental health and wellbeing of children (up to age 11) in family and community settings (see Appendix 2). This may limit the generalisation of the findings of the research to teams serving older populations. That said, the study aimed to provide a rich sociocultural analysis of multidisciplinary practice in one particular authority context. It further aimed to support an exploratory approach and to consider what development work may be beneficial both in the authority and elsewhere. Indeed, as highlighted earlier in this chapter the study came at a time when the team involved was undergoing considerable change. In particular, consideration was being given to whether

the team would become part of a wider school and community mental health and psychological service. Those who commissioned the study viewed the research as helping to inform this development. A further discussion of potential limitations and threats to the credibility, transferability and dependability of this research are given later in this chapter

3.9. ETHICAL AND PRACTICAL CONSIDERATIONS

In order to ensure the research was conducted within the ethical guidelines of the British Psychological Society (2004) and the University of Birmingham (2007) an ethical audit was conducted and approval sought from the University of Birmingham School of Education Ethics Committee for this research. The following issues were carefully considered and planned for both in seeking this approval and in conducting the research.

3.9.1. Informed consent

All participants and managers were provided with a research briefing (see Appendix 1i) providing details of the research including information on issues of confidentiality, terms of involvement and the voluntary nature of participation prior to giving consent. The briefing covered their right to withdraw, and issues of data ownership and access to the research report and findings.

3.9.2. Maintaining confidentiality

To maintain the security, anonymity and confidentiality, all responses and information were kept securely and all identifying subject or participant details were removed from records. Individual data was treated as confidential to the participant and researcher. Participants were given the opportunity to review the written record of their interview and to check and confirm its accuracy. Electronic records including tape recording were kept in accordance with Data Protection Act (1998) requirements.

3.9.3. Data ownership and accessibility

All participants were asked to consent to their anonymous individual data being used for the purposes of the research and its publication only. The wider dissemination and publication of the findings was also included in the research briefing. In addition, participants were made aware of their right to ask for their personal data to be destroyed and to have access to the data and the report of findings at anytime.

3.9.4. Terms of involvement and right of withdrawal

Access to the researcher, the terms of involvement and right to withdraw was made explicit in the research briefing (see Appendix 1i). The researcher further explained the nature, extent and level of involvement and the time required to all participants. They were informed of their right of access to further information, advice and support from the researcher if and when this was necessary. Participants were further made aware of the British Psychological Society (2004) and University of Birmingham Guidelines (2007) codes of conduct and ethics, under which the research was being conducted,

3.9.5. Status relationship

The researcher considered at the planning stage how his own role as an educational psychology practitioner, manager and trainer might influence participants' responses. The researcher recognised that his professional background and position was a potential limitation and challenge to the validity of the research. To ensure that the position and status of researcher

did not have an undue influence on the participants' responses, the researcher addressed any perceived power imbalances felt by the research participants and encouraged participants to ask questions about the research. Moreover, a combination of iterative processes and quasi-ethnographic approaches were used to maintain dialogue and informal contact with all participants outside the structured interview and formal research. Nevertheless, it has to be acknowledged that the researcher belonged to one of the professional groups researched and therefore may be considered by some as biased. However, it was hoped that any potential power imbalance, subjectivity and bias felt were minimised within the design, methods and approach used.

3.10 THE RESEARCH PROCESS AND PROCEDURE

This section of the thesis outlines the different phases of this exploratory research and the levels of analysis used at each stage of the study. It explains each phase in turn and outlines the principal purpose, strategy and methods used. This includes description of the research process and the actual data collection techniques used. It further explains the different levels and methods of data analysis used to support the interpretation of the data. Finally, the researcher looks reflexively at the methods and approaches used and draw these together as a summary of the process.

3.10.1. The phases of research

The phases of research are summarised in Table 3.7 in order to provide an overview of the process used. This is followed by a more detailed discussion of each phase, drawing on examples from the current study.

3.10.2 . Phase one - negotiating an entry;

The main purpose of this phase of the process was to explain the rationale for the research to key stakeholders and to obtain their permission and consent to undertake the research. The methods used included meetings with personnel at all levels of the service. At each meeting the rationale for the research was introduced, in addition to the research proposal and methodology and methods to be used. This was supported by a written research briefing, which can be found Appendix 1i.

Table 3.7 A summary of the phases of research in this study

Phase One – Negotiating an entry point

Purpose: Introducing the research, initial negotiation and discussion with the Team Manager, Steering Group and Team to gain permission and consent for the research.

Method: Using collaborative action research, co-operative enquiry and drawing on Research and Development in Organisations (RADIO) framework (see Timmins et al, 2006)

Phase two – Interview with individual professionals

Purpose: To undertake activity theory analysis of individual team member's work using individual interviews based on the activity theory framework

Method: A semi-structured interview/discussion using an activity triangle and back up tape recording, followed by written feedback to individual participants via e-mail. This involved an iterative process and checking with participants the accuracy of the interpretation made. This phase involved data collection, data reduction, data display and analysis of contradictions for each individual participant's activity triangle.

Phase three – Feedback and discussion with professional groups

Purpose: To provide an initial activity theory analysis of professional group and whole teamwork for team consideration and discussion. To undertake Initial analysis by professional group and whole team activity triangles using focus group discussion and aspects of the Development Work Research (DWR) techniques.

Method: Use of data reduction, data display and initial analysis of contradictions, and an iterative process using focus group discussion and use of aspects of the development work research.

Phase four – Detailed thematic analysis

Purpose: To provide a comprehensive analysis linking themes/patterns identified to data extracts from individuals. To undertake a detailed thematic analysis of each aspect of the activity triangle to ensure the themes identified can be supported by data taken from individual and group analyses.

Method: A further process of data analysis and display use of thematic analysis including coding, grouping data and to generate themes and display them using tabular matrices.

At this stage the principal purpose was to introduce the aims of the study and outline the methods for all those involved in the service and seek their permission and then consent to undertake the research. The researcher also provided participants an opportunity to ask questions, make comments and feedback on the proposal. The process enabled the researcher to introduce himself as a person, professional practitioner and researcher and to begin to develop confidence and trust between the researcher and the researched. The researcher also placed an emphasis on the reciprocal nature of the research process as a shared learning experience.

This stage of the research included individual meetings with:

- managers of the service and team;
- the multiagency steering group; and
- the whole multiagency tier 2 team itself.

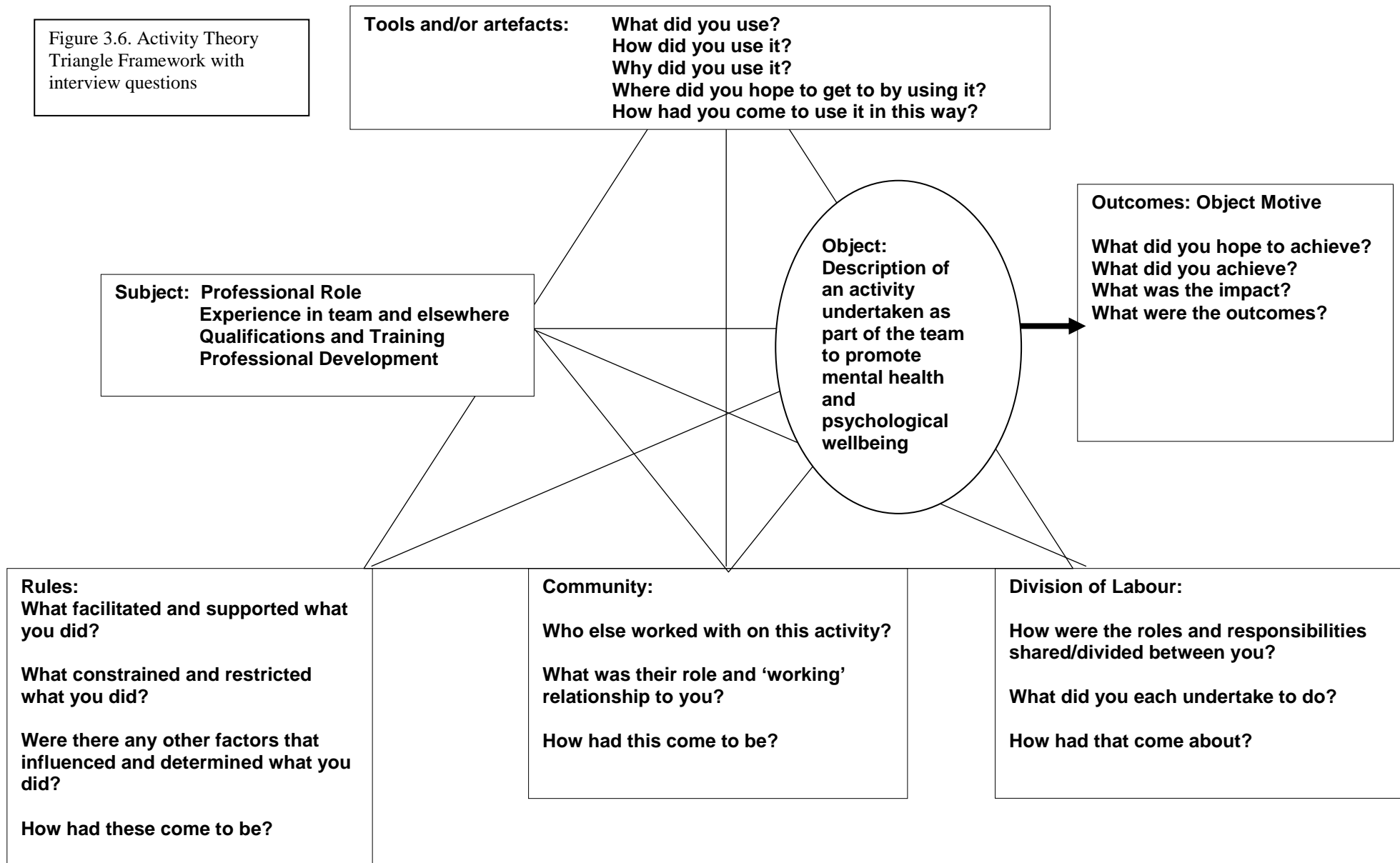
After each meeting, participants were given time and opportunity to reflect on the research proposal and consider whether they wished to participate and to give consent. All those who participated were asked to give written consent (see Appendix 1ii.). After the meeting, team members were given two weeks to consider whether they wanted to participate and consent to involvement. At this stage of the research no consent and permission had been given so no formal records were taken of the meetings. The main resources and tools used in the meetings included the research briefing, the consent form and the researcher's diary. The minutes of the meeting were held by the service itself.

The main outcome of this phase of the research process was that permission and consent was given at all levels of the service to undertake the next phase of the research, and initial working relationships had been established between the researcher and the researched. An extract from the researcher's diary at the time can be found in Appendix 4, which illustrates some of the additional points that were highlighted and queried at the time by participants and the researcher.

3.10.3. Phase two - interviewing individual service members

As a consequence of the preparatory work, meetings with all levels of the team and consent given by both team managers and members, the researcher was in a position to move to the next phase of the research. The principal purpose of this phase of the research was to gather data, using an activity theory framework, from each individual team member about a specific example of their work aimed at 'promoting mental health and psychological wellbeing.' The specific methods used at this stage included the semi-structured interview with each team member using Engestrom's(1987) Second-Generation Activity Theory Triangle as a conceptual framework. Associated prompt questions for each element of the triangle were used to ensure the activity was explored in sufficient breadth and depth (See Figure 3.6). These questions were used flexibly to facilitate discussion. A written record of each meeting was made on an enlarged activity triangle and a back up tape recording was made to support the analysis of each triangle.

Figure 3.6. Activity Theory Triangle Framework with interview questions



At the beginning of each interview, participants were asked if they understood or had any questions about the research, and to confirm that they had given written consent and that they were still happy to proceed. Participants were asked to introduce themselves as 'subjects' and then to outline the activity that they had chosen to discuss. Interviews more often than not followed a similar order around the triangle of Subject, Object, Outcomes, Community, and Division of Labour, Rules and Tools. However, interviews were conducted in a flexible way and involved moving around each element or node of the triangle which seemed to naturally flow from what came before. The final stage of the process involved the researcher and participants considering and highlighting any contradictions found in the activity. Contradictions were discussed within and between each element i.e. primary and secondary contradictions and between the individual's activity system and its wider interrelationship with other systems to which the participant belonged (i.e. quaternary contradictions). Contractions were then recorded on the written framework and were highlighted in speech bubbles. These are illustrated by Figure 3.7, which provides an example of the final written record.

Tools and/or artefacts: Conceptual: Understanding of family development and make up and its influence on child development; understanding of parenting skills and their assessment; understanding of the influences of family environment on separation anxiety and of how to build the resilience and confidence of parents. Concrete: Using previous experience as both parent and family support worker, to demonstrate empathy and understanding. Solution focused techniques including problem free talk, building on the positives and resources of parent, Records of 1st Response including case record, use of scaling questions of confidence and triplicate record of actions for parent, Tier 2 team staff and others involved.

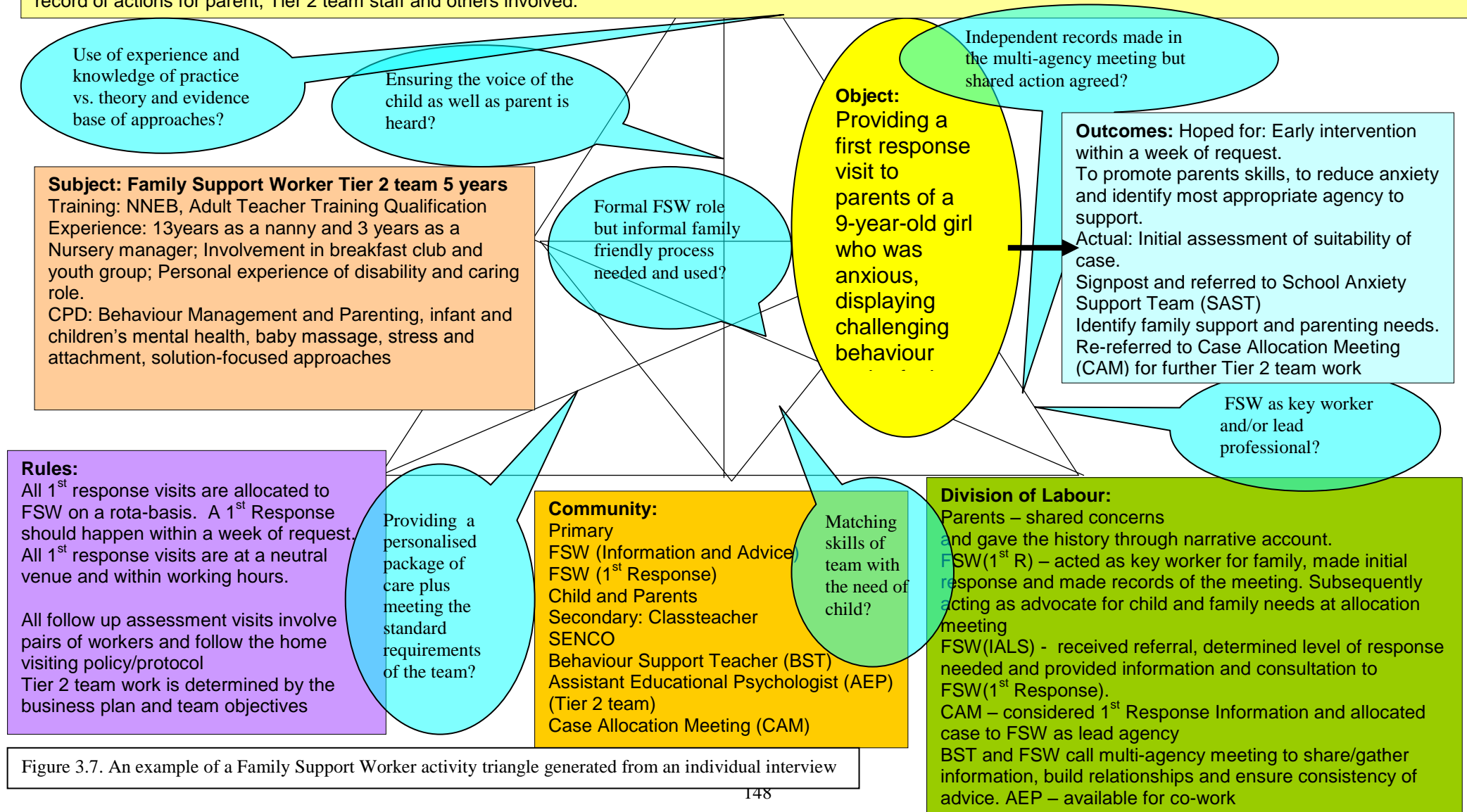


Figure 3.7. An example of a Family Support Worker activity triangle generated from an individual interview

Interviews were concluded with each interviewee being asked to highlight and comment on any learning that occurred during the interview and to offer evaluative comments on the process used. Short extracts of this aspect of the interview were transcribed, an example can be found in Appendix 3.

Interviews typically lasted from an hour to an hour and a half. 25 Interviews were completed in total. This represented 25 members out of the team of 28 i.e. nearly 90% sample of the team. The sample, therefore, could be considered to be representative of the team's membership and provided opportunity to gather a rich sociocultural picture of the team's activity. It was hoped that this would support the applicability and transferability of the research findings. The outcomes of this process will be discussed later in Chapter 4

The researcher converted each interview record into a summarised electronic record of the activity triangle using both the written record and, where necessary, the tape recording to check the accuracy of the written record and to aid analysis and interpretation. Electronic records of each meeting were then e-mailed to participants for them to check for accuracy, to suggest revision and stimulate further learning. Records were provided in both black and white and colour to aid printing and screen viewing respectively. Participants were asked to confirm the accuracy of the records, highlight points for amendment and any further learning points that came from reviewing the record. E-mail was chosen to facilitate speed of communication and to take account of time limitations of both the researcher and researched.

An example of the e-mail and a response can be found in Appendix 5 and an overview of other response can be found in Appendix 7iii.

However, there were some difficulties in the use of e-mail as an efficient and effective tool for disseminating findings and in mediating feedback and further learning. Some participants took a long time to respond to the e-mail and one had difficulty accessing the files in the correct format. On reflection, the presence of the researcher to mediate the feedback might have been preferable but time did not allow for this. This observation will be discussed in further detail in Chapter 5.

It should be noted that even at this stage of the process the researcher was involved in some early analysis and interpretation of the data. During the interview process the researcher, with the agreement of the respondent, had to decide what to record and where it was recorded. In the transcription of data from oral to written and then to electronic form the researcher, by necessity, was performing a degree of data analysis and interpretation through the use of the data collection tool, data reduction and data display, as outlined by Miles and Huberman (1994). Of course, the accuracy of each stage was checked with participants to ensure it represented a fair and accurate summary of the discussion. This ensured that the data recorded was accurate and representative of what the participant had said.

The main outcomes of this phase of the research were 25 completed electronic records of the individual triangles fed back to participants and

records of the iterative process used, including the e-mail correspondence.

Having completed all of the interviews and initial analysis of each interview the next phase of the research could begin.

3.10.4. Phase three - feedback to professions and team

3.10.4.1 Developmental work research

The developmental work research session with the team involved five related parts. These included:

- 1) An introduction to the purposes of the day and an icebreaker activity.
- 2) Consideration of initial thematic analysis of professional group activity systems by three small focus groups of each profession.
- 3) Consideration of the initial thematic analysis of multidisciplinary team activity system by two mixed professional focus groups.
- 4) Consideration of some mirror data reflecting some of the dilemmas highlighted by these analyses.
- 5) Further small group development work on the main objects themes of the team using the activity theory analysis by three small groups of mixed professionals.

A full day training session was provided for the team supported by a sole researcher. The aims of the DWR session were outlined in a PowerPoint presentation by the researcher. Extracts of the slide presentation used in the research can be found in Appendix 6v. The researcher directly facilitated parts 1 and 4 on the day. In parts 2,3 and 5 participants worked as small groups with occasional visits by the researcher to clarify any issues about the

process. This inevitably led to some compromises in how the researcher was able to mediate the process and gather data from small group activities when these were running in parallel.

3.10.4.1 Records of the DWR

The written records of the day represent the only tangible outcomes of the DWR day. A review of these products of the day provides the basis from which the researcher is able to consider what, if any, learning activity had taken place and whether evidence of learning actions, expansive learning activity and expansive learning was evident. It was not considered feasible or appropriate to make video and tape recordings of the sessions because of

- 1) the context of the session (a faith community education centre);
- 2) the potential impact such methods of observation may have had on participants; and
- 3) the size and the unstructured nature of the data that may be generated.

The records taken were as follows:

- In part 1 no records were made as this was very much introductory and icebreaker activity.
- In part 2 responses were recorded by each professional group on their own activity system (see Figures 4.1, 4.18 and 4.23 for activity systems considered).
- In part 3 the responses were recorded by two multiprofessional groups on the initial analysis of the full team activity system (see Figure 4.34 for activity system considered).

- In part 4 the responses of the full team responses to the DWR mirror data were recorded on flipchart (see Appendix 6v and Figure 4.41, 4.42, 4.43 for examples of the mirror data used and recorded responses)
- In part 5 the recorded responses of three small multiprofessional groups' discussions of the team's main objects and activity systems.

The final records available from the day was the researcher's own log entry at the time extract (see Appendix 5iii, for extract) and the participant's evaluative comments on the DWR process (see Appendix 7ii). Each part of the DWR is outlined below and its outcomes considered in relation to the learning that was generated.

The principal purpose of this phase of the research was to provide feedback on the initial group analyses. This was done to begin the process of identifying and feeding back some of the emerging themes for each professional group; and to offer some interim feedback to the professional group and the whole team participating in the research. This provided the team and its managers with some early feedback on some of initial findings and outcomes, as had been requested, and provided a further step in the iterative process to check out the validity of the initial analysis and interpretation made. The main methods used here were data display and data reduction. This began by displaying the triangle records of individuals in professional groups and the themes drawn out by the researcher for each professional group.

The summaries were then presented to each professional group as activity systems. This is illustrated by Figure 3.8. Each profession took part in a focus group and a 'developmental work research' discussion of the composite triangle. The latter technique proposed by Engestrom (1987) was outlined earlier in this chapter. An iterative process was used and each professional group was asked to consider whether the summarised triangle provided an accurate and fair record (see Appendices 6i. & 6ii for pro-forma used). Each group was also asked to provide written comments on the summaries provided and the analysis and interpretation made (see Tables 4.14, and 4.15 and Appendix 6v).

Tools and/or artefacts: Concrete tools: include initial assessment pro-forma, observation in school of teacher-child interaction and at home of parent-child interaction. Teacher and parent Strength and Difficulties Questionnaire (SDQ) used as a measure, other scaling questions to support evaluation. Use of medical and family history. Understanding of the diagnostic criteria for mental health disorders i.e. ADHD. Case supervision.

Conceptual tools includes ideas and understanding of what is a 'mental health' issue including understanding of the principal symptoms and risks associated with particular conditions such as self harming. Understanding of what is the Primary Mental Health Worker role and understanding and specialist CAMHS services and thresholds. Attachment theory, concepts of mental health, risk and resilience and understanding of the influence of individual, family and environment factors using models from family therapy and systems theory. Knowledge of services available at tier 1,2,3 or 4. Knowledge of assessment frameworks to gather evidence of mental health need versus those that are more behavioural and socially determined. Knowledge of learning disability and its potential impact on mental health.

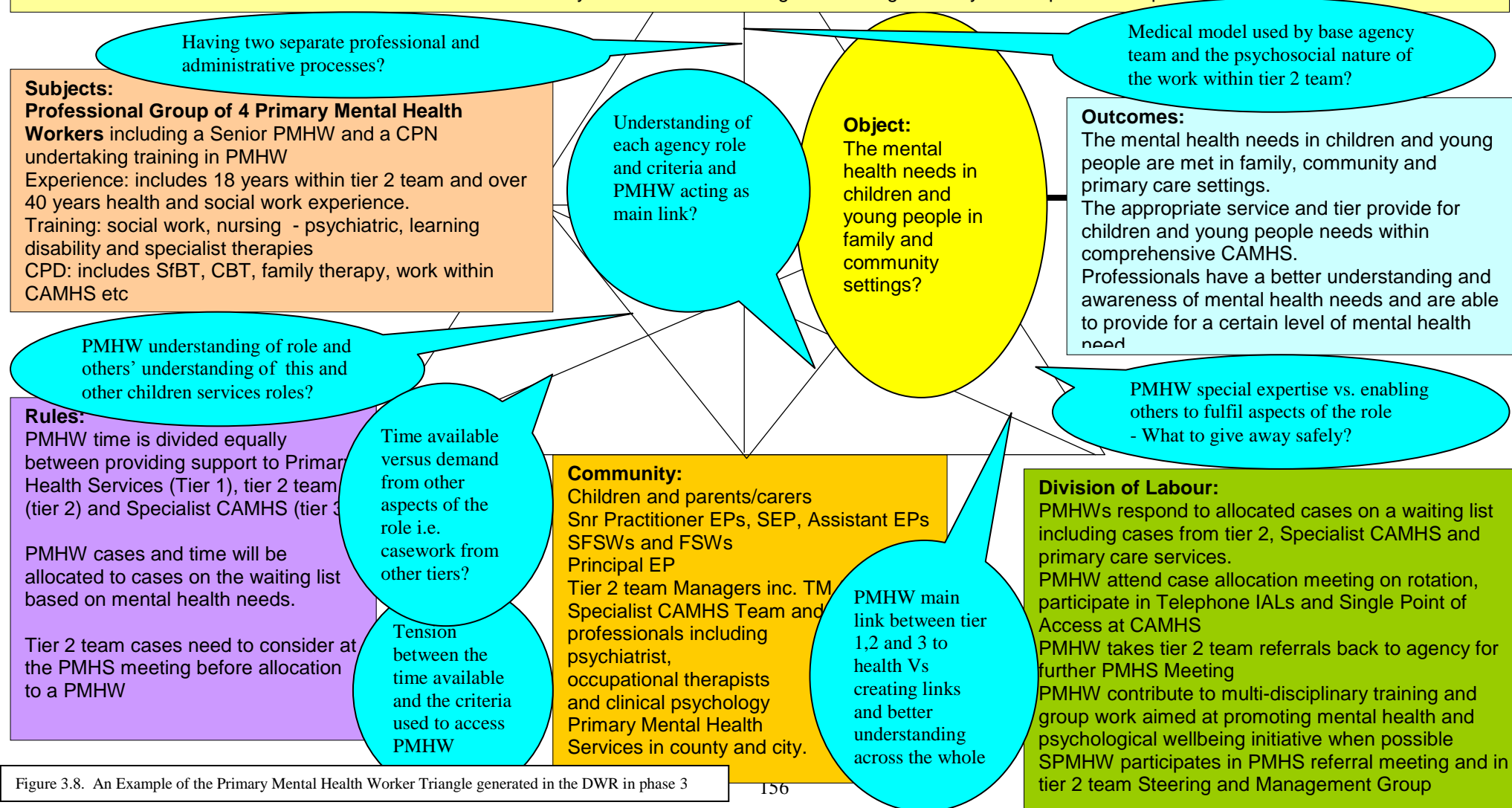


Figure 3.8. An Example of the Primary Mental Health Worker Triangle generated in the DWR in phase 3

A similar process was used for the whole team feedback. Multidisciplinary groups were provided with the initial whole team analysis highlighting any contradictions found. Team members then worked in small multidisciplinary focus groups to consider the accuracy of the triangles. Inevitably as part of this process a considerable amount of data reduction was necessary, for example, the eleven family support worker's (FSW) triangles were reduced to just one for the whole FSW professional group. The condensing of twenty-five individual team member triangles to one for the whole team involved more data reduction and inevitably led to the loss of some of the detail.

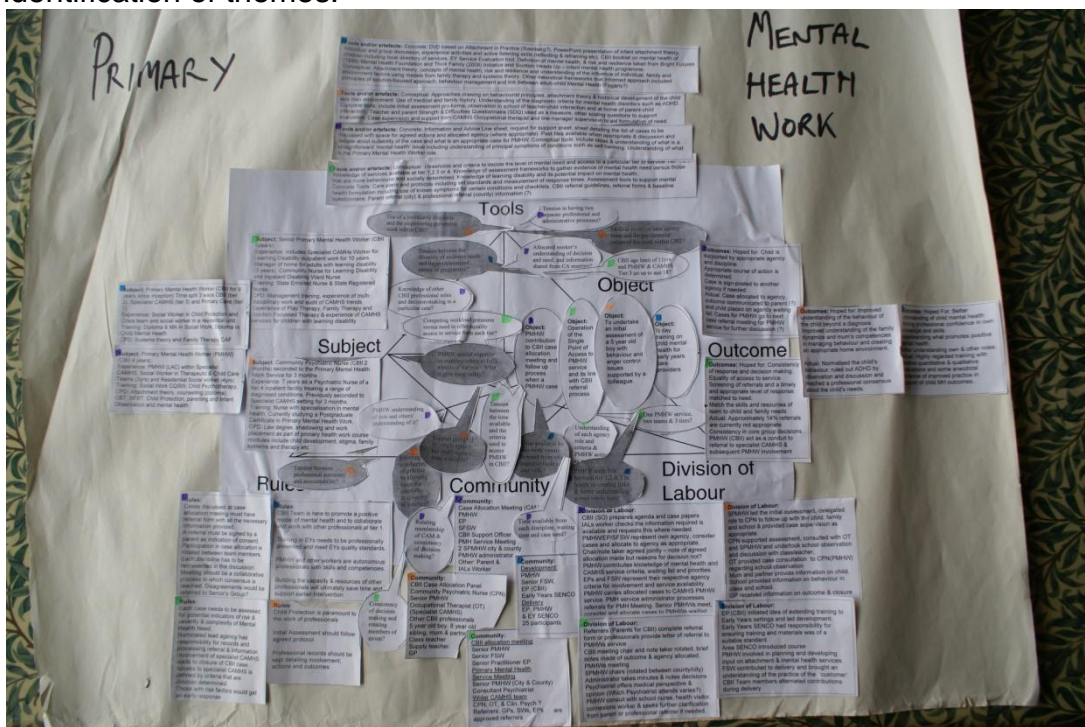
The main outcomes from this phase of the process were completed triangles for each professional group (see Figure 3.8 above, for example) and comments received from the focus group facilitators as representatives of each professional group. The other principal artefact was a triangle for the whole team and comments on this from three small multidisciplinary focus groups. These will be presented and discussed later as part of the findings of the research in Chapter 4.

All outcomes and artefacts of this phase were then transcribed and sent to all participants as a record of the 'focus group' discussion and the 'Developmental Work Research' (DWR) day. This concluded the planned fieldwork activity for the research, although the team has subsequently commissioned further work to follow on from this research and its findings. Again, this will be discussed and considered later as one of the outcomes of the research.

3.10.5. Phase Four - Detailed thematic analysis.

Following the 'Developmental Work Research' day and feedback received, a further phase of analysis was undertaken. The principal purpose of this phase of the research process was to provide a more detailed thematic analysis of the data set, to verify the initial emerging themes and to draw out any further themes using the approaches recommended by Braun and Clarke (2006). Again, a process of data display followed by data reduction was used. Each element of the triangle, from the individual interview, was grouped and displayed by professional group. Please see Figure 3.9 for an example of the data display used. Similarities between data extracts were then highlighted, coded and grouped for each element. Each coded group of data extracts was then given an appropriate theme label. This created a more specific link between similar data extracts from individual's triangles and the identified group theme for each professional group.

Figure 3.9 Photograph of the data display used in Phase 3 prior to coding and identification of themes.



Finally, the themes were organised and displayed within a thematic map and where appropriate arranged in super-ordinate primary and subordinate secondary themes. This is illustrated in Figure 3.10 below.

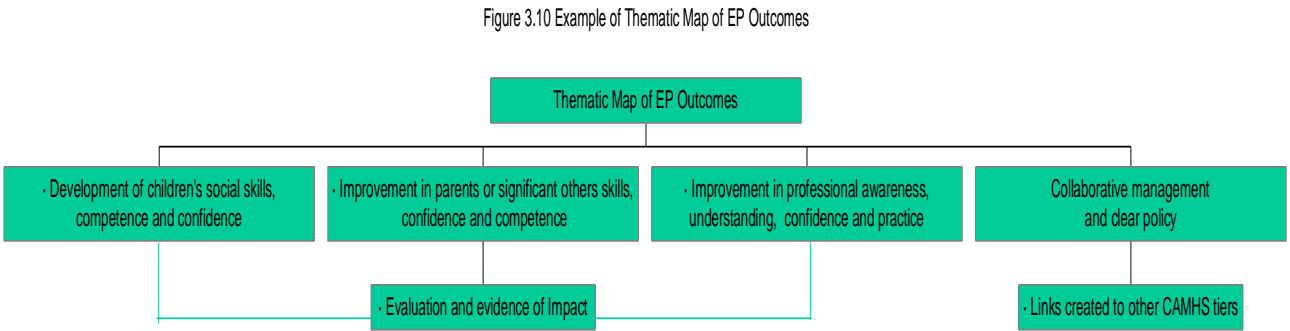


Figure 3.10 An example of a thematic map display

The main outcomes of this part of analysis were thematic grids or matrices, displaying the identified themes and their linked data extracts for each node of the triangle for each professional group. See Table 3.8 for an example of a data grid matrix and Appendices 12, 13 and 14 for further examples of the matrices generated. The findings from these analyses will be outlined and discussed fully in the next chapter.

Table 3.8: A matrix illustrating the thematic analysis of rules and the linked data extracts taken from the individual sociocultural activity theory triangle interviews.

Theme	Data extract 1	Data extract 2	Data extract 3	Data extract 4	Data extract 5	Data extract 6	Data extract 7
Budget and Funding Determinants	Projects are time and funding limited.	New initiatives rely on funding for continuation.	Service has to operate within the budget and grants that are available.	Funding is limited so the team's work has to be cost effective.			
Legislative and Statutory Determinants	Models of mental health used in team are determined and driven by statutory and non-statutory guidance.	Team works within disability, equality and diversity legislation.					
Demonstrate Evidence of Impact through Evaluation	Evaluation should use a pre and post SDQ.	Pre- measures need to be taken on initial visit using SDQ and scaling of confidence.	All team's work should be evaluated using qualitative and quantitative measures.	The team has to demonstrate its effectiveness	The team must demonstrate its effectiveness through effective evaluation.	Projects undertaken need to be evaluated and outcomes reported to managers and commissioners	
Equality and Collaboration within and between agencies expected	Each agency contribution is of equal value and importance	Tier 2 team is a multiagency initiative	Team is a Tier 2 service that should work with and link to comprehensive CAMHS	The team should be consulted in the business planning process.	When group work is offered it is expected that there will be a trained school partner who can jointly deliver the training.	EPs are expected to act as 'education' professionals in team	EPs are the lead agency when there is educational component to the issue/case

The next phase of the analysis involved comparing, grouping and then coding all the professional group themes for each element of the triangle to create the overall themes for the whole team. The main outcomes of this stage of the analysis were matrices for each element of the triangle displaying and linking the themes for each professional group with those identified for the multidisciplinary group (see Table 3.9 below for example). Finally, the multidisciplinary team themes were organised and displayed within a thematic map, and where appropriate arranged as super-ordinate primary and subordinate secondary themes. A full presentation and discussion of these occurs in the next chapter

The detailed thematic analysis of both professional and the whole team were then placed back into the activity triangle framework to provide a more holistic picture of each professional group and the multidisciplinary team's work. This enabled the dialectic relationship between each element of the activity system to be re-established. The outcomes of this analysis and interpretation will be reported and discussed further in the next chapter. These findings were fed back to team managers and are to be used in the researcher's ongoing development and follow up work with the team, as well as in reporting this research.

Table 3.9 below illustrates the outcome themes for the whole team and the linked themes identified for professional groups. These are discussed further in the next chapter.

Table 3.9 A thematic matrix linking each professional group outcome theme to the multidisciplinary team outcomes.

Multidisciplinary Team Theme	Primary Mental Health Worker	Family Support Workers	Educational Psychologist
Building Parents Skills and Confidence	Building the capacity i.e. the confidence and competence of parents	Improvements in parent(s) – child interaction (see below)	Improvement in parents or significant others skills, confidence and competence
Improving Professional Awareness, Confidence and Skills	and professionals (see above)	Supporting parents and professionals in meeting children's needs	Improvement in professional awareness, understanding confidence and practice
Demonstrate Outcomes through Evaluation	Evidence of outcome and evaluation	Clear evaluated outcomes from involvement	Evaluation and evidence of Impact
Match Service to Child Need	Matching service offered to child and family need	Level and accessibility of service. Information about, and sign-posting to, services.	Link created to other CAMHS tiers
Develop the Consistency and Quality of Service	Consensus and consistency in decision making	Quality and consistency of service	Collaborative management and clear policy
Contribute specialist and distinctive knowledge and skills	Developing awareness and understanding of child mental health	Early assessment, intervention and support	Development of children's social skills, competence and confidence
Address Unmet Needs		Some unmet needs	

3.11 Addressing threats to credibility

Mertens (2005) outlines six key features for evaluating qualitative research.

These are its:

- Credibility, which parallels internal validity.
- Transferability, which parallels external validity.
- Dependability, which parallels reliability.
- Confirmability, which parallels objectivity.
- Authenticity.
- Emancipatory.

The researcher considered each of these features and, in particular, any threats to the credibility of the research.

3.11. 1 Credibility of research

Mertens (2005) further suggested that the credibility of qualitative research could be determined by consideration of:

- length of engagement;
- persistence of observation;
- peer debriefing;
- negative case analysis;
- progressive subjectivity;
- member checks; and
- triangulation.

This research involved commitment to working with multidisciplinary team for a full year. The fieldwork research began in July 2008 and the initial phase of the research was concluded in April 2009. However, the follow-up work and

dissemination of findings to the team continued until May 2010. Please see Table 3.10 below which gives an indication of the prolonged and substantial nature of the engagement.

Table 3.10. Timeline for research.

Activity	Date
Phase 1 -Negotiating involvement <ul style="list-style-type: none"> • Initial meeting with service managers • Meeting with service steering group • Meeting with team 	June – July 2008
Preparation for fieldwork	August 2008
Phase 2 -Data collection <ul style="list-style-type: none"> • Individual interviews 	September and November 2008
Phase 3 - Initial analysis of data	December 2008 to January 2009
Developmental work session <ul style="list-style-type: none"> • Initial feedback • Further data collection 	February -March 2009
Phase 4 Further detailed analysis of data	April – June 2009
Writing thesis and research report	January – October 2009
Feedback to service managers	September –October 2009
Follow-up work with team	October 2009 to date

In addition to the sustained nature of the involvement, the researcher ensured that a range of observations were made including interviewing twenty-five members of the multidisciplinary team, and discussion with team managers and the whole team. Furthermore, the findings of the research were shared with researcher's supervisor and the professionals involved at each stage of the process. The researcher kept a research diary to monitor his subjectivity and to reflect on cases that didn't fit the interpretation made (see Appendix 4 and 5iii, for example).

Mertens (2005) describes member checks as being the single most important criterion in establishing credibility of qualitative research. The findings of this research were checked out with team members and managers at different stages of the research process. In addition, the researcher did specific checks with participants on the initial analyses made of individual, group and whole team's activity system.

Finally, Mertens (2005) identified triangulation as an important aspect of establishing the internal validity of qualitative research involving collecting from a range of sources and using a number of different methods. As mentioned above, this research obtained twenty-five different professionals perspectives on their work. Moreover, it worked across three different professional groups and the whole team to obtain these perspectives. The research also employed a variety of methods including individual interviews, focus and small group discussion and Developmental Work Research with whole team. In addition, the researcher collected a range of documents and artefacts from participants to aid his cultural-historical analysis of the team.

It should be acknowledge that the researcher was a lone researcher undertaking a time-limited piece of research for the purposes of his doctoral thesis. The amount of opportunity for peer debriefing was also limited due to the lone nature of the research. A further potential threat to the credibility of the research is that the researcher is a member of one of the professional groups being researched, the use of member and professional group checks was used in order to try overcome this threat but it nevertheless remains a

limitation. That said, the researcher contends that the above steps have helped to ensure the credibility of this research is maximised.

3.11.2 Transferability

Mertens (2005) citing Guba and Lincoln (1989) further argued that in qualitative research it is the reader who determines the similarity of the research to their own situation. It is therefore the researcher's duty to provide as much detail as possible to allow the reader to make this judgement. The researcher has to provide what is deemed a 'thick description' of the time, place, context of the research and culture of the researched. In addition, Yin (2009) suggests that multiple cases can also be used to extend external validity of qualitative case study research.

The present study has attempted to provide a rich or thick description of the individual participants, the professional groups and the multidisciplinary team involved, whilst still seeking to uphold ethical principles and guidelines for the research. The researcher has provided detailed description of the sample of subjects and objects taken in the research for each professional group and the multidisciplinary team in Sections 4.5.1 and 4.5.2. The researcher has also presented anonymised subject and object details and the activity systems of individual participants (see Appendices 8, 9, 10 and 11). In addition, in line with the activity theory framework used in this research, the researcher has provided a detailed overview of the history and culture of the multidisciplinary team, as well as much background information as can be provided within the confidentiality and ethical principles detailed in Section 3.9 below.

In terms of any potential threats to the transferability or external validity of the research, it has to be acknowledged that whilst multiple perspectives were taken within the team, the multidisciplinary team researched does represent a single case study. However, the use of single case design is particularly suited to sociocultural activity theory research which emphasises the need to understand human activity in culturally mediated and locally situated practice (Murphy and Rodriguez-Manzanares, 2008).

3.11.3 Dependability and confirmability

Yin (2009) suggests that dependability (reliability) of the case study research require that the researcher detail each aspect of the research process. The present study has attempted to support the dependability of the research by providing a detailed outline of each phase of the research and methods of data collection and analysis used in Section 3.10 above.

In terms of confirmability (or objectivity), Mertens (2005) suggests that it is important that qualitative data can be tracked using an audit trail back to its source and the link between data analysis and interpretation are made explicit. The researcher has attempted to ensure that the confirmability of the research by providing a detailed outline of the analysis and interpretation made and by providing linked raw data to allow the reader to confirm the validity of the themes identified and the logic of the interpretations made.

3.11.4 Authenticity

Mertens (2005) suggests authenticity in research have three main features. These are fairness, and ontological and catalytic authenticity. Fairness is determined by giving details of all respondents (see Table 4.5 in the Chapter 4 and Appendices 12i, 13i, and 14i) and how their constructions were obtained, outlined earlier in the present study in Section 3.10. Ontological authenticity is the extent to which participant's experience becomes more informed and sophisticated as the research progresses (Mertens, 2005). Whereas, catalytic authenticity refers to the extent to which action is generated by the research process. The latter is usually determined by participant testimony (Mertens, 2005). In terms of the former, the researcher used the activity theoretical framework (see Figure 3.1) to analyse and support participant's understanding and learning in respect of their own activity systems. In terms of the latter, the research illustrates later in Chapter 4, Section 4.6 how learning was promoted through the research and how it impacted on the thinking and practice of those involved.

3.11.5 Other considerations

Finally, in terms of transformative paradigm, Mertens (2005) identifies six considerations that could be made in determining the quality and effectiveness of research.

- Positionality and Standpoint Epistemology;
- Community;
- Attention to voice;
- Critical reflexivity;

- Reciprocity; and
- Sharing the prerequisite privileges.

In transformative research, the researcher needs to be clear about his/her position and standpoint, the context of the research and needs to know the community well enough to link the results to positive action. The researcher also has a duty to seek out those who are silent and not involved (Mertens, 2005). The author should also have a heightened sense of critical subjectivity and self-awareness in respect of personal transformation. The researcher also needs to develop a sense of trust and mutual respect and involve participants in any privileges that come from it (Mertens, 2005).

The researcher took extensive steps to build familiarity and trust with the team (see Section 3.10). The researcher identified and outlined in chapters 2 and 3 his position and epistemological standpoint in respect of this research. The researcher also worked in quasi-ethnographic ways, drawing on his experience of the principles of co-operative inquiry (see Heron and Reason, 1996), collaborative action research (see McNiff, 2002) and sociocultural activity theory (Engestrom, 1987), in order to establish rapport with participants (see Section 3.10.1). Moreover, to enable the research findings to be converted to action in the professional community and context in which the research took place, the researcher did a number of preliminary and follow-up activities and visits to share findings of the research with managers and participants (see Table 3.10 above).

The researcher achieved nearly 90% engagement in the phase 1 of the project. Indeed, phase 2 of the study involved two further participants, meaning that over 90% of team members were involved in the research at some stage. The one person (an assistant psychologist) unable to participate in the research indicated that this was due to other work and family commitments. The author also used a research log at each stage of the research process (see Appendix 4 and Appendix 5iii, for examples). He listened and noted comments and attempted to be sensitive to participants who were challenged by the research process. However, it has to be recognised that the researcher was external to the team and also depended on internal collaborators to implement and follow-up any learning actions stimulated by the study.

3.10.6. Summary of section

This section of the thesis has outlined the four phases of this research used, including the initial meetings, individual interviews, professional group and whole team analyses and detailed thematic analysis. It has described the data collection methods, the iterative process used with participants and the methods of analysis used at each stage. It has also highlighted some of the challenges and threats faced in conducting research of this kind. It has further outlined the steps taken to ensure a credible, valid and reliable process of data collection and analysis including the use of data reduction, data display and thematic analysis. It has highlighted how each method of data collection, data display, data reduction and thematic analysis was used to support the analysis and interpretation of findings. It has described how data taken from individual

interviews was used to inform professional group and whole team activity systems, and to identify contradictions therein. In addition, it outlined how contradictions were identified and used to promote professional learning at the level of the individual, professional group and the multidisciplinary team. Finally, it described the measures taken to ensure the credibility, transferability, dependability and confirmability of the research and its findings.

The next chapter outlines the research findings that have been generated by the process given above in detail for each professional group and the multidisciplinary team as whole. This is followed in Chapter 5 by a discussion of the potential implications of these findings for each professional group, the multidisciplinary team and research of this kind.

CHAPTER 4 RESEARCH FINDINGS

4.1 Introduction and overview of chapter

This chapter outlines the detailed research findings for each professional group and then moves onto the whole multidisciplinary team. In describing the findings, the chapter draws on the different phases of the research and levels of analysis undertaken. It illustrates points made with reference to examples of linked raw data, group themes and individual activity triangles. It describes the findings in relation to each element of the activity triangle in turn and concludes by reviewing the contradictions highlighted for each profession. Finally, it highlights and discusses the learning that took place at the level of the individual professional, professional group and the multidisciplinary team

4.2. Educational psychology findings

4.2.1. Subjects

Of the eight representatives of the educational psychology group sampled, there were two professional managers, six EP practitioners, many of whom were senior practitioners, and one assistant educational psychologist. The EP group represented over 25 years collective work in the team and over 125 years of professional practice experience. Experience in the EP role varied from 4 years to over 20 years. All except the assistant EP had undertaken further Masters level professional training in educational psychology. In addition, two had also undertaken doctoral level postgraduate study in educational psychology (see Appendix 13i for full profiles of EPs).

4.2.2. Objects

The objects identified in the educational psychology group's activity can be described as:

- the strategic management of the multiagency team;
- providing multidisciplinary mental health training;
- providing group-work to build children's social skills, understanding and confidence;
- resolving the problems of individual children and their families through casework.

The precise objects identified for each individual educational psychology group member are detailed in Appendix 13ii.

4.2.3. Outcomes

The principal outcomes highlighted in the initial analysis (see Figure 4.1 below) and stemming from the more detailed thematic analysis (see Figure 4.12 and Appendix 13vi) indicate that educational psychologists' activity is principally directed toward:

- the development of children's social skills, competence and confidence;
- the improvement in parents or significant others' skills, confidence and competence; and
- the improvement in professional awareness, understanding, confidence and practice in meeting the mental health needs of children and young people.

.

Tools and/or artefacts: Concrete: included the use of consultative skills with other professionals inside and outside the team and parents. Direct work skills of psychological assessment and intervention based using a 'research practitioner' hypothesis-testing model drawing on theory, research evidence and applied practitioner skills. The use of group facilitation skills and knowledge of intra and interpersonal skills, what supports group functioning and the development of social, emotional and behavioural skills in children and young people at home and in schools. The use of co-work, single discipline work and development. Conceptual Tools used include behavioural, cognitive-behavioural, humanistic person centred and solution-focused approaches. Drawing on knowledge of learning, behavioural and other psychological theory such as attachment theory. In addition by using their knowledge understanding of educational contexts, policies, processes, practices and systems. They adopt consultative, problem solving and solution orientated frameworks which draw on constructionist (social and personal), humanist and behaviourist thinking

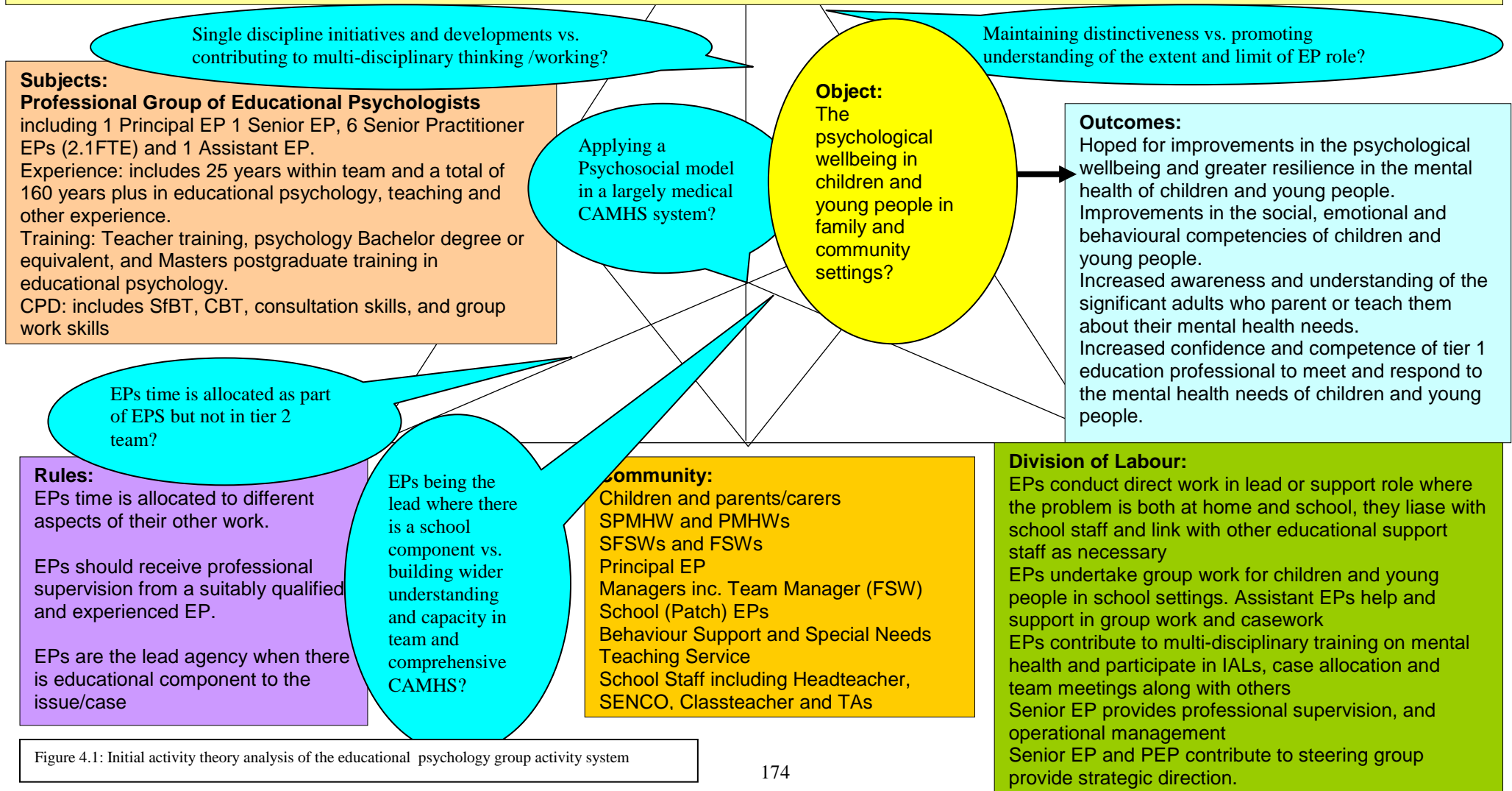
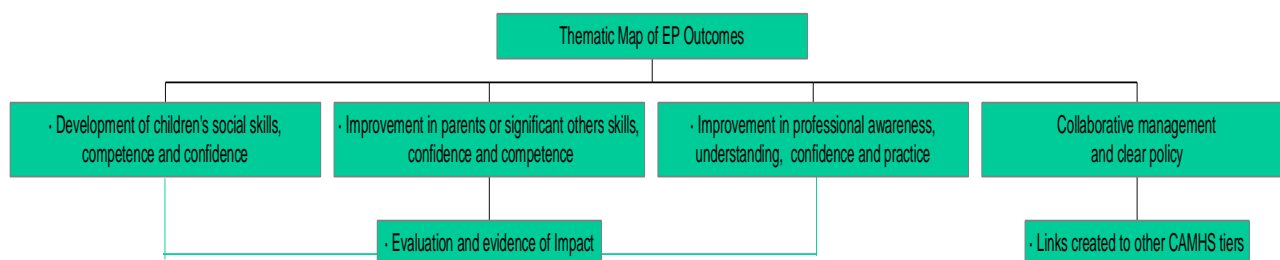


Figure 4.1: Initial activity theory analysis of the educational psychology group activity system

Figure 4.2 Thematic Map of EP Outcomes



These outcomes were underpinned by some further object motives identified through detailed analyses (see Appendix 13vi) and represented along with the other themes in Figure 4.2 above and in Figure 4.12 later in this chapter.

These were identified as processes that supported the team in achieving its principal outcomes which included establishing:

- collaborative management and clear policy arrangements;
- links to other comprehensive CAMHS tiers; and
- providing evaluation and evidence of impact.

A large part of the educational psychologists' work in this tier 2 team appeared to be directed to supporting the development of children's social and emotional skills through the use of individual and group work (see Appendix 13vi). This is further exemplified in Figure 4.3 below which illustrate the outcomes sought by an EP undertaking group work in support of vulnerable pupils' transition to high schools. A contradiction highlighted in this case, and in other examples of EP group work, was that emphasis appeared placed on teaching children to develop skills rather than on how the context, significant others and wider school environment might develop and change (see for example, Appendices 10iii, 10v and 10vii). It could mean that in this locality

the child might be prepared for the context but the context not necessarily prepared for the child.

Outcomes:

Hoped for outcomes:

- Help the children to feel prepared for secondary school and education
- Help the children to develop social and communication skills.
- Building the young person's confidence

Actual:

- Evaluation indicates initial positive response and enjoyment of the group sessions

Figure 4.3. An example of the outcomes identified by an EP whose object was transition group work with children in Year 6

The example also illustrates the tension that existed for EPs and others in gathering evidence of short-term satisfaction and providing evidence of long term impact and outcomes.

4.2.4. Community

The initial and detailed thematic analyses, given respectively in Figure 4.1 above and Figure 4.12 later in this chapter, suggest that the community with whom educational psychologists work to promote mental health and psychological wellbeing include children, parents and families, as their main client groups. Secondary client groups, however, include school staff, education professionals and, to a lesser extent, other agency professionals.

Further detailed analysis of community, summarised in Table 4.2 below, indicated that education professionals were twice as more likely than health

professionals and three times more likely than social care professionals to be mentioned as in the community with which EPs worked. Considerable caution needs to be taken in the interpretation of this finding as it does not represent statistical evidence but it is an indicative and exploratory finding. However, it appeared to suggest that education and educational professionals remained a significant part of the EPs' community, even where they are working in family and community settings, as was the case in this team.

Table 4.2 A table to show the frequency of community links mentioned by EPs

Community	Within team	Outside team	Total
Education	12	17	29
Health	6	8	14
Social care	7	2	9
Total	25	27	52

The other feature of the EP community worthy of mention was that EPs were twice as likely to mention other EPs as being in their community than they were other professionals from a health and social care background. Again caution needs to be used in the interpretation of this exploratory finding. However, it appeared to suggest that within this particular multidisciplinary team EPs principal reference point remained the EP discipline itself. Further research in this local authority and in other settings would be required to examine the precise reasons for this finding and whether it is reflected in the work of similar teams and services.

Finally, EP community links were found to be almost entirely within the tier 1 and tier 2 community of professionals. Links and liaison with the Tier 3

Specialist CAMHS were very limited indeed and, perhaps unsurprisingly, Tier 4 in-patient provision was not mentioned at all. In this locality there appeared to be a high level of contact between educational psychology, health and social care colleagues at strategic and managerial levels but fewer links found at other levels, particularly with tier 3 specialist CAMHS professionals. The precise reason for this finding is uncertain and warrants further exploration in the local authority concerned.

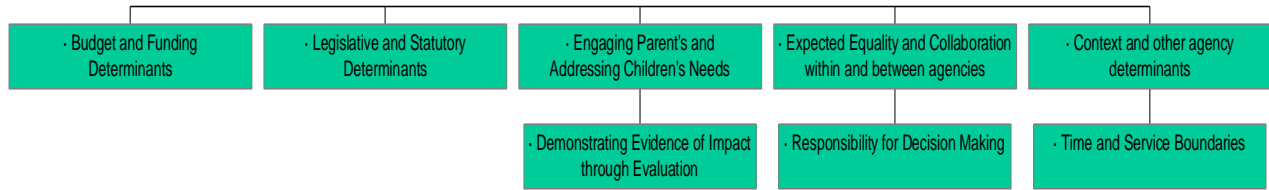
4.2.5. Rules

The rules identified by EPs as supporting and constraining their work within this tier 2 multidisciplinary team were:

- budget and funding determinants;
- legislative and statutory determinants;
- context and other agency determinants;
- providing evidence of impact through evaluation;
- equality and collaboration within, and between agencies;
- responsibility for decision making;
- engaging parents and addressing children's needs; and
- time and service boundaries.

These are represented visually below in Figure 4.5. The linked data extracts from which each of these themes was derived can be found in Appendix 13v.

Figure 4.5 Thematic Map of EP Rules



It is perhaps unsurprising that EPs indicated that their work needed to occur within the finances and resources available to the team. However, EPs also reported being constrained by the statutory nature of some of the work and the way their time was allocated. They also highlighted other contextual issues such as the school timetable and policy arrangements that hindered their work within schools and other settings. In addition, other services' policies and procedures and criteria for involvement also constrained EP activity and work. There was also an expectation within this particular multiagency team that EPs and other professionals would evaluate the impact of their work, collaborate with other disciplines and agencies and participate in decision making. Furthermore, along with others in the team, EPs were expected to meet both parents' and children's needs in family and community settings.

Figure 4.6 provides an illustrative example of how rules both supported and constrained EP casework. The time-limited nature of the work of the team, the case allocation process and the importance of matching the child and family need as well as the importance of evaluation and follow-up review are highlighted as rules here. Interestingly, there was also an assumption held in the team that where there was a school-related problem then EPs would be

best suited to respond to the need. Conversely, where it was concluded that a case did not involve a school or educational issue then EPs were assumed not to be required.

Figure 4.6. An example of the rules that an EP identified as supporting and constraining their casework with a child and family.

<p>Rules:</p> <ul style="list-style-type: none">• Team involvement should be an 8-session short-term change programme• Involvement should be followed by a three-month review.• Cases should be allocated to the appropriate agency and caseworker based on client need• Evaluation should use the pre and post Strengths and Difficulties Questionnaire.

See Appendices 10i to 10xiii for further examples of the rules identified within EPs' individual activity systems.

4.2.6. Division of labour

The overall themes identified for the division of labour between EPs and others working in the multidisciplinary team (MDT) were in:

- strategic and operational management;
- service delivery, target setting and monitoring and evaluation;
- allocation of work;
- offering professional perspectives;
- undertaking lead professional or support roles;
- single or multiagency initiatives;
- providing the link to schools and other education professionals;
- working at the level of the child or adult; and
- the development and delivery of training.

The linked data extracts from which each of these themes was derived can be found in Appendix 13iv.

Senior Practitioner EPs contributed an educational psychology perspective to case allocation meetings to support the effectiveness of the decision-making processes. Work was allocated to EPs in either a lead professional or support role. In undertaking the work allocated to them EPs often worked with, and alongside, other disciplines offering them consultation, supervision and support as required. However, a tension existed for EPs in performing both a support and challenge role when working with parents and others. This is illustrated in the division of labour in Figure 4.7 below and Figure 4.10 an activity system whose object was casework with a child with behavioural problems and his family. In this case the tension was reconciled by the FSW performing the support role and the EP taking on the challenge role.

Figure 4.7: An example of the division of labour within an activity system of an EP undertaking casework.

Division of Labour

- Case Allocation Panel allocates the case to relevant discipline (in this case the EP).
- Senior EP allocates case to an appropriate EP.
- EP performs nominated lead agency and professional role.
- FSW provides support role.
- EP/FSW undertake joint consultation and planning meeting prior to involvement to plan home visit and joint assessment arrangement.
- Grandma provides information on her concerns and sets goals.
- EP leads initial assessment and took on the challenge role in the work with the adult.
- FSW took support role and provided positive feedback to family and worked with child.
- EP liaised with BST/SENCO re school behaviour.

The EP group also seemed to initiate and lead the development and implementation of almost all group work initiatives. Indeed, a significant part of EP work was directed toward developing children's pro-social and social skills via structured group work activities in schools (see Appendices 10iii, 10v and 10vii and 13vi). It was also interesting to note that EPs did much of this work as a single discipline rather than as part of a multiagency team (see Appendix 13iv). This area of work appeared to provide EPs with an aspect of work they felt they could make a unique and distinctive contribution to drawing on their teaching skills, knowledge of psychology of groups and an understanding of the factors that promote pro-social and social skills. A final and key finding, in respect of division of labour, was that EPs appeared to perform the main link role between the multidisciplinary team (MDT), schools and other education professionals (see Appendix 13iv). This is in line with the rule expectation and community links highlighted earlier in this chapter in Section 4.2.4 and 4.2.5. Please see Appendices 10i to 10viii for further examples of the divisions of labour identified in individual EPs' activity systems.

4.2.7. Tools

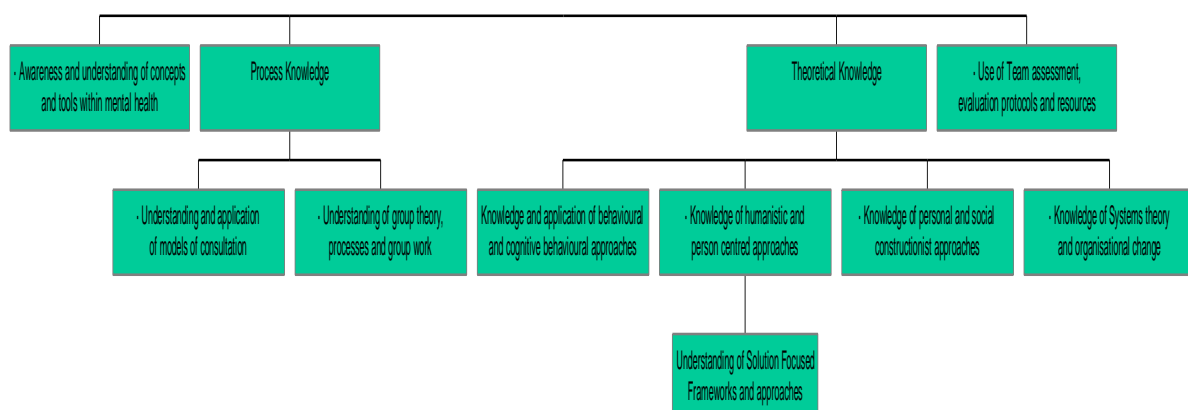
The conceptual and concrete tools that EPs used when working to promote psychological wellbeing in children and young people in family and community settings included:

- knowledge and application of behavioural and cognitive behavioural approaches;
- knowledge of humanistic and person centred approaches;
- knowledge of personal and social constructionist theories;

- knowledge of systems theory and organisational change;
- understanding and application of models of consultation;
- understanding of group theory, processes and group work;
- awareness and understanding of concepts and tools within mental health;
- understanding and application of solution-focused frameworks and approaches; and
- use of team assessment, evaluation protocols and resources.

Please see Appendix 13vii for details of the data extracts linked to the themes above. These are also represented thematically in Figure 4.8 below.

Figure 4.8 Thematic Map of EP Tools



EPs seemed to draw on a variety of psychological theories to inform their practice, in particular behavioural, cognitive behavioural, humanistic, systemic and constructionist theories. They also appeared to use process skills such as consultation, groupwork and solution-focused work to support the promotion of mental health and psychological wellbeing in children. Moreover, they drew on a basic awareness of mental health concepts and associated assessment tools and used team protocols for assessment, evaluation and resource sharing where necessary. Whilst EPs used the common process tools of the team, they appeared confident not to use them when they didn't support

meeting the needs of the child, family or situation (See for example, Appendices 10i, 10iii and 10vii).

Figure 4.9. An example of tools used by an EP in an activity whose object was contributing to the development and delivery of mental health training.

Tools and/or artefacts:

Conceptual tools used included person-centred approaches, solution-focused methods, models of consultation including process consultation, concepts of risk and resilience found in Rutter et al (1979) and psychosocial concepts of mentally healthy children and environments (and the myths surrounding this). Understanding and knowledge of SEAL, systems theory, understanding of concept of hero innovator/expert versus process facilitator who supports and challenges.

Awareness of the National Service Framework for the Mental Health (MH) of Children and Young People and Every Child Matters (ECM) Green Paper, Mental Health Foundation Bright Futures Paper.

Concrete tools used included group work, experiential learning activities and adult learning models. Risk and resilience 'strips' activity/exercise, case studies/scenarios on risk and resilience, a booklet on mental health with information on what promotes MH plus service contacts details.

The most noticeable feature of the tools that EPs used was their theoretical orientation illustrated above by Figure 4.9. Whilst EPs did draw on practical strategies and approaches, these appeared to be a far less prominent feature of the tools they used in their work (see Appendix 13vii). More evident in EPs work was the application of the theoretical principles, which underpinned a particular approach (see Appendix 13vii and for examples, Appendices 10i - 10viii). Furthermore, EPs work and activity appeared to be mediated by their knowledge of process (e.g. consultation) rather than a detailed knowledge of a topic area (e.g. mental health). In addition, whilst EPs drew heavily on solution-focused approaches, the use of other therapeutic approaches and other specific mental health work were not a prominent feature of the tools they deployed (see Appendix 13vii).

Figure 4.10 provides a further illustrative example of an activity system of an EP whose object was to support the main carer of a child with emotional and behavioural problems. This demonstrates how an EP combined the use of knowledge of behavioural theory, educational contexts such as schools with solution focussed thinking, counselling skills and consultative approaches to find a way forward with a concern. It further illustrates how EPs used an integrative and eclectic approach in their work drawing on a range of theories and approaches to promote positive mental health and psychological wellbeing in children and families. This, however, may create a tension for EPs in how to demonstrate fidelity to a particular approach and remain true to the principles of the base theory. Further individual EP activity systems can be found in Appendices 10i -10viii which provide further evidence of how the tools and artefacts identified above mediated different aspects of EPs' work within the multidisciplinary team.

Tools and/or artefacts: Conceptual Tools: Understanding of behaviour theory including the principles of reinforcement and what leads to attention seeking. Knowledge of approaches to behaviour management such as those suggested by Bill Rogers. Knowledge of schools and school systems and solution-focused brief therapy approaches. Understanding of the impact of bereavement on adult behaviour toward children.

Concrete Tools: Active listening and use of counselling skills such as challenging and confronting carer with their own behaviour and its potential consequences to create opportunity for change. Initial assessment visit form, SDQ, scaling questions, carbonised pads to record outcomes and provide complements. The use of peer consultation within joint working partnership.

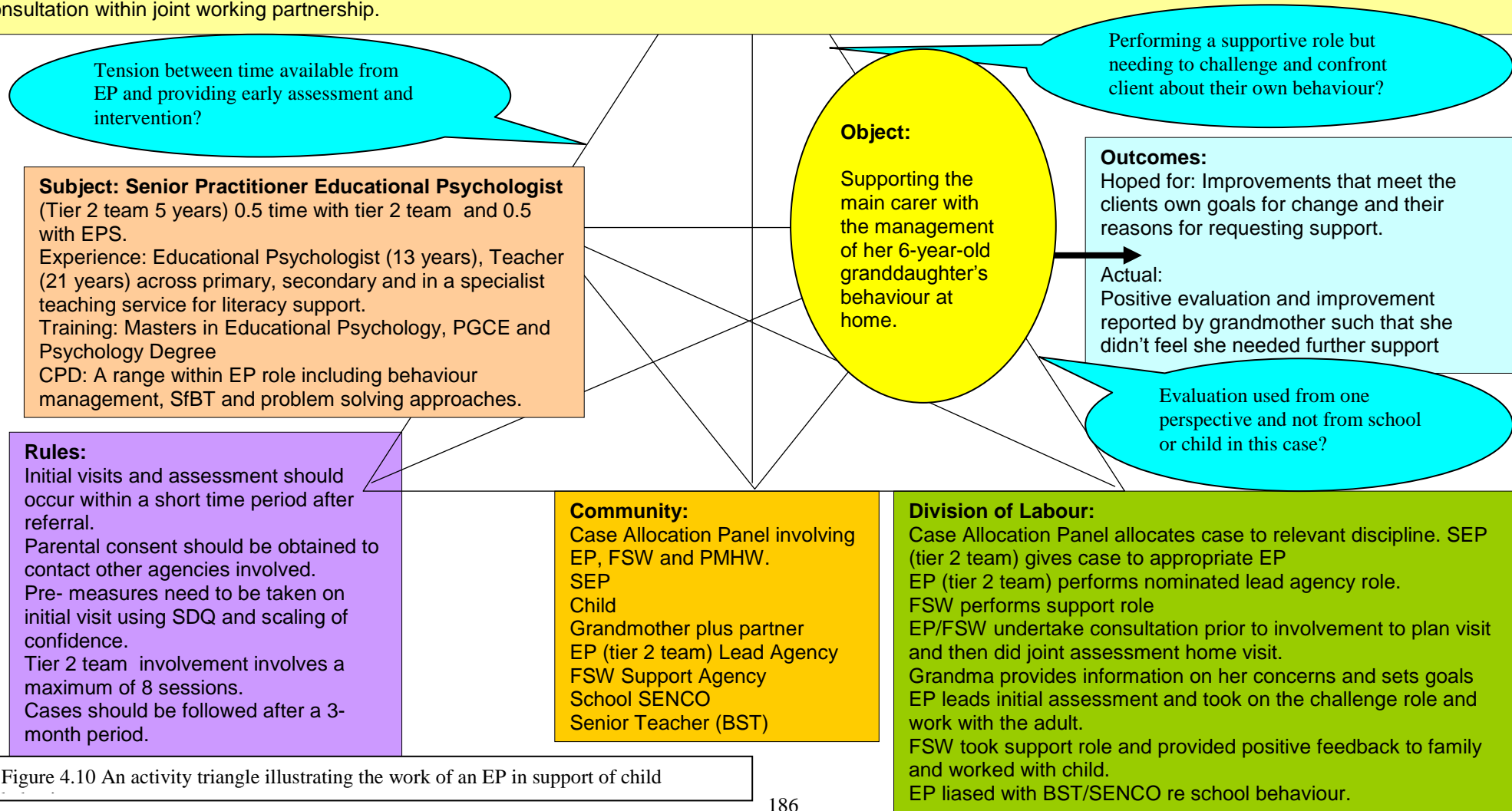
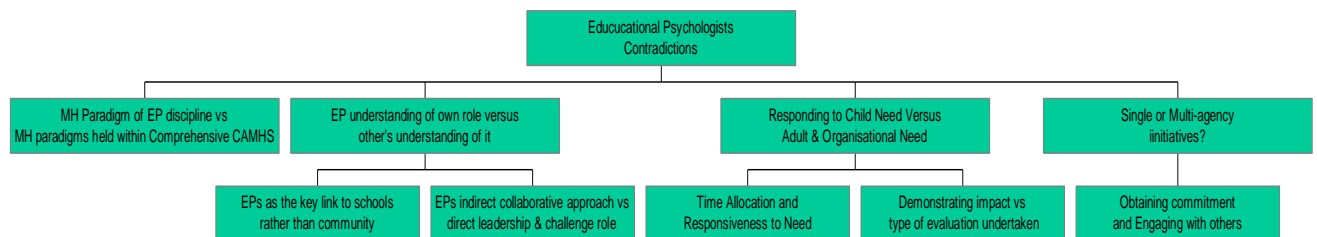


Figure 4.10 An activity triangle illustrating the work of an EP in support of child

4.2.8. Contradictions

The contradictions identified through detailed thematic analysis of individual EP activity systems (see Appendix 13viii) are represented thematically in Figure 4.11 below.

Figure 4.11 Thematic Map of EP Contradictions



The contradiction themes found were as follows between:

Community and Division of Labour

- EPs as the key link to schools rather than community;
- the EP group undertaking single agency work within a multiagency team initiative;

Tools and Community

- EP understanding of their own role versus others' understanding of it;
- the mental health paradigms of the EP discipline versus the principal paradigms held by others within comprehensive CAMHS;
- obtaining commitment and engagement of other agencies;

Tools and Object/Outcomes

- EPs responding to child need versus meeting adult and organisational need;
- EPs demonstrating impact vs. the type of evaluation undertaken;

Tools and Rules

- EPs' indirect collaborative and supportive approach versus having direct leadership and challenge role; and

Rules and Outcomes

- EP time allocation and their responsiveness to need .

The linked data extracts related to each of these contradiction themes can be found in Appendix 13viii. Please see Appendices 10i to 10viii for further examples of the contradictions surfaced during individual interviews and analyses of EPs' activity systems.

The contradictions highlighted above represent the potential 'learning space' and areas that may be amenable to change through 'expansive learning' activity within the EP group and multidisciplinary team activity system. These contradictions, along with the other themes identified for all the other nodes of the EP group activity system, are summarised in the detailed thematic activity system given in the Figure 4.12 below.

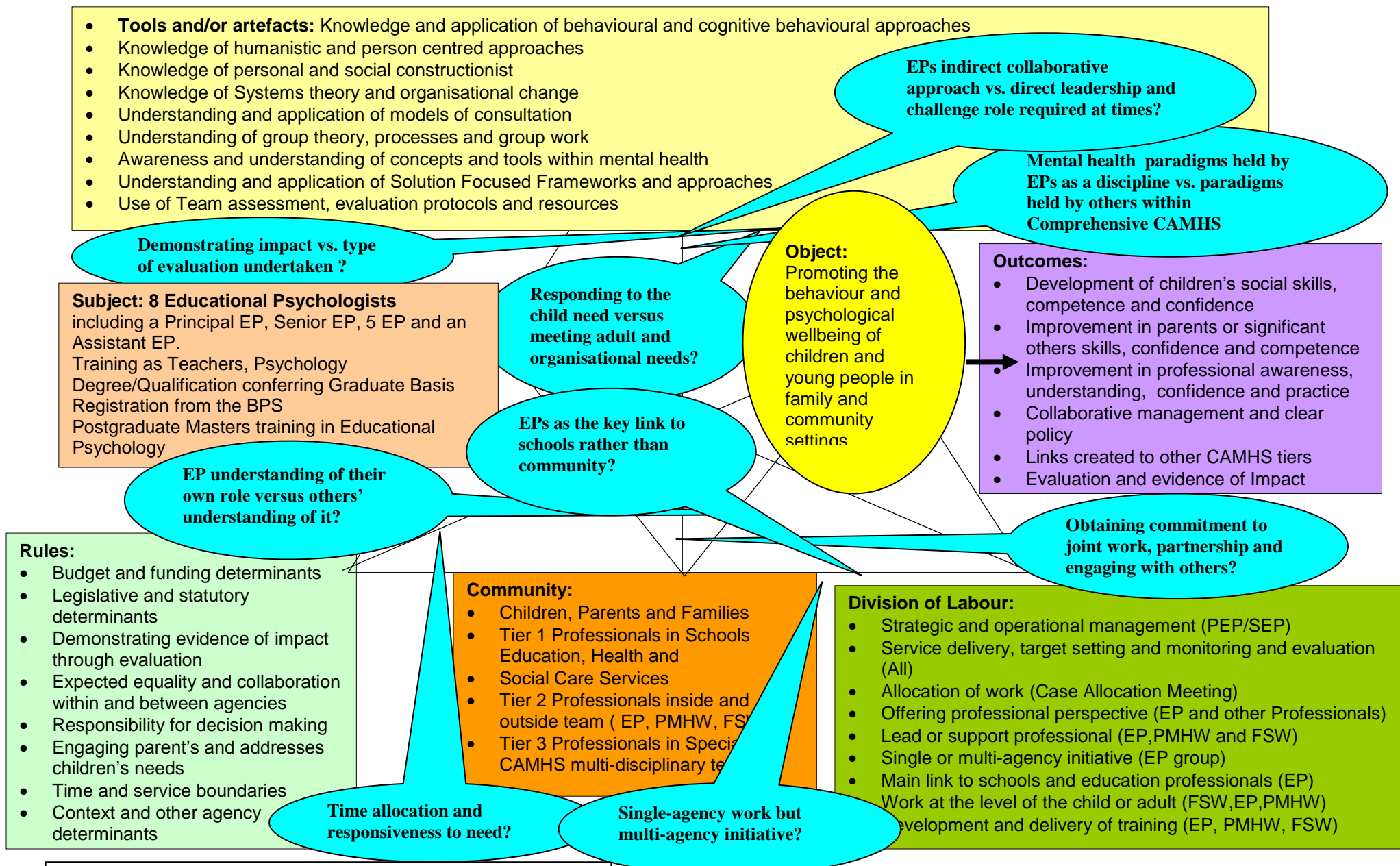


Figure 4.12. Detailed thematic analysis of the EP group activity system

The contradiction between community and division of labour highlighted above, and represented in Figure 4.12, appears to suggest that despite EPs historical attempts to be community-orientated practitioners within this multidisciplinary context, much of EPs' work still appeared associated with, and linked to, educational settings and issues. A further contradiction found between tools and outcomes appeared to indicate that EPs were attempting to respond to individual children's needs and organisational needs at one and the same time. Working directly with children seemed to have reinforced the view that it was EPs' role to assess 'within child' factors as well as working with the system and context around the child.

A further tension highlighted between rules and outcomes, was where EPs responsiveness to need appeared to be affected by how their time was allocated in other aspects of their work. Much of EP work outside the team appeared allocated and planned in advance, but this seemed in direct contradiction to the multiagency team approach of providing an early reactive response and intervention to families in need. Furthermore, the findings of this study suggested a tension between the EP group's tools and rules, in that EPs were expected to work in a consensual, consultative and collaborative way, but they also held considerable power and capacity to challenge those they worked with and for.

An additional contradiction, found between tools and outcomes, was that the short-term evaluation undertaken by EPs appeared to be in conflict with measuring and demonstrating the longer-term impact of their work. This raised the questions: What represents 'good' evidence of EP practice in

promoting mental health and psychological wellbeing? And how do EPs demonstrate the long-term impact of their work when it is complex and multi-layered?

A further contradiction found, between tools and community, was that the paradigms of mental health held by many of the EP discipline in the team (i.e. seeing mental health as a psychosocial issue) in contrast to the paradigms held by parents and many other professions in comprehensive CAMHS. (i.e. viewing mental health as a medical or psychobiological phenomena). In addition, a contradiction was indicated between community and division of labour, where the EP group appeared to undertake and retain some aspects of their work as a single discipline rather than adopting a multidisciplinary approach. Indeed, EPs seemed to show some reticence in collaborating with other disciplines for certain activities e.g. social skills and other group work in schools, preferring on some occasions to plan and implement the work within their own discipline, before involving and planning with colleagues from other professions.

Finally, a contradiction was observed between the EP tools and community, in that EPs' perception and understanding of their own role contrasted with the views of the role held by the other professions and clients seemed. For example, EPs appeared to see themselves as community-orientated practitioners who contributed to supporting children's mental health and psychological wellbeing across a range of settings. Whilst other disciplines appeared to consider EPs to be school and education-orientated professionals, whose principal area of knowledge was in understanding

learning difficulties. Moreover, a further contradiction highlighted between EPs' rules and tools was that they viewed themselves as working indirectly with adults via consultation but many in their community saw them as working directly with children and young people. EPs also appeared to consider themselves psychological practitioners but others seemed to view them more as educational practitioners and specialists.

These contradictions and the other elements of the EP professional group activity system are worthy of further discussion and are returned to in the next Chapter in Section 5.2. Please see Appendices 10i to 10viii for all individual EP activity triangles and Appendices 13i to 13viii for data extracts linked to the detailed thematic analysis of EP activity system discussed here and represented holistically in Figure 4.12 above.

4.3. Primary mental health worker findings.

4.3.1. Subjects

The sample of four primary mental health workers (PMHWs) included a Senior PMHW, Two PMHWs and a Community Psychiatric Nurse who was temporarily in the role. The PMHW group represented just under 20 years experience of working in the team and approximately 36 years experience working in other professional roles related to child mental health or welfare. This represented a total of approximately 56 years experience in child mental health, health and welfare roles between the four PMHWs interviewed. The professional background and training of PMHWs was either a specialist nursing or social work background. The group also had a range of specialist knowledge, skills and experiences including work with children with learning disability and work in specialist tier 3 and 4 CAMHS. A sample of four creates limits to the richness of sociocultural picture that can be drawn. However, the PMHW subject perspective taken here represented the entire professional group working in the team and therefore could be said to be representative of PMHW work within the team. See Appendix 12i for full details of all PMHW subjects involved

4.3.2. Objects

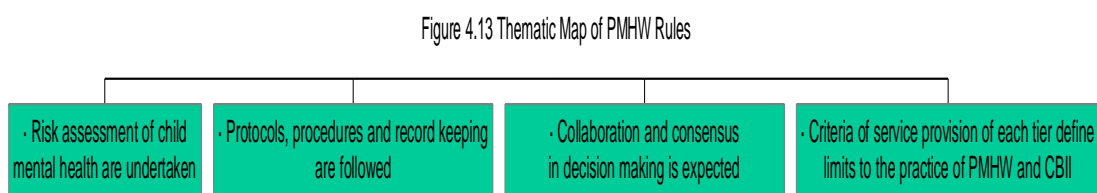
The activities chosen by PMHWs included the case allocation processes within the PMHW service and the multiagency tier 2 team, multidisciplinary mental health training and individual casework. Although this represented a limited range of activity, the PMHWs involved in the research reported that it

represented a reasonable cross section of the work they performed. See Appendix 12ii for precise details of the objects chosen by each PMHW.

The overall object of PMHW work might be summarised as meeting the mental health needs of children and young people in family and community settings through assessing and managing mental health risk, contributing to collaborative decision making, multidisciplinary training and casework as appropriate. Please see the thematic grid of objects given in Appendix 12ii and Appendices 9i to 9iv, for individual examples of the objects within PMHW activity systems.

4.3.3. Rules

The Rules that underpinned, and constrained and supported PMHW activity were identified by detailed thematic analysis as (see Appendix 12v and thematic map in Figure 4.13 below) as the:



- protocols, procedures and recording keeping systems;
- risk assessment processes and procedures;
- criteria which define and limit practice; and
- collaboration and consensus in decision making is expected.

The data extracts from which each of these themes was derived can be found in Appendix 12v.

Firstly, it seemed that PMHW's activity was both supported and constrained by the standard protocols, procedures and record keeping systems of the team and the wider PMHW service (see Appendix 12v). Secondly, these systems appeared to be used to ensure children's mental health and its associated risks were properly assessed before decisions were made. This is illustrated in Figure 4.14. Thirdly, PMHWs were expected to ensure that an appropriate response was made from the comprehensive CAMHS system to the child's presenting need. They are supported in doing this by the criteria that both define and limit their own role as well as their understanding of the criteria of other CAMHS services. Furthermore, this study's findings suggested that collaborative case discussions allowed the risks associated with child mental health to be considered and moderated within a multiprofessional context.

Figure 4.14. Example of the Rules identified within the activity triangle of a Senior PMHW whose object was to participate in a multiagency case allocation meeting.

Rules:

- Each case needs to be assessed for potential indicators of risk and severity and complexity of mental health need.
- Nominated lead agency has responsibility for records and processing referral and information
- Involvement of specialist CAMHS leads to closure of MDT tier 2 case.
- Access to specialist CAMHS is defined by criteria that are clinician determined.
- Those with risk factors would get an early response.

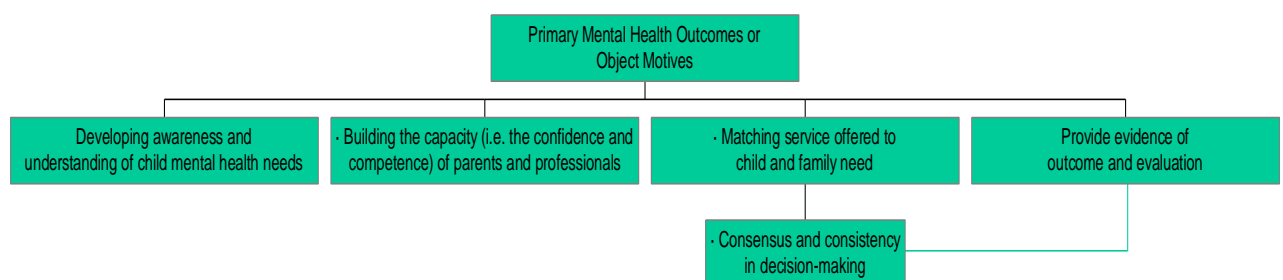
Figure 4.14 provides an example of how rules shaped the role a PMHW played in assessing risk and in managing the interface between tier 3 and tier 2. It also illustrates the importance of collaborative discussion and decision-making in helping the PMHW to perform their duties. This is also exemplified by the activity triangle in Figure 4.17 below, which outlines an activity system of a PMHW working as part of the case allocation system.

4.3.4. Outcomes

The principal outcomes (represented in Figure 4.15 below) that PMHWs' work in the multidisciplinary team seemed directed toward were:

- developing awareness and understanding of child mental health needs;
- building the capacity (i.e. the confidence and competence) of parents and professionals;
- matching the service offered to child and family need ;
- providing evidence of outcome and evaluation; and
- consensus and consistency in decision making.

Figure 4.15 Thematic Map of PMHW Outcomes



Full details of the data extracts from which these themes were derived can be found in Appendix 12vii.

Firstly, PMHWs' work appeared to be aimed at increasing the awareness and understanding of parents and professionals in respect of mental health needs. Secondly, their work was directed toward building the confidence and competence of other professionals and parents in responding to children's needs. For example, PMHWs contribute to training as well as offering a consultative service to tier 1 professionals. Thirdly, a significant part of the outcomes that PMHW sought was to ensure that a child's and/or family's need was matched to the most appropriate mental health provision within the comprehensive CAMHS. Finally, underpinning these outcomes were two further secondary outcomes, these were ensuring that decision making was performed consistently by PMHWs and other staff, and in demonstrating evidence of the outcomes and impact of PMHWs' work. These are illustrated in Figure 4.16.

Figure 4.16 An example of the outcomes sought by a SPMHW attending a case allocation meeting

<p>Outcomes:</p> <p>Hoped for:</p> <ul style="list-style-type: none"> • Consistency in response and decision making. • Equality of access to service through screening of referrals and ensuring a timely and appropriate level of response matched to need. • Match the skills and resources of team to child and family needs <p>Actual:</p> <ul style="list-style-type: none"> • Approximately 14% referrals are currently not appropriate • Consistency in core group decisions. • PMHW (Tier 2 team) act as a conduit to referral to specialist CAMHS and subsequent PMHW involvement

Tools and/or artefacts: Concrete: Information and Advice Line sheet, request for support sheet, sheet detailing the list of cases to be discussed with space for agreed actions and allocated agency (where appropriate). Past files when appropriate and discussion and debate about suitability of the case and what is an appropriate case for PMHW. Conceptual tools: include ideas and understanding of what is a straightforward 'mental health' issue including understanding of principal symptoms of conditions such as self harming. Understanding of what is the Primary Mental Health Worker role.

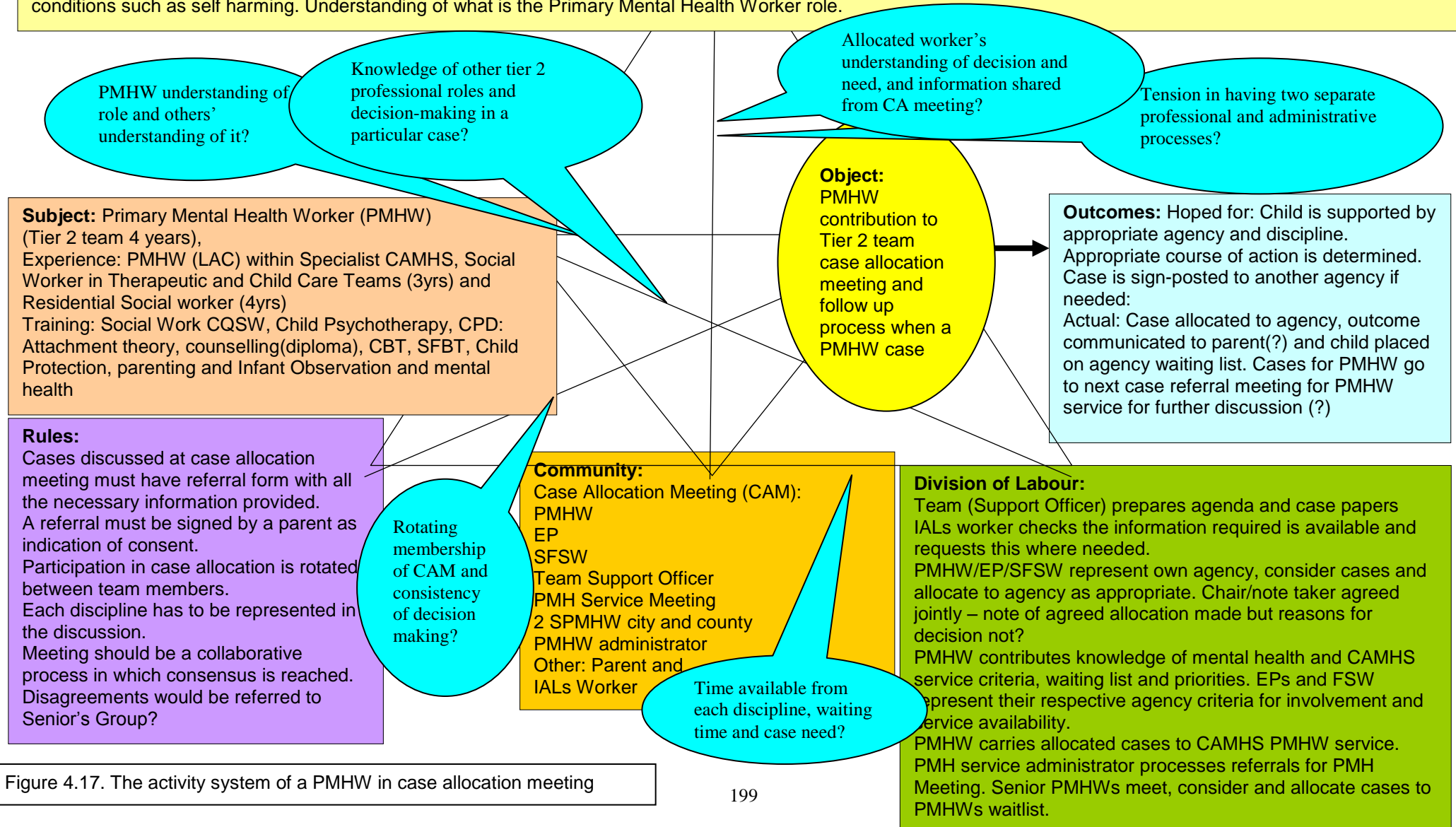


Figure 4.17. The activity system of a PMHW in case allocation meeting

Tools and/or artefacts: Concrete tools: include initial assessment pro-forma, observation in school of teacher-child interaction and at home of parent-child interaction. Teacher and parent Strength and Difficulties Questionnaire (SDQ) used as a measure, other scaling questions to support evaluation. Use of medical and family history. Understanding of the diagnostic criteria for mental health disorders i.e. ADHD. Case supervision. Conceptual tools includes ideas and understanding of what is a 'mental health' issue including understanding of the principal symptoms and risks associated with particular conditions such as self harming. Understanding of what is the Primary Mental Health Worker role and understanding and specialist CAMHS services and thresholds. Attachment theory, concepts of mental health, risk and resilience and understanding of the influence of individual, family and environment factors using models from family therapy and systems theory. Knowledge of services available at tier 1,2,3 or 4. Knowledge of assessment frameworks to gather evidence of mental health need versus those that are more behavioural and socially determined. Knowledge of learning disability and its potential impact on mental health.

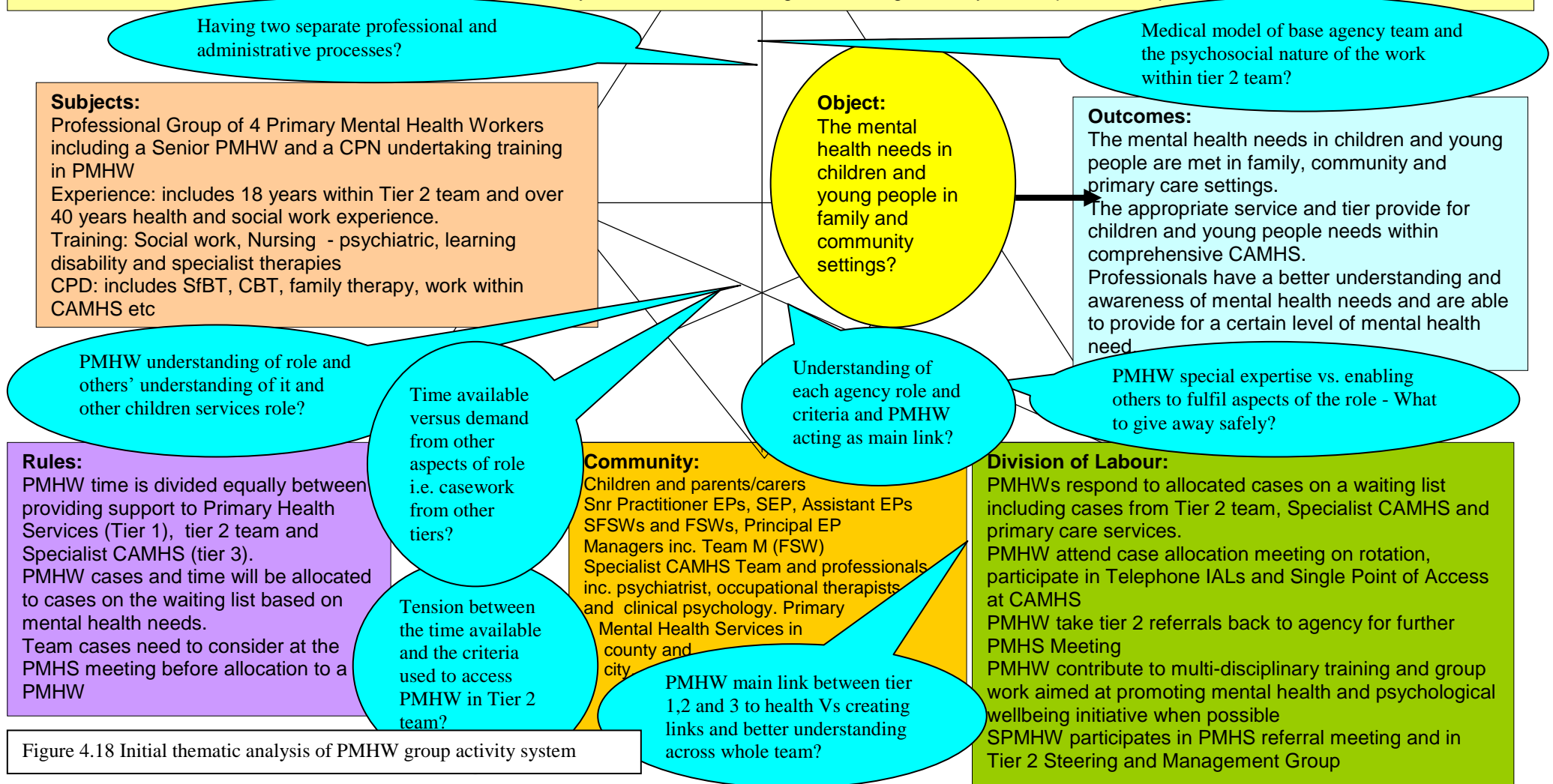


Figure 4.18 Initial thematic analysis of PMHW group activity system

4.3.5. Community

Initial analysis suggested PMHWs main client groups included children, parents, wider family and other professionals (see Figure 4.18 above). In addition, further detailed analysis of the PMHW is summarised in Table 4.3.

Table 4.3 A table to show the frequency of community links mentioned by PMHWs.

Community From	Professionals within the team	Professionals outside team	Total
Health	7	10	17
Education	4	3	7
Social care	4	1	5
Total	15	14	29

Table 4.3 indicates that, of the group of PMHWs sampled, health professionals were two times more likely to be named in PMHWs' community than education professionals and three times more likely to be mentioned than social care professionals. Caution needs to be taken in interpreting this exploratory finding as it does not represent statistical evidence. Nevertheless, it provides an indication of the nature of the community with which PMHW work. Table 4.3 suggests that links to education and social care disciplines were more frequent within the multidisciplinary team. PMHWs appeared to have fewest community links with staff outside their own agency of health and the multidisciplinary team.

However, it appeared that PMHWs' community links extended across all tiers of comprehensive CAMHS except the specialist tier 4 in-patient provision (see Figure 4.22 below). One of the PMHWs interviewed described the role as

being split three ways and delivered in roughly equal proportions to tier 1, tier 2 and as outreach from tier 3 services (see Appendices 9i to 9iv for examples). This created a dilemma for the PMHWs in how to meet the diverse and varying demands made on their work and time by each tier (see Figure 4.18 above).

It appeared that PMHWs provided the principal link to health colleagues and services for the MDT (see Figure 4.18 above). Despite working in the MDT, PMHWs seemed to use health colleagues as their main community reference point for liaison and joint work in the multiagency team (see Table 4.3). This raised the question - what was contributing to the relatively small number of direct links found between PMHW and staff in education and social care settings outside the MDT? This question is discussed later in Chapter 5.

4.3.6. Division of labour

The way labour was divided between PMHW and others in their community can be summarised as through:

- referral and provision of information (by parents and professionals);
- independent and collaborative multiagency work in casework and training (by PMHW and other professionals);
- contributions to decision making within team, discipline and agency (by professionals attending Case Allocation Meeting and PMHW service meeting); and
- professional supervision and support (by clinicians, SPMHW and PMHW).

Full details of the PMHW division of labour and linked data extracts for each of these themes can be found in Appendix 12iv.

The first aspect of how labour was divided between PMHW and others was in the making of referrals and provision of referral information, which was largely done by parents and other professionals referring to the service. A large part of the PMHW's work was in contributing, alongside other professionals, to casework or training. PMHW also participated in, and provided supervision and support for others' work with children with mental health concerns. Finally, PMHW worked alongside others to support effective decision-making in case allocation meetings as illustrated in Figure 4.19.

Figure 4.19 An extract from a PMHW triangle showing how labour was divided in an activity whose object was to allocate case to an appropriate professional.

Division of Labour:

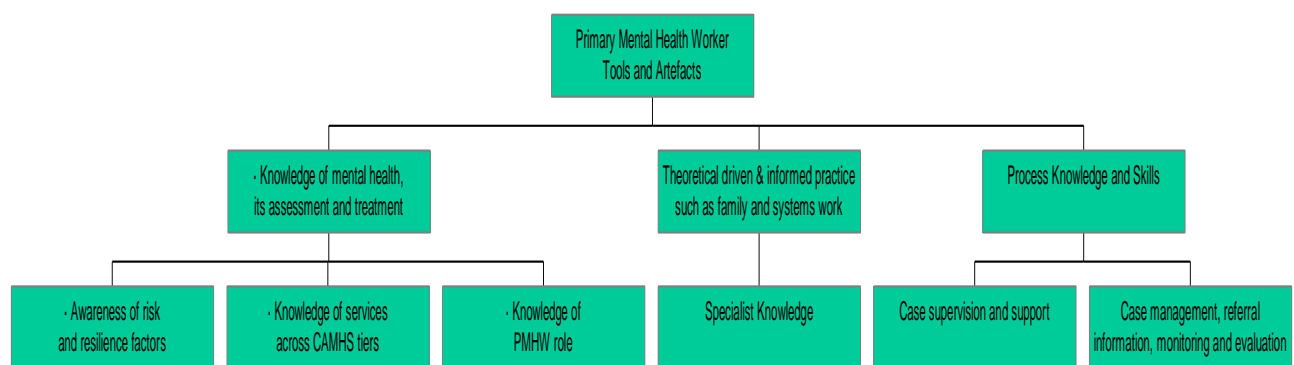
- Support Officer prepares agenda and case papers.
- Telephone Advice Line worker checks the information required is available and requests further information where needed.
- PMHW/EP/SFSW represent own agency, consider cases and allocate to agency as appropriate. Chair/note taker agreed jointly – note of agreed allocation made but reasons for decision are not?
- PMHW contributes knowledge of mental health and CAMHS service criteria, waiting list and priorities.
- EPs and FSW represent their respective agency criteria for involvement and service availability.
- PMHW carries allocated cases to CAMHS PMHW service.
- PMH service administrator processes referrals for PMH Meeting.
- Senior PMHWs meet, consider and allocate cases to PMHWs waiting list.

4.3.7. Tools

The tools that PMHWs used when working to promote mental health in children and young people, represented thematically in Figure 4.20 below, were identified as:

- knowledge of mental health, and its assessment and treatment ;
- awareness of risk and resilience factors;
- knowledge of services across CAMHS tiers;
- knowledge of the PMHW role ;
- case management, referral information, monitoring and evaluation;
- theoretically driven and informed practice;
- case supervision and support ; and
- specialist knowledge such as learning disability;

Figure 4.20 Thematic Map of PMHW Tools



Full details of the data extracts from which these tool themes were derived can be found in Appendix 12vi.

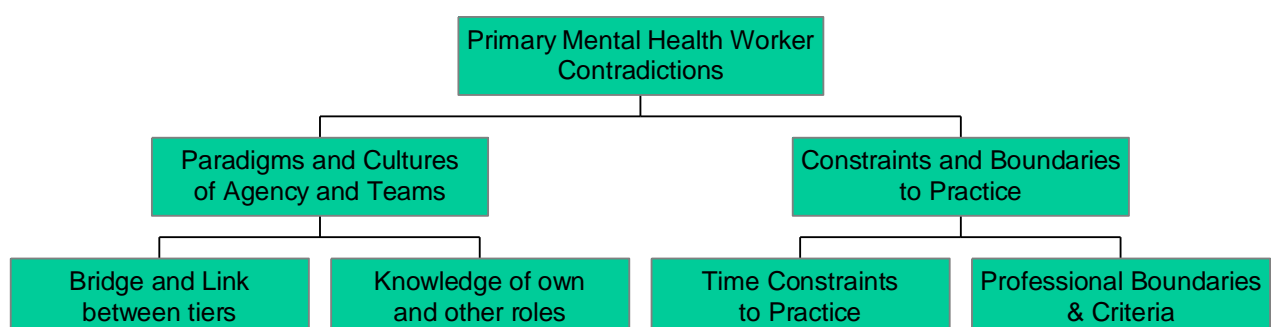
Given the role title, it is perhaps unsurprising that one of PMHW's principal tools was knowledge of how to assess and respond to issues of mental health in children and young people. However, in addition, PMHW also used an awareness and understanding of the factors that made children more vulnerable or resilient to mental health problems. They also used an appreciation of the continuum of need in determining the nature of the response they made to a mental health need. A further key tool that PMHWs

used was an understanding of the range of provision available to meet these mental health needs across comprehensive CAMHS services.

Furthermore, the importance of understanding the extent and limits of the PMHW role appeared important in their work i.e. knowing when to refer things on to other professionals and tiers. Moreover, the tools used to underpin this work included the use of case notes, record keeping systems and professional supervision to ensure safe and ethical practice. Finally, some PMHWs described the conceptual and theoretical underpinnings of the approaches they used but no single paradigm appeared pre-eminent in their work. Above all, PMHWs' work was focussed on promoting mental health and supporting mental health needs through assessment and intervention suited to the particular need, and in deploying their specialist knowledge and skills in areas such as learning disability when this was needed.

4.3.8 Contradictions

Figure 4.21 Thematic Map for PMHW Contradictions



The main contradictions found in the work of PMHWs within the multidisciplinary team are represented thematically in Figure 4.21 and can be summarised as between:

Tools and Community

- knowledge of their own and other professionals' roles;
- paradigms and cultures of agencies and teams;

Rules and Division of Labour

- time constraints to their practice;

Rules and Tools

- consistency in decision making ;

Community and Division of Labour

- being a bridge and link across tiers; and
- professional boundaries and criteria.

The details of the data extracts from which each of these themes were derived can be found in Appendix 12viii.

These contradictions represent the areas of potential expansive learning activity in the PMHW group. Indeed, these and other contradictions were used as a stimulus for a focus group discussion and 'Developmental Work Research' with the PMHWs and MDT. The outcomes of these are described later in this chapter in Section 4.6.2.

The first contradiction highlighted, between tools and community, was that PMHWs' understanding of their own role and other professionals'

understanding of the role differed. This suggested that there could be a task for PMHWs in promoting and explaining their role to others, including giving details of the functions they perform, and the methods and approaches they use.

A further contradiction found between rules and division of labour, was where there appeared to be competing demands and pressures for the time of the PMHWs (see Appendix 12viii). This seemed, in part, due to the small size of the PMHW team at the time of this study (see Appendix 12i). In addition, the PMHWs sampled reported being members of one service, two teams, and working across three tiers, all of which wanted a share of their time (see Appendices 9i to 9iv, for examples). The difficulties this created in their divisions of labour led to considerable tensions in PMHW's work within, and between, teams (see Table 4.12 given later in this chapter). However, this contradiction did provide a stimulus for some of the PMHWs interviewed to consider whether they needed to 'give away' aspects of their knowledge and skills in, for example, the initial assessment of mental health concerns (see Figure 4.18 above and for example, Appendix 9i).

Another contradiction identified within PMHWs' tools and community, was between the largely psychosocial model of the tier 2 MDT and the predominantly medical model used by other teams in which PMHWs worked (see Figure 4.18 above). PMHWs were often required to work and move between different models and approaches (see Appendices 9i and 9ii, for examples). They also appeared to perform a delicate balancing act in

mediating understanding between the different team cultures and activity systems, whose objects at times appeared to be in direct contradiction to one another (see Appendices 9i to 9iv). The paradigms held by each team appeared to create differences in understanding, interpretation and opinion around the nature of mental health needs and how best to assess and meet these needs (see Appendix 9iv, for example).

A further important contradiction observed between the community and division of labour, was in PMHWs' role acting as the main bridge and link to their own agency and team i.e. health and specialist tier 3 CAMHS (see Figures 4.18 above and 4.22 below). It was not entirely clear whether this role was building or hindering the development of wider links and understanding between the different teams and professionals involved in the multidisciplinary team and comprehensive CAMHS. It appeared that other professionals from both teams, in part, relied on PMHWs to perform this key link role (see Figure 4.22 below, and FSW and EP community in Figures 4.33 and 4.12 respectively). This in turn created a significant pressure on PMHW's time and work (see Table 4.12).

These, and other contradictions highlighted above, act as the basis of further development work with the PMHW group and wider multidisciplinary team (see Section 4.6.2). Moreover, they can also be used as a stimulus for future expansive learning activity in the PMHW group. PMHW's activity system and the other contradictions highlighted above are discussed further in Chapter 5, Section 5.3.

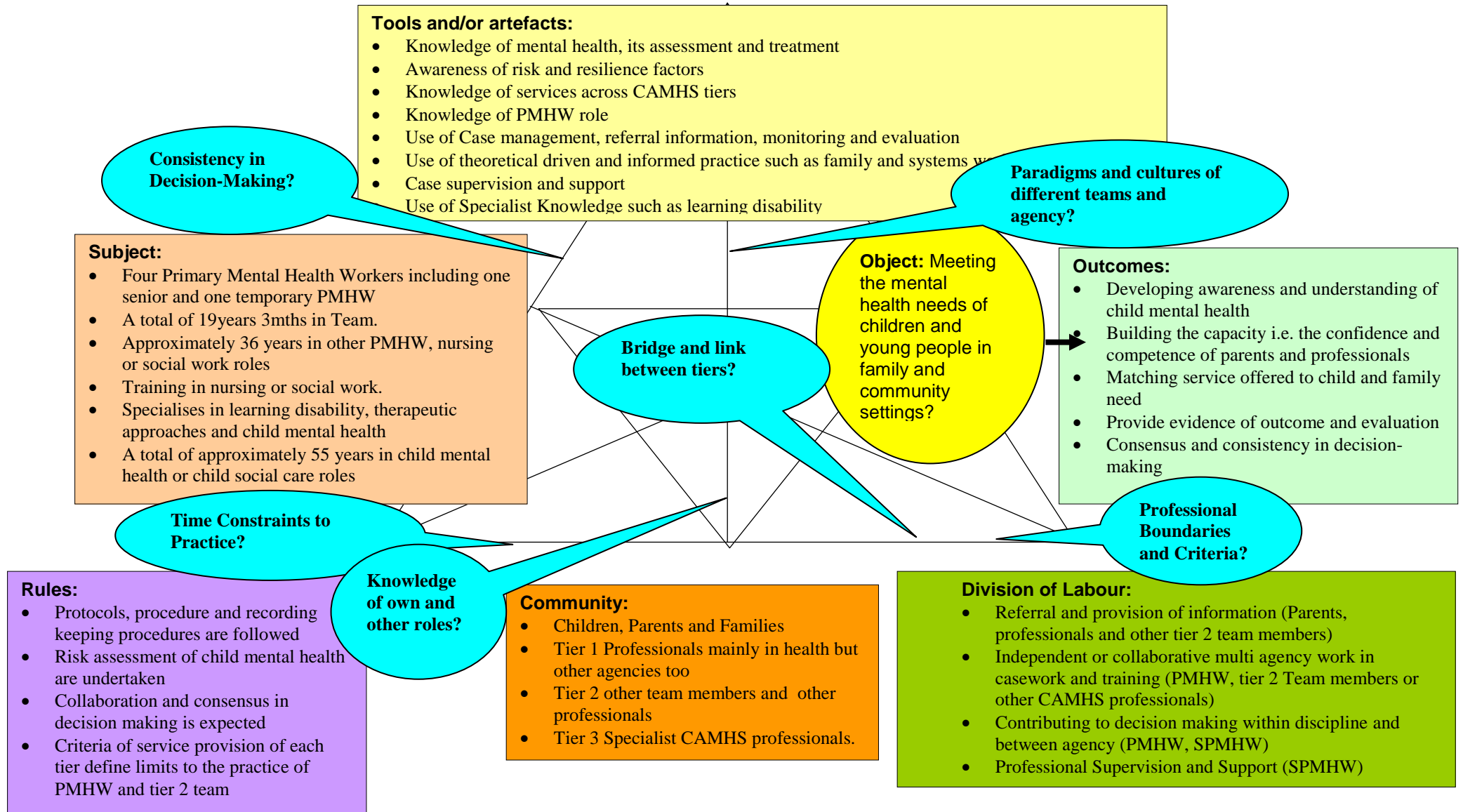


Figure 4.22 Detailed thematic analysis of Primary Mental Health Worker Activity System

4.4. Family support worker findings

4.4.1. Subjects

The eleven participants sampled from the family support work group included a team manager, three senior family support workers and seven family support workers, with varying degrees of experience in the team from 3 months to 10 years i.e. since the team's inception. The cumulative years of experience amounted to over 55 years experience in the team. FSWs had over 140 years collective work experience in other child social care, nursery nurse or child welfare roles. Many of the family support workers had had considerable experience in other child social care roles (see Appendix 14i).

FSWs principally came from social care background but some notable exceptions included a trained teacher, a former personnel manager and two in the team who had contributed to training in childcare within further education colleges. In addition, the FSW team manager was a trained and experienced social worker and several of the FSWs in the team were undertaking additional training and study to become qualified social workers. Typically FSW training and qualifications included NNEB Nursery Nurses, NVQ level 3 or BTEC in Childcare. The principal areas of specialist knowledge were knowledge of childcare and parenting skills, experience of child protection procedures and social care services and provision. In addition, it was evident that the FSW practical knowledge of working in childcare roles, their knowledge about different cultures and experience of parenthood were influential in their work and role. Please see Appendix 14i for an overview of FSW subject details.

Tools and/or artefacts: Concrete: Knowledge of child development milestones, appropriate environments to promote play and child development and parenting. The use of direct work involving assessment based Quality Protects Children in Need framework and CAF IALs rota, first response rota and visits, contributing to mental health awareness training and training in solution focused approaches and as lead or support for initial assessment visits and short term intervention programme over 8 sessions. Using a combination of hands on direct support and work and indirect empowerment of other professionals in tier 2. Knowledge of child protection and safeguarding procedures. The use of effective case management, record keeping and file management. The use of informal support, line manager supervision, induction and professional development activities. Team, Case Allocation and professional group meetings

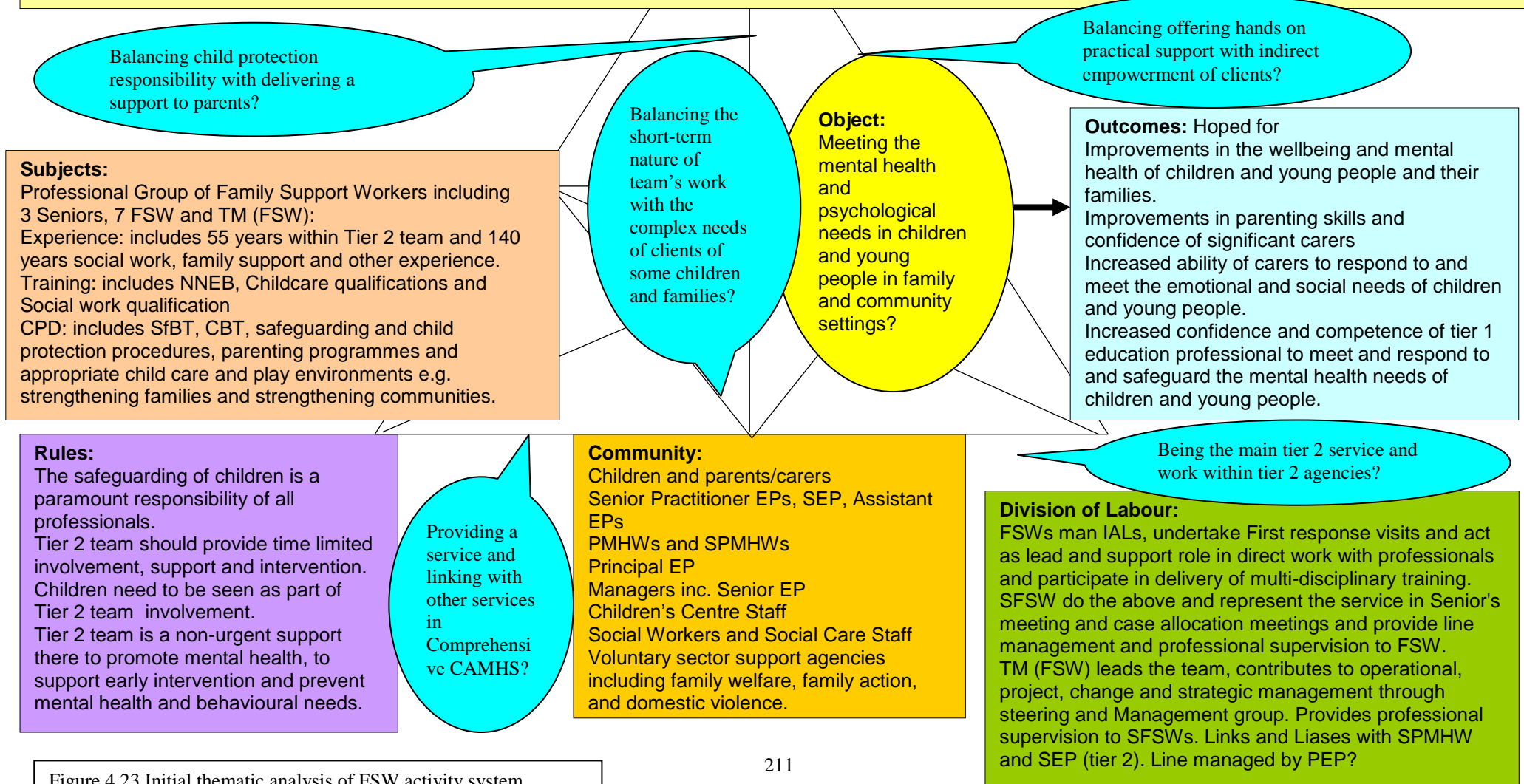


Figure 4.23 Initial thematic analysis of FSW activity system

4.4.2. Objects

The principal object of family support workers' activity appeared to be in providing practical direct and indirect support to parents and their wider families, supporting them in meeting children's care needs including their physical, behavioural and emotional needs (see Appendix 14ii).

Of the activities sampled; three involved team management processes; two involved contributing to training of professionals and the remainder were either direct or indirect casework activity. The latter included working on the team's telephone information and advice line and supporting early intervention through provision of the first response appointments for the team. Moreover, the FSWs' role involved face to face contact with children as well as offering direct practical and emotional support to parents and families in need. In addition, FSWs supported collaborative team processes through contributing to multidisciplinary case allocation meetings and working jointly with other professionals in training on mental health and related issues.

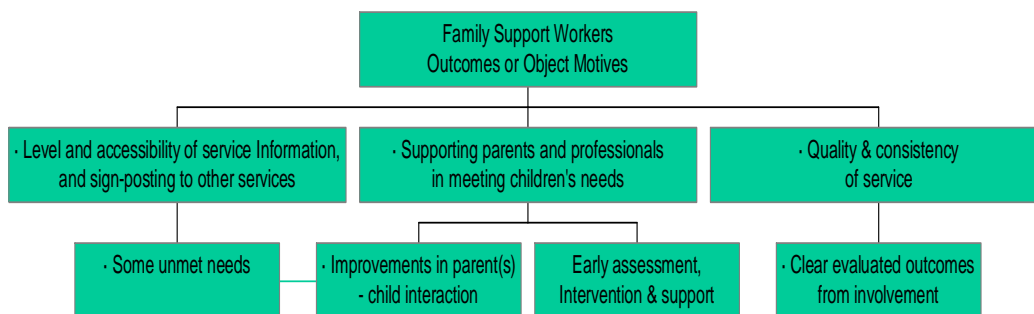
4.4.3. Outcomes

The outcomes that the activities of FSW group seemed to be aimed at are represented thematically in Figure 4.24 and can be summarised as:

- ensuring the quality and consistency of service;
- ensuring the appropriate level and accessibility of service;
- providing information on, and sign-posting to other services;
- supporting parents and professionals in meeting children's needs;
- offering clearly evaluated outcomes from involvement;

- early assessment, intervention and support;
- seeking improvements in parent(s) and child interaction; and
- meeting unmet needs.

Figure 4.24 Thematic Map of FSW Outcomes



The detailed data extracts from which of these themes were derived can be found in Appendix 14vi. Some of the outcomes are further illustrated in the data extract in Figure 4.25 below of a FSW's activity system whose object was to provide a first response visit to parents who were concerned about their 9-year old daughter's emotional needs. This further exemplifies the importance of the provision of early assessment, advice and support for parents within the work of FSWs and of matching the service provided to the child and family's needs.

Figure 4.25. An example extract showing the identified outcomes of a FSW whose object was the provision of a first response visit to a family in need.

<p>Outcomes:</p> <p>Hoped for:</p> <ul style="list-style-type: none"> • Early intervention within a week of request. • To promote parents skills, to reduce anxiety and identify most appropriate agency to support. <p>Actual:</p> <ul style="list-style-type: none"> • Initial assessment of suitability of case. • Signpost and referred to School Anxiety Support Team (SAST) • Identify family support and parenting needs. • Re-referred to Case Allocation Meeting (CAM) for further Tier 2 team work

The FSW outcomes are further exemplified within the activity systems shown in Figure 4.28 and Figure 4.29 below. These illustrate the importance that assessment, support and identifying appropriate provision in family support staff's work. Underpinning all these outcomes is the importance to the FSW group of ensuring that their services were offered in a consistent way, which meet service quality standards and demonstrate impact through evaluation.

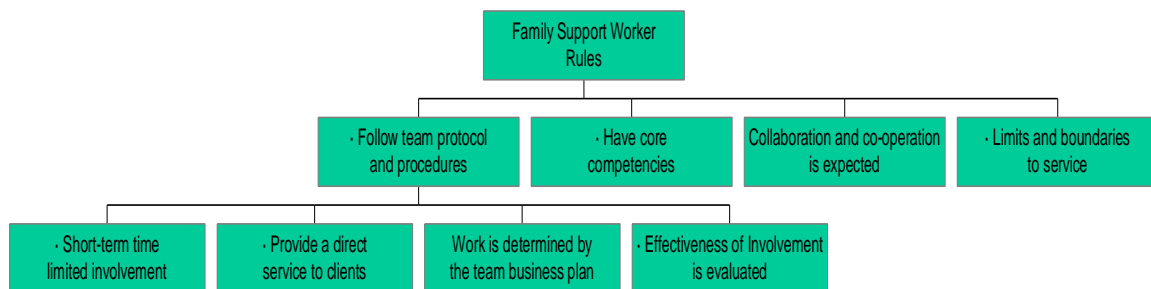
4.4.4. Rules

The rules that supported and constrained the work of family support group are represented in Figure 4.26 below and can be described as follows:

- Short-term time-limited Involvement is required;
- effectiveness of involvement is evaluated;
- collaboration and co-operation is expected;
- work is determined by the team business plan;
- provide a direct service to clients;
- follow team protocols and procedures;
- have core competencies; and
- limits and boundaries to service.

The detailed data extracts from which each of these themes was derived can

Figure 4.26 Thematic Map of FSW Rules



be found in Appendix 14v.

The rule that constrained the FSW activity most was the time-limited nature of their interventions and their ability to meet the complex needs of families within the short eight-session change programme used (see Appendix 14v and Appendices 8i, 8ii, 8iv, 8vii, 8xi for examples). The FSWs also seemed constrained by the fact that direct work with children was expected in the role, when some believed that enabling and empowering parents by offering indirect support and consultation was an important aspect of their work (see Appendix 14v and Appendix 8vii, for an example). The work of FSWs also seemed, more than the other professional groups, to be directed and supported by team plans, procedures and protocols (see Appendix 14v and Figure 4.27 below, for example). In addition, FSWs' work was supported by the expectation of collaboration within the team, by having a common core of knowledge and skills and common evaluation mechanisms in the team (see Appendix 14v). Finally, FSW appeared to be constrained by the rules held by other professional groups both within and outside the team. FSWs were expected to undertake a short-term involvement but at the end of this involvement other services could be reluctant to accept a referral and to

engage with a child or family because of the criteria determining access to their service activity (see Appendices 8i, 8vii, 8xi, for examples).

Figure 4.27 An example extract of the rules of a FSW whose object was the delivery of a multiagency mental health training

Rules:

- Training is done in pairs. You observe and participate in training before undertaking delivery.
- You have to perform work in accordance with the business plan.
- All training should be evaluated and include equal opportunity monitoring including records of ethnicity, gender and area of work

Tools and/or artefacts: Conceptual: Knowledge of child protection procedures, the impact of emotional abuse, parenting, age appropriate development, play environments for children and behavioural strategies.
Concrete: Discussion with child, observation of child – parent interaction, practical help to mum to access support, solution focused approach, consultation with other professionals, use of the Quality Protects Framework for the assessment of need. Use of Magic 123-programme and sticker chart for behaviour. Active listening skills, information gathering and sharing.

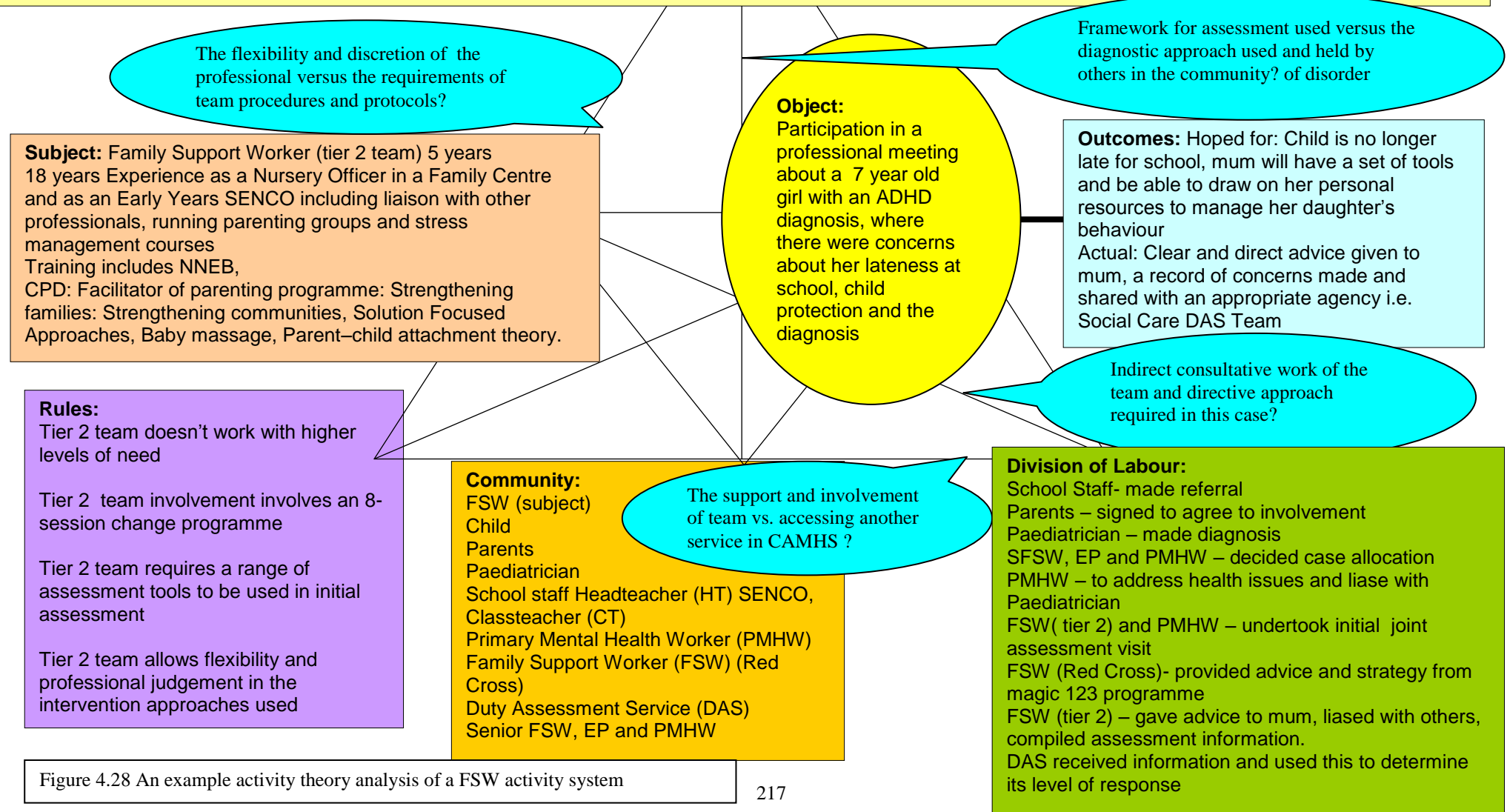


Figure 4.28 An example activity theory analysis of a FSW activity system

Tools and/or artefacts: Conceptual: ECM Agenda, UN Convention Rights of the Child, Knowledge of Child Protection Process and Local safeguarding arrangements and Children act concepts of 'Good enough parenting' and the paramount importance of meeting 'children needs'. Understanding of behaviour management techniques, children's learning and development and the impact of learning disability. Understanding of mental health and limits of Strengths and Difficulties Questionnaires (SDQ). Concrete: Observation of Parent – Child Interaction, Discussion with other relevant professionals, multi-agency meeting and liaison, Behaviour Management Advice and Strategy Sheet (adapted to be presented visually using Traffic Light Behaviour Chart). Use of Solution focused techniques. Joint home visit with other worker to introduce and facilitate transition to another service.

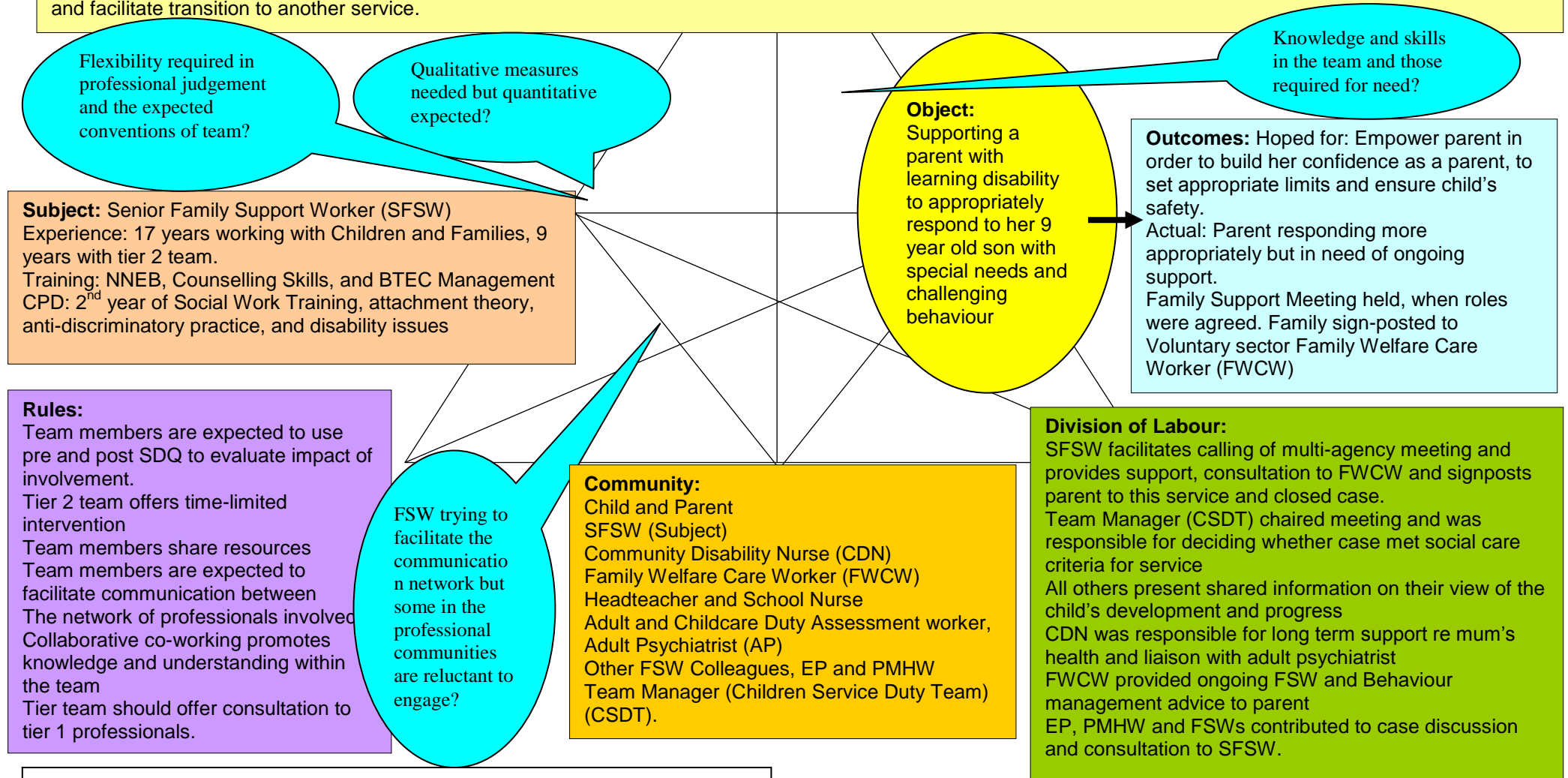


Figure 4.29 An example of an analysis of a Senior FSW activity system

4.4.5. Community

FSW were the largest professional group in the team (see Appendix 14i). .

The community with which FSWs work appeared to be dominated by their own discipline within the multiagency team (see Table 4.4 below). This may be due, in part, to the fact that each professional group in the team were located together in a base rather than in multidisciplinary groups i.e. FSWs were located together in three separate bases. That said, FSWs often worked in collaboration with a member of another professional group within the team. Indeed, it was rare for FSWs as a group to work with a community that didn't include a representative of a different professional group from the team or elsewhere. FSW workers also seemed less bound by the community origins of their own discipline, with their work with professionals external to the team being fairly evenly spread across each agency (see Table 4.4 below).

Table 4.4 A table to show the frequency of community links mentioned by FSWs:

Theme	Internal	External	Total
Education	8	13	21
Health	8	10	18
Social care	25	9	34
Other	3	7	10
Total	44	39	83

4.4.6. Division of labour

How labour was divided across the community in which FSWs work was further analysed (see Appendix 14iv) and the following themes emerged:

- referral and information source (parents, schools, tier 2 team professionals);
- allocate case and other work (SFSWs / case allocation meeting);

- Provide supervision and consultation and management support (TM, SFSW and SPMHW);
- Provide initial response, assessment and support (FSWs);
- Received referral and used information in determining action (FSW/ Other agencies);
- participate in multidisciplinary and joint working (other team and agency staff);
- provide leadership and management (team manager/ SFSW);
- provide administrative support (support officer).

The data extracts from which each of these themes was derived can be found in Appendix 14iv.

Involvement of FSW workers was often triggered by parents (through self-referral) or by schools who suggested to parents that they might benefit from support. FSW involvement was always ratified by a multidisciplinary panel and endorsed by a Senior FSW (see Appendix 14iv.). These themes are further exemplified in Figure 4.30 below showing how labour was divided between a FSW and others in an activity whose object was to support to a family with 5-year old child presenting behavioural problems.

Once a case was allocated, FSW found themselves in a lead or support role undertaking initial assessment and/or offering early support to families (see Appendix 8ii, for example). Moreover, to support this work FSWs participated in joint work or multidisciplinary meetings and where necessary passed case information onto another agency or service within comprehensive CAMHS

(see Appendices 8i and 8iv, for examples). These services then used this information to decide whether or not to accept a referral. This created a dilemma for FSW workers needing to conclude their short time-limited involvement and in referring the case onto another agency, which could be reluctant to accept the referral (see Appendices 8iv and 8xi, for examples).

Senior FSW provided supervision and support to frontline staff helping them with the difficult issues and decisions they had to make. The team's manager undertook a similar role in the supervision of the Senior FSW. It was further evident that FSW used informal and consultative support within their own discipline and, on occasions, with other professions in the team. On top of this, the team manager provided the operational and strategic management for the group. Supporting all of the FSW work was the team's administrator, who ensured that team procedures and protocols were adopted and followed (see Appendices 11i and 11ii for details of support staff activity systems).

Figure 4.30 An example extract of the division of labour from a FSW activity triangle whose object was working with the family of a 5-year-old boy with behavioural problems

Division of Labour:

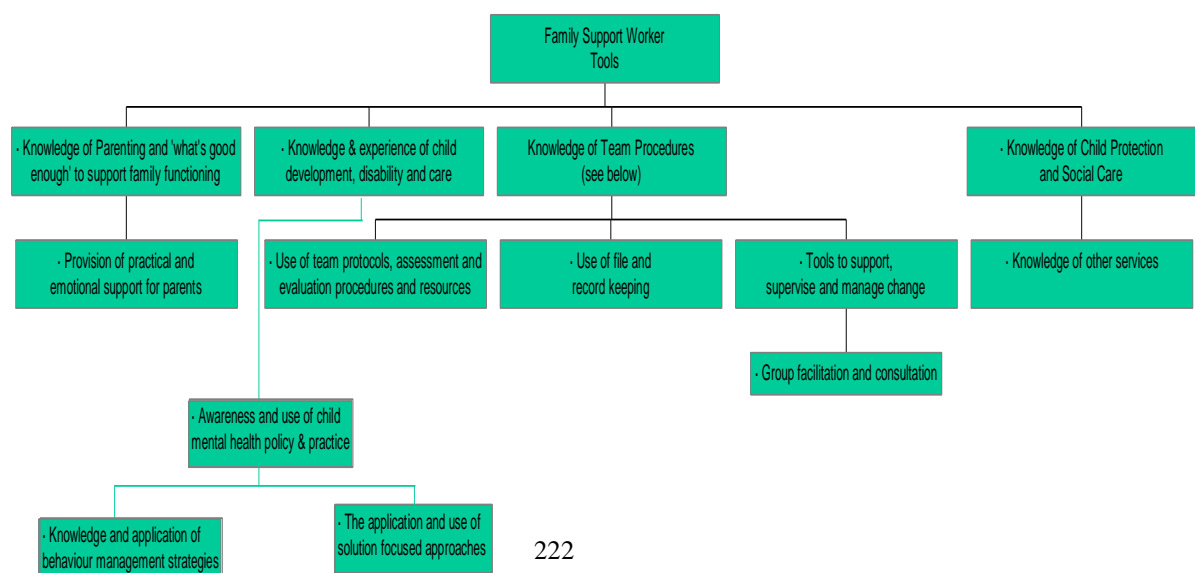
- School – publicised the service and provided information to parents.
- Parents – Self referred to service and shared concerns.
- Maternal Brother – offered respite care to parent.
- Health Visitor - undertook initial screening of child's and parent's needs.
- Senior Tier 2 team staff – considered referral and allocated the case to appropriate agency.
- FSW – provided informal and practical support to parents and referred on to another service or helped parent to access these services.

4.4.7. Tools

The tools that family support workers drew on to support their work with children and parents in family and community settings are represented in the thematic map in Figure 4.31 below and included:

- knowledge and experience of child development, disability and care;
- knowledge of parenting and 'what is good enough' to support family functioning;
- the application and use of solution focused approaches ;
- knowledge and application of behaviour management strategies;
- awareness and use of child mental health policy and practice;
- provision of practical and emotional support for parents ;
- knowledge of child protection and social care issues;
- use of team protocols, assessment and evaluation procedures;
- use of file and record keeping;
- group facilitation and consultation;
- tools to support, supervise and manage change; and
- knowledge of other services.

Figure 4.31 Thematic Map of Family Support Worker Tools



Full details of the linked data extracts from which these themes were derived can found in Appendix 14vii.

A prominent feature of the tools that FSWs drew on in promoting mental health and psychological wellbeing was their knowledge of child development, childcare and parenting. Much of the knowledge they used appeared to be of a tacit and practical nature and was grounded in their own experience and that of their clients. Furthermore, FSW appeared to adopt approaches that focussed on achieving positive change in behaviour either through solution-focused or behaviour management techniques. FSW also used an awareness of child mental health, child protection and social care provision to support them in their role. They also seemed to draw heavily on team protocols, procedures, record keeping and supervision processes in support of their work.

4.4.8. Contradictions

The contradiction themes highlighted by the detailed analysis of FSWs' activity system in Figure 4.33 and represented thematically in Figure 4.32 below can be summarised as follows:

Tools and Outcomes

- Meeting the needs of parent and child;
- Formal child protection role and informal support role;
- providing both indirect 'enabling' support and direct practical 'hands on' support;

- evaluation and evidence of impact.

Rules and Outcomes

- time and other limits to support offered vs. meeting the child and family need;

Tools and Rules

- professional flexibility versus consistency of service;

Tools and Community

- differences in understanding and co-operation and collaboration within and between services;
- level of access and involvement in team collaboration;
- models of other services and those of the team;
- links with other agencies;

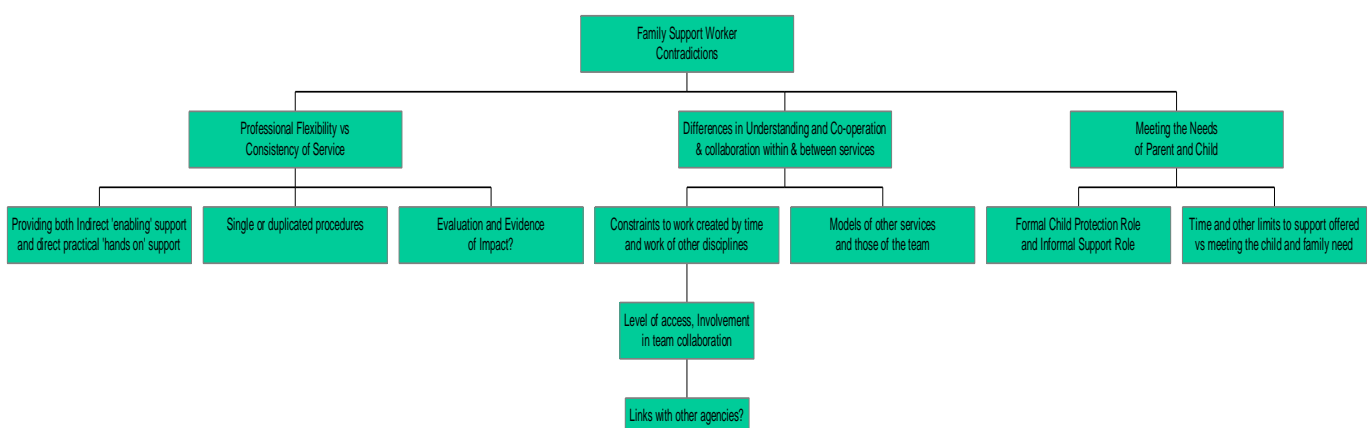
Tools and Division of Labour

- single or duplicated procedures; and

Community and Division of Labour

- constraints to work created by time/work of other disciplines;

Figure 4.32 Thematic Map of Family Support Worker Contradictions



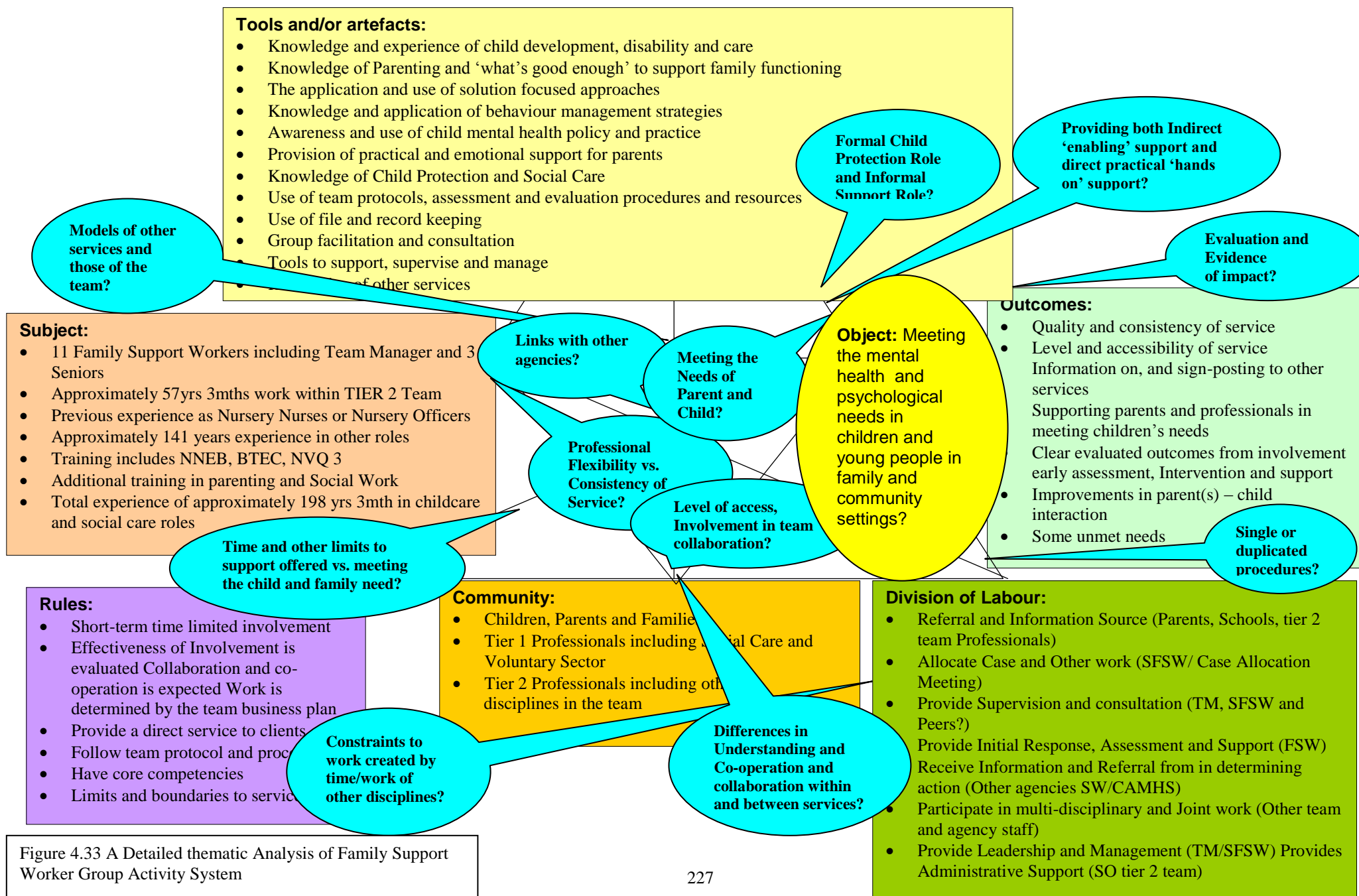
The linked data extracts from which these themes have been derived can be found in Appendix 14vii.

A recurring theme for FSWs was a contradiction found between rules and outcomes, where FSWs felt a tension between the time-limited nature of their work and meeting the complex needs of children and families. A further contradiction, identified between rules and tools, was in the FSWs desire for consistency of service and the need to have flexibility in their professional practice in particular cases. Moreover, another tension observed between tools and outcomes was that FSWs were often expected to meet the needs of both children and parents, but at times their needs could contradict one another. Linked to this, was a contradiction found between tools and outcomes, where FSWs were providing informal family support to parents alongside their formal child protection role. In addition, a tool – outcome contradiction was highlighted between FSWs offering indirect ‘enabling’ support for parents but sometimes finding that more direct practical hands-on support was required (see Figure 4.33 below).

Further contradiction identified between FSWs’ tools and community were where the time constraints of other disciplines in the team appeared to conflict with FSWs’ desire for collaborative and joint work. In addition, a further tool – community contradiction was observed within FSWs’ activity system between the different understandings and models of mental health held within and between services. This created difficulties in joint and joined-up working for

FSWs and other services within comprehensive CAMHS. Finally, a tool - outcome contradiction was highlighted in the way FSWs' work was evaluated. FSWs currently gathered and could provide evidence of short-term outcomes but evidence of the longer-term impact of their work was often needed (see Figure 4.33).

The contradictions highlighted above provided the basis for further development work with the FSW group and wider multidisciplinary team (see Section 4.6.2.2 below). Moreover, they may act as a stimulus for further expansive learning activity in the FSW group. The FSW activity system and the other contradictions identified above are discussed in more detail in Chapter 5, Section 5.4.



Tools and/or artefacts: Consultation using Information & Advice Line Support, Case Allocation Process, Direct Work involving First Response Appointment, Initial Joint Assessments and an eight-session intervention programme to family, pre-post evaluation of change measures using quantitative and qualitative measures of change in parental/carer perception. Drawing on knowledge of child development & the impact of family and parenting. Using Solution-focused, cognitive behavioural and behavioural approaches. The use of ½ day, day & two day training in promoting positive mental health in Tier 1 professionals and organisations and the use of group work to support the development of mental health awareness and skills in children and young people up to age 11. The work of the team is supported by administrative, finance, IT and file management procedures. The team Business Plan is used to determine the parameters and priorities of the team. The work of the team is developed & monitored through team meeting discussion, professional development activity, and professional supervision & performance management.

The nature & amount of clinical skills available to the team vs. the reliance on PMHW to provide these?

Subjects:

The tier 2 team including 4 PMHW, 11 FSW, 8 EPs & 2 Support Officers, Strategic & operational managers
Experience: 40 years experience of tier 2 team (From 3 months to 9 years) and 100 years of working in child mental health related services including work in nurseries officers, teaching, social work & further education. Training: includes professional, undergraduate & postgraduate training in Nursery Nurse, Social work, mental health and Educational Psychology CPD includes SfBT, CBT, Parenting, specialist knowledge & skills

Two agencies, three professional groups with different levels of involvement in tier2 MDT& their other teams – One service?

Rules:

MDT is a service for children up to age 11 within the city boundaries only. MDT is a Tier 2 service designed to support short-term intervention to children & families in community settings to address less severe & complex mental health needs issues
Tier 2 staff should provide consultation to tier 1 staff and link and liaison with specialist tier 3 as and when necessary but particularly when they feel at the limit of their knowledge and skills. MDT staff should place children's needs as their paramount concern and should consult & or refer to Child protection services if they feel a child is at risk of significant harm

As a tier 2 service the team provides consultation & direct support to parents & families but how does it provide consultation and support to tier 1 professionals?

Agency professionals link with own agency building link vs. building understanding within Comprehensive CAMHS?

Differences in processes used to allocate casework versus other work of team members & professional groups?

Community:

Other members of Tier 2 team including professional groups of FSWs, EPs & PMHW and support staff including senior and team managers
Tier 1 professionals including school staff, health visitors & GPs and children's centre & social care staff.
Tier 2 Staff including Behaviour Support Teachers, Special Needs Teachers, Social Workers and Educational Psychologists
Tier 3 Staff including specialist CAMHS team and single point of access.

Object: To promote the positive mental health and psychological well-being of children, young people up to age 11 and their families who are resident within the City Boundary

Team's key links within the comprehensive CAMHS are Tier 1 & Tier 3 but how are these tiers' perspectives represented in service development, monitoring & management?

Service looking to promote MH & PWB in children & families but service is limited by age rather than need?

Outcomes:

Hoped For: Improved Mental Health and Psychological Well-being of Children and Young People who receive a service.
Improved confidence & competence in their parents & carers in meeting the mental health & psychological needs of children.
Improved knowledge & awareness and competence of Tier 1 staff in addressing the mental health needs of children.
Improved liaison and links
Actual: Positive evaluations of impact either immediately after involvement & at 3 month follow up (?)

Short term change evident but long term impact less clear?

Division of Labour:

All tier 2 team members work on IALs on a rota. FSW undertake First Response on a rota basis. Senior representatives of each discipline attend Case Allocation Meeting to allocate referrals
All team members undertake allocated direct work including initial assessment & intervention tier 2 team Support Officer, Office Manager & Deputy operate and support the team's admin, ICT, record keeping & budget monitoring procedures
Senior professionals provide professional supervision and operational management of frontline staff.
Senior managers develop the business plan, initiate and monitor service development & performance via team's steering group.

Figure 4.34 Initial Activity Analysis of the full multidisciplinary team

4.5. Multidisciplinary team findings

In this section of the research findings, the contributions of each profession are brought together to provide an overview and summary of the overall contribution of the multidisciplinary team. The themes identified for each group were tabulated to enable the similarities and differences to be highlighted and common and overall multidisciplinary team themes identified. These are summarised for each element of the activity system below.

4.5.1 Subject

The multidisciplinary team sampled (see Table 4.5 below) was made of three professional disciplines, managers and support staff. These included:

- 11 Family Support Worker Staff (including the Team Manager and 2 Senior FSWs)
- 8 Educational Psychologists (including the Principal EP, Senior EP and Senior Practitioner EP)
- 4 Primary Mental Health Worker (including a Senior PMHW)
- 2 Administrative Support Staff

A more detailed analysis of the participants in the multidisciplinary team can be found in Appendices 12i, 13i and 14i.

Table 4.5: Table showing subjects by role and professional group

Group	Subject	Subject	Subject	Subject	Subject	Subject	Subject	Subject	Subject	Subject	Subject	Total
Educational Psychologist (EP)	Principal EP	Senior EP (1.0)	EP (0.6)	EP(0.5)	EP (0.2)	EP(0.4)	EP(0.4)	Assistant EP (1.0)				8
Family Support Worker (FSW)	Team Manager (FSW)	Senior FSW	Senior FSW	Senior FSW	FSW	FSW	FSW	FSW	FSW	FSW	FSW	11
Primary Mental Health Worker (PMHW)	Senior PMHW	PMHW	PMHW	Temporary PMHW								4
Support Staff	Office Manager	Support Officer										2
Total Sample												25

The sample includes:

- 1 senior manager;
- 3 middle managers;
- 3 professional supervisors;
- 16 frontline professional (5 EPs, 1 AEP, 7 FSW, 3PMHW)
- 2 support staff

Table 4.6a Table showing the type and number of individual objects identified by the team

Theme Direct casework aimed at supporting the mental health needs of children & young people in family and community settings?	Supporting a parent with learning disability to appropriately respond to her 9 year old son with special needs and challenging behaviour (FSW)	Providing first response to parents of 9 year old girl who was anxious, displaying challenging behaviour refusing to attend school (FSW)	To undertake an initial assessment of a 5-year old boy with behaviour and anger control issues supported by a colleague. (FSW)	Participation in a professional meeting about a 7 year old girl with an ADHD diagnosis, where there were concerns about her lateness at school, child protection and the diagnosis (PMHW)	To work with a family of a 5 year old boy to address the violent behaviour he shows towards school peers and parents (FSW)	To provide support for a 're-referred' parents to help them in understanding and managing the behaviour of their 9 year old son with learning and behavioural difficulties. (FSW)	Supporting the main carer with the management of her 6-year-old granddaughter's behaviour at home. (EP)	A joint home visit, as an exceptional arrangement, and use of video guidance of child behaviour in interaction with parents at home. (EP)	8
Multi-disciplinary training aimed at improving tier 1 professionals understanding of children's mental health	A half-day training on child mental health for early years care providers. (FSW)	Training for professionals on responding to children's emotional needs (under 5) within a Surestart setting (PMHW)	Development and delivery of a multi-agency training on mental health awareness for frontline CAMHS staff (Tier 1) (EP)	Involvement in the development and delivery of solution focused training to groups of children's service professionals (SFSW)					4
Development and delivery of group work aimed at building social and emotional competence & skills in children	Planning and delivery of the Special, Pro- social, Assertive Resilient Kids Programme. (EP)	Development and delivery of transition groups for vulnerable children in Y6 in six primary schools. (EP)	Development and delivery of a half day pilot workshop for year 6 pupils on domestic violence (DV) (AEP)						3
Collaborative team processes which aim to co-ordinate team work in support of children with mental health needs	Working on the tier 2 Information and Advice Line, providing consultation, support and advice to a parent (FSW)	The PMHW contribution to tier 2 case allocation meeting and follow up process when a PMHW case is allocated. (PMHW)	The operation of the single point of access to Primary Mental Health Worker (PMHW) Service and its link with the tier 2 team referral process. (PMHW)	Induction of FSW into tier 2 team through training, supervision and planned activities (FSW)					4
Strategic & operational management supporting the development and delivery of a multi-agency team for children with mental health needs	Participation in discussion, information exchange and decision-making in the tier 2 team steering group & linking with other strategy groups and initiatives.(PEP)	Development of the tier 2 business plan to underpin the team's activity & work. (SEP)	Responsibility for change management within the tier 2 team (August 06 – Nov 07) relating to the operation of Information and Advice line. (Manager FSW)	To undertake a review of tier 2 team file management system and implement these changes (SFSW)	The Operational management & monitoring of the tier 2 team budget. (Support Officer)	Manage and operate the database record of tier 2 team work activity. (Support Officer)			6
									25 Total

4.5.2 Objects

In order to identify the objects that individuals within the team were working on, each participant was asked, prior to their interview, the following: 'Can you describe something you are working on as part of the team that you consider promotes mental health and psychological wellbeing?' Participants made a free choice of object in response to this question. The responses given were then recorded on each participant's activity system.

After all interviews were completed responses were then grouped and analysed to provide overall object themes. The object themes for the team can be summarised as follows:

- Direct casework aimed at supporting the mental health needs of children & young people in family and community settings?
- Multi-disciplinary training aimed at improving tier 1 professionals' understanding of child mental health.
- Development and delivery of group work aimed at building social and emotional competence & skills in children.
- Collaborative team processes, which aimed to co-ordinate team work in support of children with mental health needs.
- Strategic & operational management supporting the development and delivery of a multi-agency team for children with mental health needs.

The individual objects raised and discussed by team members linked to these themes are provided in Table 4.6a above. Further analysis of the

sample of 25 objects indicates that of the overall sample included 32% Direct Work, 16% Training, 12% Group Work, 16% Team Process and 24% Team Management.

The service's statement of aims and purpose, outlined in its development plan (see Appendix 2), allows this sample of objects to be contrasted with the stated aims and plan for the team. The team plan indicated that frontline staff have three main roles, which are; direct work with children and families, group work and training. Interestingly, the work of support staff and team managers are not specifically mentioned in the plan but these are clearly key functions which underpin service delivery and support the successful operation and management of the team. The team also presented a number of objects which were shared team processes such as the team's case allocation meetings, the telephone information and advice line and record keeping systems.

The sample of the objects could be challenged as not being truly representative of the team's work, as they were not selected either at random or to reflect the team development plan. It could, however, be argued that the team plan is more an artefact of team managers' activity than of frontline staff.

It also needs to be acknowledged, that participants may have selectively chosen objects to highlight particular aspects of their work and so the sample could be considered not to be entirely

representative of the day to day work of the team. In an attempt to overcome this, the researcher took steps to ensure that the question posed to participants was the same and did not inadvertently introduce bias in the sample. In the end, the objects selected depended entirely on participants' choice.

The extent and size of the sample, participant choice of object, and their confirmation that it was accurate, all add weight to the researcher's contention that the sample is reflective of the team's activity and the objects it was working on at the time of the research.

The variable size of the professional group sample may also be criticised for introducing potential bias in the sample of objects chosen. Again the researcher attempted to work against any potential bias by allowing professionals free choice of the object, and by asking them to confirm the accuracy of the activity systems and objects therein. Indeed, all the activity systems and objects were confirmed by participants as a fair and accurate record.

The table below provides a summary of the numbers of each object theme chosen by each professional group and the multidisciplinary team. It provides an overview of the sample of objects used and which form the basis of the team and professional group activity systems sampled in this study.

Table 4.6b A Frequency of objects chosen by each professional group and the multidisciplinary team.

Professional Group	Direct work	Training	Group Work	Team Process	Team Management	Total
EP	2	1	3	0	2	8
FSW	5	2	0	3	1	11
PMHW	1	1	0	2	0	4

Support Staff	0	0	0	2	0	2
MDT Total	8	4	3	7	3	25

4.5.3. Outcomes

Further analysis highlighted a number of common outcome themes across all professional groups in the MDT. These included:

- building parents skills and confidence;
- improving professional awareness, confidence and skills;
- demonstrating outcomes through evaluation;
- matching service to child need;
- developing the consistency and quality of service;
- contributing specialist and distinctive knowledge and skills; and
- addressing unmet needs.

The data extracts linked to each of these outcome themes can be found in Table 4.7 below and are thematically represented in Figure 4.35.

Figure 4.35 Thematic Map of the Outcomes of the Multidisciplinary Team

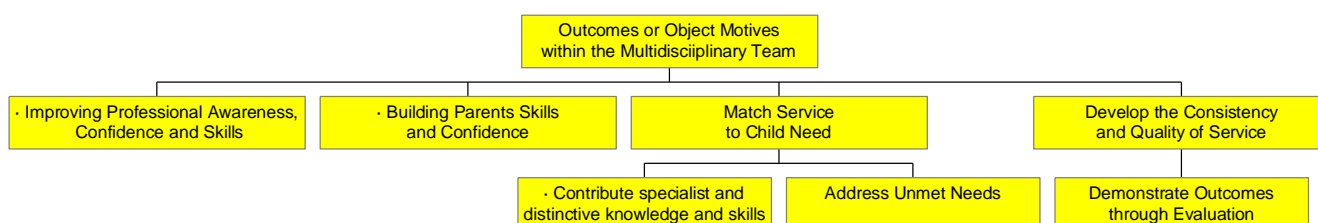


Table 4.7: A table to show the outcomes themes for the overall multidisciplinary team with linked professional group themes

Multidisciplinary team theme	Primary mental health worker theme	Family support worker theme	Educational psychologist theme
Building parents skills and	Building the capacity i.e. the	Improvements in parent(s) – child	Improvement in parents or

confidence	confidence and competence of parents and professionals	interaction. (see below)	significant others skills, confidence and competence.
Improving professional awareness, confidence and skills	and professionals. (see above)	Supporting parents and professionals in meeting children's needs.	Improvement in professional awareness, understanding confidence and practice.
Demonstrate outcomes through evaluation	Evidence of outcome and evaluation.	Clear evaluated outcomes from involvement	Evaluation and evidence of impact.
Match service to child need	Matching service offered to child and family need.	Information on, and sign-posting to services. Level and accessibility of service.	Link created to other CAMHS tiers.
Develop the consistency and quality of service	Consensus and consistency in decision making	Quality and consistency of service	Collaborative management and clear policy.
Contribute specialist and distinctive knowledge and skills	Developing awareness and understanding of child mental health.	Early assessment, intervention and support.	Development of children's social skills, competence and confidence.
Address unmet needs		Some unmet needs	

Table 4.7 illustrates the high degree of concordance found between the outcomes or object motives of each professional group. It suggested that professionals of the team had a shared purpose to which their work in the multidisciplinary tier 2 team was aimed. The extent to which the similarities found were mediated by the whole team or professional culture team was less clear. This raises the question - have team members come to adopt these shared object motives or outcomes due to being members of the team? If so, this might suggest that the team culture played a significant role in shaping the activity of the professionals in the team and professional group culture played a more secondary role in shaping outcomes. The one difference found

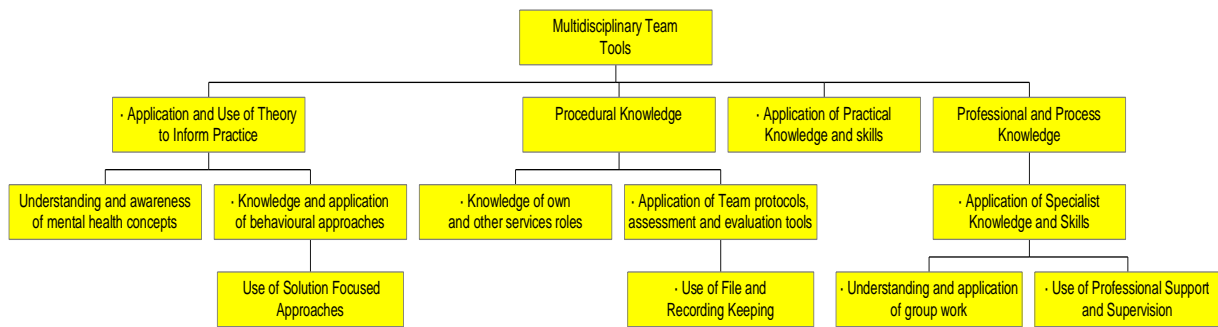
in the outcomes was the acknowledgement by FSWs that some children and families had unmet needs despite the team's best endeavours. The other noteworthy feature of the outcome themes identified was that each professional group sought to contribute a specialist area of work. In the case of PMHWs this was child mental health, for FSWs it was the provision of early assessment and intervention and for EPs the development of social competence and confidence in children (see Table 4.7 above).

4.5.4 Tools

The tools or artefacts that each profession used within the multidisciplinary were tabulated, compared and themes identified (see Figure 4.36 and Table 4.8 below). The tools identified as mediating the work of the MDT were.

- use of solution focused approaches;
- knowledge and application of behavioural approaches;
- awareness, understanding and application of mental health concepts;
- application of team protocols, assessment and evaluation tools;
- understanding and application of group work;
- use of professional support and supervision;
- application of specialist knowledge and skills;
- application of practical knowledge and skills;
- application and use of theory to inform practice;
- use of file and recording keeping; and
- knowledge of own and other services roles.

Figure 4.36 Thematic Map of Multidisciplinary Team Tools



The team had adopted a strong solution-focussed approach and ethos across all its disciplines, although it was only identified as a tool in two of the professional groups (see Table 4.8 and Appendices 13vii and 14vii). The team also drew heavily on behavioural approaches in its work with children and their parents (see Table 4.8 and Appendices 13vii and 14vii). Perhaps unsurprisingly, the common core of knowledge held by all team members irrespective of discipline was awareness, understanding and application of mental health concepts (see Appendices 12vi, 13vii and 14vii). Moreover, the application of this knowledge base was supported by the use, across the disciplines, of team protocols and procedures for assessment and intervention. In addition, understanding and knowledge of group processes was found to support the work of children's service professionals in the team. Moreover, professional supervision was also used to support the work of the frontline health and social care professionals. However, there was less emphasis placed on supervision by the educational psychology group (see Table 4.8 below and Appendices 12vi, 13vii and 14vii).

The different contributions were highlighted through a comparison of each profession's apparent specialist knowledge and skills. The areas identified included:

- EPs' understanding and application of models of consultation;

- FSWs' knowledge and experience of child development, disability and care; and knowledge of child protection, social care and parenting and what is 'good enough'; and
- PMHWs' specialist knowledge was in relation to child mental health.

This is not to suggest that other professional groups did not employ these tools but merely that each profession listed above appeared to place more emphasis on them in this study.

Another notable aspect of each profession's contribution to the MDT was the extent to which their activity appeared theoretically or practically orientated. EPs appeared to place greater emphasis on the theoretical aspects of their work (see Appendix 13vii). PMHWs also drew on theory but this seemed at a much lesser extent than EPs (see Table 4.8 below, and Appendix 12vi). However, a more practical orientation and approach was found in the work of FSWs (see Appendix 14vii). FSWs also seemed to make more use of team protocols and systems to support their work (see Appendix 14vii). Other professional groups also appeared less reliant on procedures and therefore more confident in varying from them (see Appendix 13vii and Appendix 12vi). Finally, FSW and PMHW also appeared to draw on their knowledge of other services, within comprehensive CAMHs, in fulfilling their role (see Table 4.8 below and Appendices 12vi and 14vii for the linked data extracts related to these tool themes).

Table 4.8: A table to show the tool themes for multidisciplinary team and professional group

Multidisciplinary theme	Educational Psychologists	Family Support Worker	Primary Mental Health Worker
Use of solution focused Approaches	Understanding and application of solution focused frameworks and approaches	The application and use of solution focused approaches	

Knowledge and application of behavioural approaches	Knowledge and application of behavioural and cognitive behavioural approaches	Knowledge and application of behaviour management strategies	
Awareness, understanding of, and application of mental health concepts	Awareness and understanding of concepts and tools within mental health.	Awareness and use of child mental health policy and practice.	Knowledge of mental health, its assessment and treatment. Awareness of risk & resilience factors.
Application of team protocols, assessment and evaluation tools	Use of team assessment, evaluation protocols and resources	Use of team protocols, assessment and evaluation procedures and resources.	Case management, referral information, monitoring and evaluation
Understanding and application of group work	Understanding of group theory, processes and group work	Group facilitation and consultation.	
Use of professional support and supervision		Tools to support, supervise and manage change.	Case supervision and support
Application of specialist knowledge and skills	Understanding and application of models of consultation	Knowledge and experience of child development, disability and care Knowledge of child protection and social care. Knowledge of parenting and 'what's good enough' to support family functioning.	Specialist knowledge of (learning disability, therapeutic approaches etc)
Application of practical knowledge and skills		Provision of practical and emotional support for parents	
Application and use of theory to inform practice	Knowledge of systems theory and organisational change. Knowledge of humanistic and person centred approaches. Knowledge of personal and social construction theory.		Theoretical driven and informed practice.
Use of file and recording keeping		Use of file and record keeping	
Knowledge of own and other services' roles		Knowledge of other services	Knowledge of PMHW role. Knowledge of services across CAMHS tiers

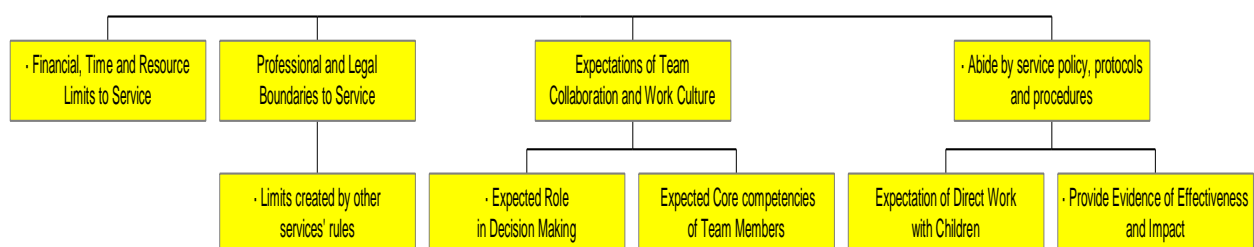
4.5.5. Rules

The rule themes identified for the whole team were:

- financial, time and resource limits;
- professional and legal boundaries;

- expectations of a collaborative team and work culture;
- evidence of effectiveness and impact;
- abide by service policy, protocols and procedures;
- expectation of direct work with children;
- expected role in decision making;
- limits created by other services' rules; and
- expected core competencies of team members.

Figure 4.37 Thematic Map of MDT Rules



The themes are represented thematically in Figure 4.37 above. The linked data extracts from which these themes have been derived can be found in Table 4.9 below and Appendices 12v, 13v and 14v.

There was a general consensus that the time limits, criteria for involvement and resources available both supported and constrained work within the whole team. The culture of team had been set with expectation that professionals would collaborate in decision making and work activity. Nevertheless, PMHW and EPs highlighted professional boundaries and statutory responsibilities and accountability as constraining their respective roles and the work of the team.

Table 4.9: A table to show the Rule Themes for the MDT and Professional Groups

Multidisciplinary team	Primary Mental	Family Support	Educational
------------------------	----------------	----------------	-------------

theme	Health Workers	Workers	Psychologists
Financial, time and resource limits to service	Criteria to define and limit practice.	Short-term time -limited involvement. Limits and boundaries to service.	Time and service boundaries. Budget and funding determinants
Professional and legal Boundaries to Service	Risk assessment.		Legislative and statutory determinants
Expectations of team collaboration and work	Collaboration and consensus.	Collaboration and co-operation is expected.	Equality and collaboration within and between agencies expected
Evidence of effectiveness and impact		Effectiveness of Involvement is evaluated	Demonstrate evidence of impact through evaluation
Abide by service policy, protocols and procedures	Protocols, procedures and record keeping.	Follow team protocol and procedures. Work is determined by the team business plan.	
Expectation of direct work with children		Provide a direct service to clients.	Engage parents and address children's needs.
Expected role in decision making			Responsibility for decision making.
Limits created by other services' rules			Context and other agency determinants.
Expected core competencies of team members		Have core competencies.	

The team had a further expectation that all of its work was evaluated, and team members would adopt and follow team protocols and procedures, although EPs appeared less bound by the latter. Moreover, there was an expectation within the team that professionals' work would involve some direct work with children and their families. Other rules identified included the expectation that each member of the team would have a common core of competencies that they could bring to bear on their activity. Indeed, the team offered multidisciplinary training to ensure all in the team had for example, a basic understanding of solution focused approaches and could apply these in

their work along with other core competencies. The rule themes are shown with the linked data extracts for each professional group in Table 4.9 above

4.5.6. Community

Table 4.10: A table to show the percentage of community links mentioned by each professional group during individual activity theory interviews

Agency	Primary Mental Health Workers	Educational Psychologists	Family Support	Whole Team
Health	59%	27%	22%	30%
Education	24%	56%	25%	35%
Social care	17%	17%	41%	29%
Other	0%	0%	12%	6%

The community within which this multiagency tier 2 team worked is illustrated in Table 4.10 above. The data from which it has been derived can be found Appendices 12iii, 13iii and 14iii. The overall MDT community links appear to be in roughly equal proportions to health, social care and education services. This finding is line with the team's overall object to promote children's mental health and psychological wellbeing across a range of family and community settings through multidisciplinary teamwork. That said, Table 4.10 further shows that each professional discipline had a substantially higher percentage of community links mentioned to their base discipline and agency. For example, EPs had a higher percentage of community links mentioned with educational professionals and settings (56%) than they did health (27%) and social care (17%). This raised the question whether a profession acting as the link to its own discipline and agency was building a wider understanding between disciplines and agencies in the multidisciplinary team and comprehensive CAMHS.

Table 4.10 further suggests that PMHWs had a higher percentage of community links mentioned to health professionals and agency (59%) than Education (24%) and Social Care (17%). Moreover, PMHWs were the only professionals who had substantial links with specialist tier 3 CAMHS team (see Figures 4.12, 4.22 and 4.33). This raises the question as to whether the PMHW role had become a substitute for wider links and collaboration between other tier 2 professionals in the team and the specialist tier 3 team. Indeed, EPs' and FSWs' community links appeared almost entirely with professionals at tier 1 and tier 2 (see Figures 4.12, 4.22 and 4.33). Furthermore, the amount of contact between strategic managers and practitioners at tier 2 and 3 was reported to have reduced over time and was limited at the time of the study (see Appendix 10iv, for example). As a consequence, it appeared that the responsibility had fallen to the PMHWs to facilitate communication between each team and tier (see Figures 4.18 and 4.22 and Appendices 9i to 9iv).

4.5.7. Division of labour

Analysis of the division of labour themes in the MDT is displayed in Table 4.11 below. This detailed analysis indicates that the following aspects of the MDT activity were distributed across the team and elsewhere:

- provision of information and make referral;
- allocation of work to team members;
- provision of supervision and support;
- participation in independent and joint casework and training;
- provision of leadership and management;
- provision of response and support for children and families;
- liaison and links with other services and agencies; and

- provision of administrative support;

The data extracts from which these themes have been derived can be found Appendices, 12iv, 13iv and 14iv.

Firstly, information and responsibility for referral to the team rested with parents, who were sometimes supported by other professionals and team members in doing this. Once a case was referred to the team it was considered by a multidisciplinary case allocation panel and then allocated to an appropriate team member as a lead professional. The lead professional then undertook the work required in response to a particular child or family needs, either independently or collaboratively. Lead professionals sought a co-worker, if necessary, and were supported by their supervisor, the team's administrator and line manager in undertaking and reviewing their work. Team members linked and liaised with other professionals inside and outside the team at the point of referral, during their ongoing work and when the case was closed. A notable exception to this process was in how managers allocated training and group work activity to professional groups rather than to individual team members.

Table 4.11. A table to show the division of labour themes for the multidisciplinary team with the linked themes for each professional group.

Multidisciplinary team theme	Primary Mental Health Worker	Family Support Workers	Educational Psychologists
Provide information and	Referral and provision	Referral and	

make referral	of information (parents)	information source (parents, schools, tier 2 team professionals)	
Allocate work to team members	Contributions to decision making within discipline and agency	Allocate case and other work (SFSW/ Case Allocation Meeting)	Allocation of work and offering professional perspective
Provide supervision and support	Professional supervision and support	Provide supervision and consultation (TM, SFSW and Peers?)	
Participate in independent and joint work in casework and training	Independent or collaborative multiagency work in casework and training	Participate in multidisciplinary and joint work (Other tier 2 team and agency staff)	Single or multiagency initiative. Development and delivery of training
Provide leadership and management		Provide leadership and management (TM/SFSW)	Operational management, strategic management, service delivery, target setting and monitoring and evaluation
Provide response and support for children and families		Provide initial response, assessment and support (FSW)	Work at the level of the child or adult
Liase and link with other services and agencies	Contributions to decision making within discipline and agency	Receive Information and referral from agencies in determining action (Other agencies SW/CAMHS)	Main link to schools and education professionals
Provide administrative support		Provides administrative support (SO tier 2 team)	

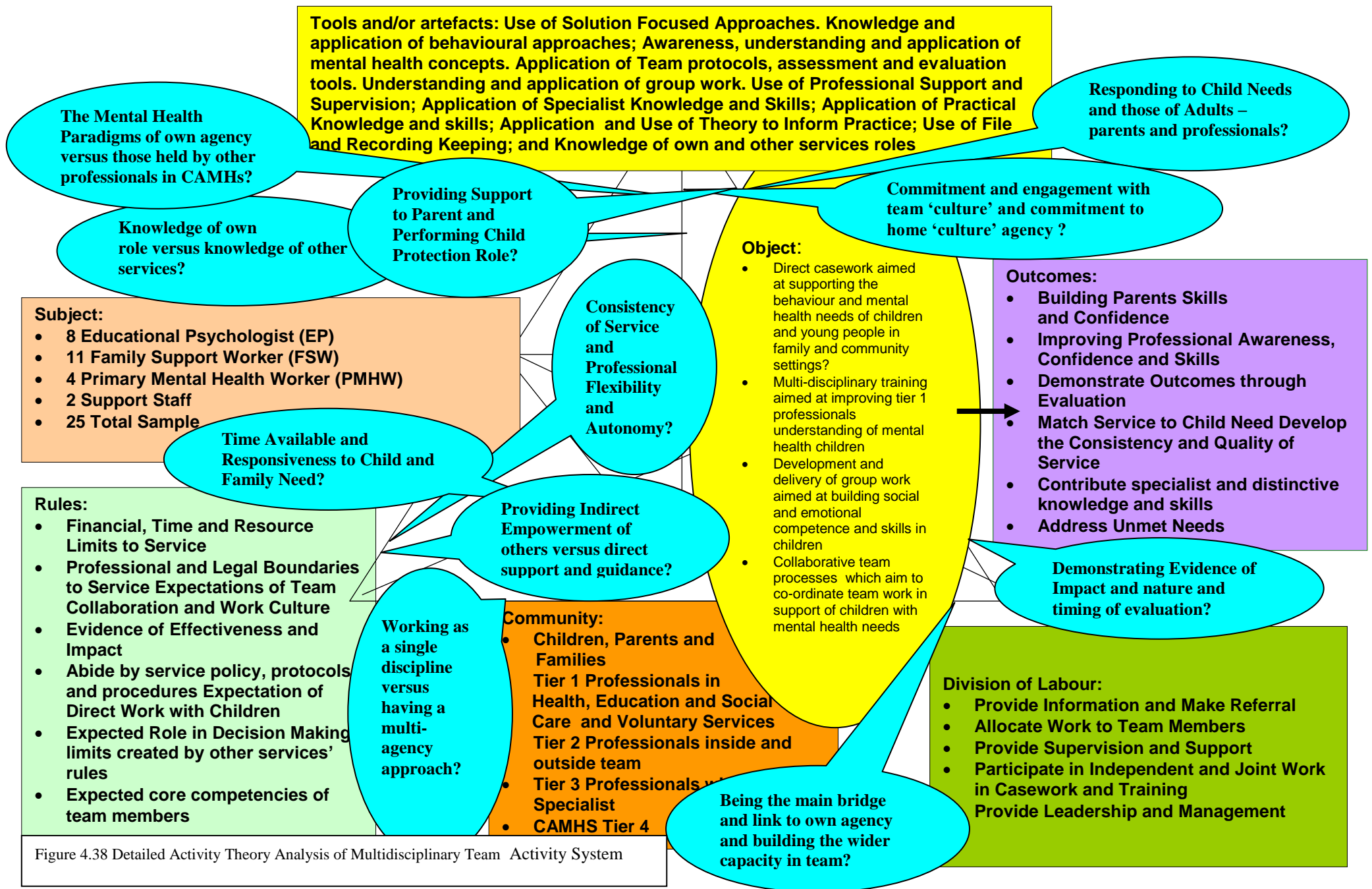
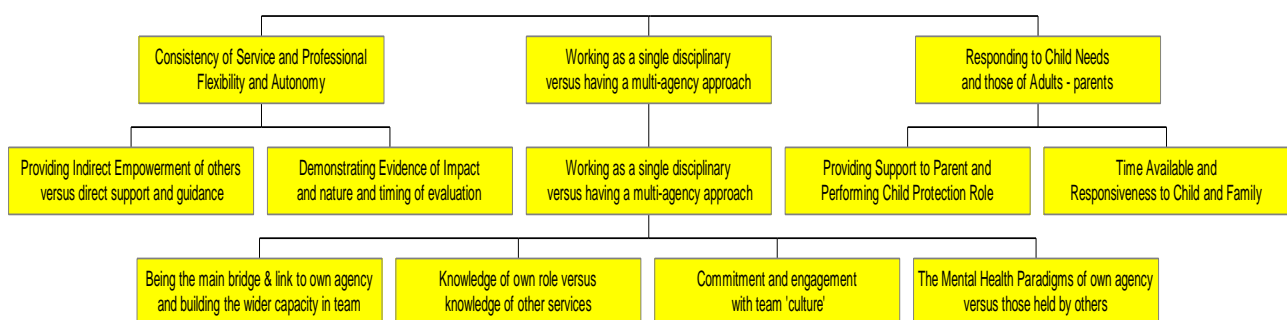


Figure 4.38 Detailed Activity Theory Analysis of Multidisciplinary Team Activity System

4.5.8. Contradictions

Contradictions were surfaced and worked on by the multidisciplinary team, as stimuli for their development and learning. The contradictions found across the whole team are summarised in Table 4.12 below and represented thematically in Figure 4.39. They are also displayed holistically in Figure 4.38 above .

Figure 4.39 Thematic Map of the Multidisciplinary Team Contradictions



The contradictions identified in relation to the team's activity aimed at promoting mental health and psychological wellbeing in community and family settings were as follows:

Tools and Community

- **Knowledge of own role versus knowledge of other's roles;**

In two of three professions (PMHWs and EPs) there seemed to be a tool-community contradiction (see Figures 4.22 and 4.12) between the profession's definition and understanding of its own role and the understanding and construction of the role held by others. In addition, each profession understanding of each other's role could be discrepant. This contradiction led one group to highlight the importance of role definition in the team (see Table 4.16 below)

- **The mental health paradigms of the tier 2 team versus those held by other professionals in wider CAMHS.**

A further tool–community tension was observed between the predominantly psychosocial model of the tier two team, and the medical model used by other professionals within the wider comprehensive CAMHS activity system. This contradiction was found in all three disciplines activity systems (see Table 4.12 below) and it led both EP and PMHW groups to consider how such models and paradigms could work alongside one another within comprehensive CAMHS (see Table 4.14 and Appendix 6iv)

- **Commitment and engagement in the team ‘culture’ and commitments to home agency ‘culture’**

Some of the professional groups in the MDT worked in more than one team and service. Where this occurred, a tool-community tension was observed between the priorities of the tier 2 MDT and those of other teams. For example, PMHWs highlighted the very different priorities and work of the teams and services they worked with and for (See Figure 4.38 above and Appendices 9i. to 9iv). This created contradictions in other disciplines activity systems (see Figure 4.12 and Figure 4.22) and led one MDT group to highlight the difficulties created by different service boundaries and rules (see Table 4.16 below)

Tools and Outcomes

- **Responding to child needs and those of the adults – parents and professionals.**

A tool–outcome contradiction was found between the team attempting to support adult needs, at the same time as ensuring that children’s mental health needs were met too. It was acknowledged that different tools were needed for work with parents and children and sometimes meeting the needs of one contradicted the outcomes sought for the other. This was particularly a feature of FSWs and EPs activity systems (see Figure 4.12 and Figure 4.33 respectively).

- **Providing support to parent and performing child protection role.**

A further tool–outcome contradiction was found in team members performing both child protection and parent support roles. This may relate to the contradiction identified above, where children and adult support needs could sometimes be at odds. The contradiction was particularly evident in the activity system of FSWs (see Figure 4.33) but may apply to other disciplines too. The example, discussed earlier in this chapter, illustrated how the contradiction emerged during a FSW work on the Team’s Telephone Information and Advice Line. It led the professional involved to consider how they could attempt to reconcile and address this contradiction, if similar circumstances arose again (see section 4.4.8).

- **Demonstrating evidence of impact and the nature and timing of evaluation**

A strong culture found throughout the team was in the importance of demonstrating the impact of their work through evaluation. However, a tool – outcome contradiction was also observed, in that much of the evidence of the team’s activity showed short-term outcomes rather than providing evidence of

long-term change. The latter was recognised as being much harder to establish and achieve. The importance of evaluating outcomes was a particular feature of FSWs and EPs activity systems (see Figure 4.12 and 4.33). Further discussion of this contradiction in response to mirror data presented in the DWR (see Appendix 6v) also suggested that the team acknowledged that its main evidence was of short-term outcomes. However, it also led the team to consider a time when it had used more longitudinal evaluations (see Appendix 6v)

Community and Division of Labour

- **Being the main bridge and link to own agency and building the wider capacity in team;**

Each professional group within the multiagency team acted as the main link to its own agency. However, this appeared to create a division of labour—community contradiction, as it seemed the approach had not necessarily led to wider understanding, extended links and joint working between the professionals in different agencies, disciplines and tiers in comprehensive CAMHS. This was particularly evident in the work of EPs and FSWs (see Figure 4.12 and 4.33). It is also exemplified later in the discussions of the EP and FSW group activity systems (see Section 4.6.6.2 and 4.6.6.3 below), which emphasised the value of joint planning and work with other disciplines, when identifying and supporting children's and family's needs. It also led each profession to reflect on the importance of involving other disciplines and obtaining a different perspective in support of a case.

- **Working as a single discipline versus having a multiagency approach**

Some of the team's activity, notably training and group work, was undertaken by single discipline alone, despite the team being configured to provide a multidisciplinary approach. This division of labour–community contradiction was particularly evident in the EP profession's lead role in developing and delivering social skills groups for children (see Figure 4.12). However, the contradiction was found across all professional groups' activity systems (see Table 4.12). It also led the PMHW and EP groups to consider and discuss how they might enhance and extend their joint work with other disciplines (see Sections 4.6.2.1 and 4.6.2.3 below).

Rules and Tools

- **Consistency of service and professional flexibility and autonomy**

A further rule-tool contradiction was identified between the expectation of a consistency in approach and professionals' desire to have a degree of autonomy and flexibility. Some professionals appeared more confident to rule bend and break team expectations to ensure that a child and family's needs were met. Nevertheless, the contradiction was a feature of several team members activity systems (see Appendices 8, 9 and 10, for examples) and was identified as a key theme within FSWs and PMHWs' activity systems (see Figures 4.22 and 4.33). Moreover, it led FSWs group to question whether different expectations and rules existed in each professional group within the team (see section 4.6.2.2 below).

- **Providing indirect empowerment of others versus direct support and guidance;**

Another contradiction was observed between the expectation (rule) of providing direct support to children and families and the indirect consultative approach (tool) that some professionals in the team preferred. Direct work with children was seen by some as a core and distinctive aspect of the team's activity, whilst others felt that indirect support, enabling and empowering parents and other professionals, was more beneficial and likely to lead to sustained change in families. This was a particular feature of FSW and EPs work (see Figure 4.12 and 4.33), where the expectation of direct work was sometimes at odds with the desire to work using an indirect consultative approach.

Rules and Outcomes

- **Time available and responsiveness to child and family need.**

Finally, the short-term time-limited nature of the team's work and the long-term needs of some children and families was highlighted as a contradiction between rules and outcomes. Team members reported that, on some occasions, the complex needs of a child and family could not be addressed in the time allocated and available. This was feature of all professional groups activity systems (see Figures 4.12, 4.22 and 4.33), but is exemplified in the activity systems of individual EPs (see Appendices 10i, 10vi and 10viii), PMHWs (see Appendices 9ii and 9iii) and FSWs (Appendices 8viii and 8xii).

Table 4.12 A table to show the contradiction themes for the multidisciplinary team and professional group.

Multidisciplinary theme	Primary Mental Health Worker	Family Support Worker	Educational Psychologist	Contradiction Classification
Knowledge of own role versus knowledge of other services	Knowledge of own and other roles		EP understanding of own role versus other's understanding of it	Tools-Community
Being the main bridge and link to own agency and building the wider capacity in team	Bridge and link between tiers	Constraints to work created by time/work of other disciplines	EPs as the key link to schools rather than community	Community – Division of Labour
Responding to child needs and those of adults – parents and professionals		Meeting the needs of parent and child	Responding to child need versus adult and organisational need	Tools-Outcomes
The mental health paradigms of own agency versus those held by other professionals in CAMHS	Paradigms and cultures of agency and teams	Models of other services and those of the team. Links with other agencies? Differences in understanding and co-operation and collaboration within and between services.	MH paradigm of EP discipline vs. MH paradigms held within comprehensive CAMHS	Tools-Community
Time available and responsiveness to child and family need	Time constraints to practice	Time and other limits to support offered vs. meeting the child and family need	Time allocation and responsiveness to need:	Rules –Outcomes
Providing indirect empowerment of others versus direct support and guidance		Providing indirect 'enabling' support and direct practical 'hands on' support	EPs indirect collaborative approach vs. direct leadership and challenge role	Tools-Rules
Working as a single disciplinary versus having a multiagency approach	Professional boundaries and criteria	Single or duplicated procedures	Single agency work vs. multiagency initiative	Division of Labour – Community
Demonstrating evidence of impact and nature and timing of evaluation		Evaluation and evidence Of impact?	Demonstrating impact vs. type of evaluation undertaken	Tools-Outcomes
Commitment and engagement with team 'culture' and commitment to home 'culture' agency		Level of access, Involvement in team collaboration	Obtaining commitment and engaging with others	Tools–Community-
Consistency of service and professional flexibility and autonomy	Consistency in decision making	Professional flexibility vs. consistency of service		Rules- Tools
Providing support to parent and performing child protection role		Formal child protection role and informal support role		Tools – Outcomes

4.6. PROFESSIONAL LEARNING

The final section of the thesis' findings presents an overview of the professional learning and development that occurred over each phase of the project. First, it reflects on the learning that came from the activity theory analysis with individual team members. Next, it considers the learning generated from focus group discussion of the activity theory analyses at the professional group and whole team level. Finally, it seeks to demonstrate how learning actions and potential expansive learning activity were stimulated through the use of a combination of developmental work research (DWR) techniques.

4.6.1. Individual professional activity systems

4.6.1.1. What learning took place?

While the study found some evidence of change and learning in individuals, groups and the team, it was much harder to isolate and identify the precise nature of the learning that had taken place and, more specifically, to link it to the SCAT analysis and intervention. Despite these difficulties, there appeared to be some evidence of expansive learning activity, at Stage 1 and 2 of Engestrom's (1999b) expansive learning cycle model. For example, professionals were observed surfacing and questioning the contradictions that appeared within, and between, elements of their different activity systems.

There was also some evidence to suggest that individual professionals who participated in the SCAT interview and analysis had found that it had helped them to identify contradictions and consider change. For example, analysis of an EP's activity system directed toward developing pro-social group work

skills in children led to the identification of a contradiction, between community and division of labour (see Appendix 10vii), in how the evaluation of the programme took place. This led the EP to consider a new model of evaluation, involving changes in the division of labour between the EP and her assistant. This new model was subsequently implemented in practice with the support of other colleagues involved.

Another example involved a discussion with a service manager about their work within the team's steering group. A contradiction was identified, between community and division of labour, around the involvement of the specialist CAMHs team representative in the group. As a result, the service manager began to consider how to widen the remit and membership of the group to ensure all stakeholders were involved. It also led the service manager to consider a new model that involved widening the remit of the steering group to reflect the proposed extension in service delivery. As a consequence, the membership of the steering group was revisited and reformulated.

4.6.1.2 How was learning supported?

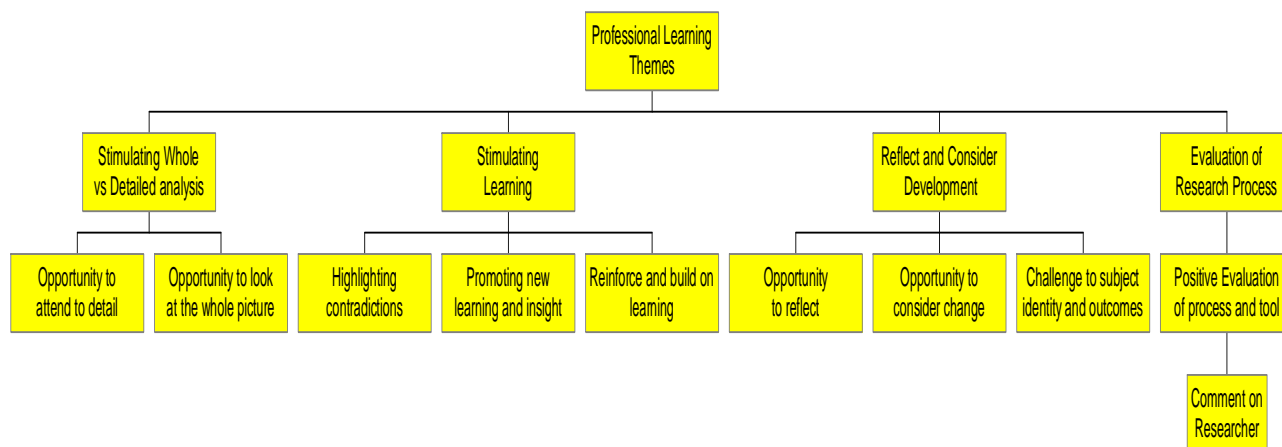
At the end each interview individual participants were asked to reflect on the process used, and to consider what learning had occurred for them as result of the discussion. They were asked to comment on the usefulness of the activity theory framework and process used. Each of twenty-five interviews was taped and the sections relevant to these questions was then transcribed. The transcriptions were analysed and coded to identify any recurring themes. Table 4.13 provides an illustrative example of a transcribed dialogue.

Table 4.13 Excerpt from Individual interview illustrating professional learning

R: Are there any other comments that you'd like to make on the process? It's strengths, its weaknesses.... obviously we have looked in depth at two aspects of your work... How did you find that? ...How has it felt?
 PMHW: Very useful ...very useful in terms of the questioning, because you don't really get a lot of time to look at the processes. You are very much case oriented, y'know there is this issue about the child and you think this is what I am considering doing, you don't really get chance to look at the processes involved in the way you work . I've really valued that and enjoyed that. It is almost like looking from above down on the work, considering a case. I am sure I could have got as much out of it with another case, a case that has been done and dusted with a good outcome.

A further example transcription can be found in Appendix 3. Detailed analysis of all transcripts highlighted a number of themes and sub-themes, these are presented in the thematic map in Figure 4.40 below. Each of the themes is arranged to show super-ordinate and sub-ordinate themes. A thematic grid with linked data extracts for each of these themes can be found in Appendix 7i.

Figure 4.40 Thematic Analysis of the professional learning coming from Activity Theory Analysis of Individual Professional's work



The first theme identified suggested that the process had created an opportunity for individuals to examine their work in both a holistic and detailed way (see Figure 4.40 and Appendix 7i). Moreover, comments received suggested that those who had participated found that it stimulated their learning, thought and insight, around the activity they chose to discuss. Many

reported considering taking the learning from this analysis into their future activity. Although, it should be said, for some the process appeared to solely to confirm their current tacit knowledge and learning. The precise reasons for these differential outcomes were not clear.

Comment was made about the value of the process in providing professionals with the opportunity to verbalise and reflect on their own practice (see Appendix 7i). Also, for some it created an opportunity to discuss and consider changes in their activities and practice. For others the process appeared to challenge an aspects of their practice and led them to re-evaluate the object and outcomes they sought through their work and activity (see Appendix 7i). . Finally, all interviewed gave a very positive evaluation of the usefulness of the process, the tool used and the researcher mediations in supporting their learning and development. This is illustrated by the feedback received from one participant following their initial interview:

‘The activity triangle is a great way to provide an overview and capture the complexities of social activity – the discussion provides a systematic structure for thinking and the record supports further reflection. The discussion has highlighted some ‘intervention drift’ in practice, particularly around the EP role in follow-up and contribution to formal evaluation. The discussion encouraged me to be more proactive in this area (addressing contradictions between the tools, object and division of labour?) A worthwhile activity – I was glad I made time for this.’ (EP participant)

4.6.2 Professional group activity systems

The principal purposes of the third phase of the research was to provide some initial feedback on the research findings, to check out the accuracy of the professional group analyses and stimulate further learning in professional disciplines through the use of Developmental Work Research (DWR)

techniques. The initial thematic analyses provided the 'mirror' data for the team to consider and discuss (see Figures 4.1, 4.18 and 4.23).

The three professions reviewed their own professional group activity system. They considered the analysis of their disciplines' activity system given earlier in Figure 4.1, 4.18 and 4.23 separately as focus groups. Each group was facilitated by their professional leader, using a pro-forma prepared by the researcher to support the discussion. Comments were recorded on a pro-forma or flip chart (see Appendix 6i). The researcher floated between groups in order to sample the discussion and answer any questions about the process from participants. Each group approached the task in slightly different way. In addition, some groups felt they needed further time to consider their professional group activity system after the DWR day. These factors created some limitations to the data collected from the day. Despite these limitations, each group had chance to discuss their own discipline's and the whole team's activity triangle. The evaluative comments received indicated that the process had stimulated further discussion, thought and learning in each professional group and the team as a whole (see Appendix 7ii). The recorded outcomes of each group's deliberations are discussed below and given in Table 4.14 for PMHW Table 4.15 for FSW and Appendix 6iv for EPs.

4.6.2.1 PMHW group

Table 4.14 below illustrates how the initial activity triangle analysis generated considerable discussion about the role of PHMW within the professional group and consideration as to how the PMHWs might develop and change in future, for example, by contributing to multidisciplinary training. They also highlighted

a notable rule – division of labour contradiction between PMHW time use and availability to participate in joint training. Furthermore, it shows how PMHWs were questioning aspects of their position and practice in comprehensive CAMHS. For example, they ask ‘Is PMHT beginning to feel like a stand alone service?’ They further begin to envision themselves working in a different way e.g. ‘How do we ‘cross the divide’ and have a PMHT involvement in all tier 2 activities?’ They also ask, for example, ‘How can we join tier 2 and specialist tier 3 up to feel more of a whole team/service?’

Table 4.14 Table to show a summary of PMHW responses to focus group discussion of activity theory analysis during development work research

Recorded comments of 4 PMHWs (including a Senior PMHW and one PMHW who hadn’t participated in earlier part of research):

- Sharing the delivery of activities i.e. training, it is a strength that we don’t deliver on our own but because of *time constraints* PMHT can’t always contribute.
- Difficult for another agency to join in when whole team are managing activities successfully (because of capacity). How do we ‘cross the divide’ and have a PMHT involvement in all tier 2 activities when the *PMHW capacity of the team* increases?

Tension Role of PMHW/PMHT being part of tier 2 and specialist tier 3 CAMHS

- Different partnerships expected to work to different models/demands i.e. medical vs. preventive
- Competing importance between individual casework, training and group work
- CAMHS having anecdotal evidence and not evidence-based results
- Being valued and undervalued depending on the agency PMHW are working in. Very welcomed and valued in tier 2 team
- Having a foot in each camp – Universal CAMHS and Specialist CAMHS mediating between teams

Tension Is this building capacity in the wider CAMHS or not?

- Is PMHT beginning to feel like a stand alone service
- Importance of the different skills in tier 2 team . How can we join tier 2 and specialist tier 3 up to feel more of a whole team/service?

with different models, demands and approaches, and their role in mediating between the different team cultures. The professional group analysis allowed the PMHW to examine a division of labour–object/outcome contradiction and, in particular, to question whether its position in comprehensive CAMHS bridging the gap between tier 2 and tier 3 services was building capacity of other professionals in comprehensive CAMHS or not.

The time-limited nature of the research and intervention does not allow the researcher to conclude that expansive learning in its fullest sense had taken place here, but there is some evidence of mini cycles of learning action and an indication of some potentially expansive learning activity in the PMHWs deliberations. The researcher's ongoing work with the group and team will determine whether these early indications actually lead to expansive learning.

4.6.2.2 FSW Group

FSWs explored their activity system and commented on each element (see Table 4.15 below). In particular, they highlighted that some in the FSW group had 10 years practical experience of working in the team. They further pointed out that there had been a recent change for the group in both their line management and home agency. In addition, they allude to the role that legislation, as well as the business plan, had in guiding their work. Next, they mention the impact that the professional and locality base protocols had had on their activity. They also highlight the extensive community of professionals with whom they work and their involvement in collaborative team processes, such as case allocation meetings and reviewing the business plan.

The FSW group identified a number of potential inner contradictions in their activity system, in particular between community–division of labour. FSWs indicated that they were the only professional group who was fully employed in the tier 2 team. Moreover, they also highlighted a rules and division of labour contradiction between the very different expectations of each profession and their commitment to the team. Also, FSWs located in three

separate bases described a tension created due to differences in the expectations and culture of the different bases. Finally, they identified a significant community–division of labour contradiction with regard to the team’s support staff, who were key to the successful operation of the team but who did not attend team meetings or participate in the DWR. The researcher involved the support staff in Phase 1 of this research (see Appendices 11i and 11ii) and invited them to participate in the DWR, but the recent practice of the team had been not to include support staff in full team meetings and training activities.

Table 4.15 Record of FSW group discussion of the initial analysis of FSW activity system

Feedback on the analysis of professional group activity system

Family Support Workers' Group

Recorded comments of 8 FSW (including a Team Manager, 2 SFSW and one FSW who hadn't participated in the earlier part of research) stimulated by professional activity triangle feedback

- 1) Object - Promoting positive mental health
- 2) Tools - Continuing professional development
- Legislation (use plus knowledge)
- 3) Subject - Nursing and teaching qualifications
- Community work
- Ten years tier 2 team practical/operational experience
- 4) Rules - Expectation to involve outside agencies
- Follow Business Plan, referral guidelines plus current legislation that underpins our work
- Professional background (mainly social care and health)
- Formal & informal rules which effect professional protocols
- Rules/guidelines of community venue and base
- Flexibility
- Formal change of division and management
- 5) Community - school staff
- universal health staff (GPs, Paediatricians)
- Community within bases and wider e.g. Surestart
- Adult services
- Drug and alcohol services
- YIP(?), Police, YOT
- Teenage pregnancy
- Extended schools
- Teenage pregnancy
- School anxiety team
- Education Welfare Service
- Bereavement services
- 6) Division of Labour - Case allocation responsibility is that of FSWs as well
- It is the responsibility of the whole team to contribute plus review business aims, outputs and evaluations
- 7) Contradictions - Only FSWs are employed solely for tier 2 team
- Expectations of individual agencies within the whole team (?)
- Commitment to the service of each individual agency
- 3 agencies or 2?
- Support staff not attending workshop and team meeting
- Differences in cultures of certain bases
- 8) Outcomes - Empowerment of parents
- Not creating dependency
- Provide support, advocacy, facilitation and encouragement

The FSWs' deliberations offer some evidence of the group surfacing and working on primary and secondary contradictions and questioning their current approaches. For example, they describe a tension between empowering parents and providing direct work for families without this creating dependency. Moreover, they begin to define how they would do this through providing 'support, advocacy, facilitation and encouragement.' The time-limited nature of the research does not allow the researcher to conclude that expansive learning in its fullest sense had taken place here but there is some evidence of mini cycles of learning action and some indication of potentially expansive learning activity in the FSW group.

4.6.2.3 EP Group

The EP group tackled the same task, but approached it in a slightly differently way. The group used the activity theory model (see Figure 3.1) as a tool to review their own professional activity system. This might be considered to be another example of 'dual or double stimulation' in which the activity theory model provided was used by the group as a tool to work on their own professional group activity system. Unfortunately, a lot of the EP discussion was not recorded, and represents a limitation to the findings from the group.

Nevertheless, the activity system given in Appendix 6iv provides some evidence of the discussion and learning actions that had taken place. The written record made suggests that the team discussed a number of the elements of the system and expanded their object to include 'behaviour' as well as mental health and the outcomes to include 'the confidence and competence in parents and work with a range of tier 1 professionals'.

The most notable aspects of the recorded response of the EP group were the two contradictions discussed. First, the group considered a tool-community tension and questioned how the psychosocial model used by the group could work alongside the medical-diagnostic model. This seemed to be related to another dilemma highlighted within EP tools and a suggestion that the Diagnostic and Statistical Manual IV was not a necessity for a diagnosis. Finally, a notable community–division of labour contradiction was discussed between the EPs work as a single discipline and the work they did with others in the multidisciplinary team. This led the group to consider how they were moving towards working more collaboratively with other professionals in the team.

The EP group discussion outlined above provides some evidence of the group actively grappling with dilemmas in their activity system (see Appendix 6iv), and offers some indication of their work on primary and secondary contradictions between tools and community and community and division of labour. The evidence above also suggests that the group was considering redefining aspects of its activity system and object. Again, this could be considered to be evidence of learning actions, and potentially expansive learning activity. However, further work is required to determine whether expansive learning can be realised in the group and the wider team.

4.6.3 Multidisciplinary team activity system

In part 3 of the DWR, two small multidisciplinary groups considered the initial analysis of multidisciplinary team activity system provided by the researcher

(see Figure 4.34). Again, groups were facilitated by two managers of the team, using a pro-forma provided by the researcher (see Appendix 6ii). Each group recorded their discussion (see Table 4.16 below and Appendix 6iii). These records indicate that the groups' discussions covered the nature of the tools the team used, the transparency and collaborative nature of the team's work and processes, and the need to review their core business plan and activities. The latter provided an indication that the team felt that a reconsideration of its core activity and business plan was needed.

In one group, the activity system analysis seemed to have provoked a desire for a complete review of the MDT activity, its object and outcomes, as represented in the business plan. Moreover, the group highlighted a rule – division of labour contradiction between the different expectations or rules of each agency and the service boundaries it created. Consideration was also given to the different expectations of how labour was divided within the team and the tension this created within the team's activity system. There was also some evidence to suggest that the activity theory analysis stimulated the group to consider the nature and position of the team and its activity system (see Table 4.16 below). It led the group to reflect on how labour was divided in the team and how some of the rules supported or constrained the team's work.

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Table 4.16 Multidisciplinary group discussion of the MDT activity system.

Multidisciplinary Group 1	
Recorded comments of 8 tier 2 team staff (including a Manager, PMHW, FSW and EPs and one who hadn't participated in the earlier part of research) stimulated by whole service activity triangle feedback	
1) Tools	<ul style="list-style-type: none"> - Transparent processes and system - Shared vision and mission between team - Joint forums – sharing knowledge - Reflection: Skills need to be revisited - Revisiting core business/business plan needed
2) Rules	<ul style="list-style-type: none"> - Different rules between agencies - Changes in contractual agreements - Definitions of roles <p>Contradiction: Difficult to manage different rules between different agencies, service boundaries</p>
3) Division of Labour	<ul style="list-style-type: none"> - Definition of difficulty impacts on allocation - Administration support – equal between 'services/agencies - Resources for tier 2 team – availability is limited - Between professionals rather than joined service & team - Lines of supervision have changed - Consultation input into business plan from all members of the senior team and all team members - Reflection: additional support needed - Rules for division of labour create a tension/contradiction
4) Outcomes	<ul style="list-style-type: none"> - Long term change - shared view - Fragmented service - Opportunities diminished
5) Contradictions	<ul style="list-style-type: none"> - One agency, team or service? Three agencies, one team? - Pressures from different organisations - In Division of Labour – administration/clerical support for whole team and each agency - Role definition - Inclusion of all agencies at all levels - Are we a team, agency or service (transparency)? - Do we have shared vision? - Revisit Business Plan - Revisiting Core Business and what is offered
6) Subject	- include teaching
7) Community:	Paediatrician

The second group focussed on three aspects of activity system, namely the rules, community and divisions of labour. Their comments indicated that there was an expectation that the service would support early intervention, the whole family and professionals at tiers 1 and 2. Consultation was further identified as a key tool that the team used to work with across all tiers in

comprehensive CAMHS. The group further highlighted the important role that the voluntary sector, as community members, had in supporting children and families in the area. In addition, the group began to question whether long-term evaluation and follow up might provide evidence of the team's sustained impact. Interestingly, they also began to expand the team's object to include developing the skills and resources of the team to enable them to support an extended age range of clients. This suggests that the group was beginning to rethink the object of their activity system and to contemplate developing tools to support the team in working with a wider range of children and young people.

Both of these examples provide illustrations of learning actions and some potentially expansive learning activity in the team. Primary and secondary contradictions were identified, and some consideration given to how the team's main object and activity system might be expanded. For example, the group highlighted a need for the team to reconsider its vision and business plan. This suggests that the group was considering the development of a new or redefined object and activity system for the team.

4.6.3.1 Use of Double Stimulation with the team

The researcher provided a presentation and summary of the key findings of the research, followed by the use of stimulus ‘Mirror’ data within the DWR highlighted. These are illustrated in Figure 4.41, 4.42 and 4.43 below:

Figure 4.41 An illustration of Stimulus material and responses mediated by dual stimulation using activity theory model

Mirror Data Stimulus 1- First Response

The Mirror

❖ ‘First Response helps the Tier 2 Team to provide an effective early intervention and consultation service for those families who need it?’

Notes of comments made by participants on flipchart

- How much is the first response (F-R) known beyond the service itself ?
- Is F-R promoted as a part of the service offered by the tier 2 team to external agencies and bodies?
- Is there internal consistency in the decision making of who gets F-R?
- FSW are the only members of the tier 2 team to do F-R, and so other members of the service who do not deliver F-R might not fully understand and know about it?
- There has been a noticeable increase in uptake of F-R?

The researcher explicitly used the principle of dual or double stimulation during the third phase of the present research. The researcher presented stimulus material in the form of PowerPoint slides (see Figure 4.41, 4.42 and 4.43 and Appendix 6v for further examples). Notes and paraphrased comments were made of participant’s responses to these stimuli. The work activities and dilemmas presented were identified from the individual interviews in Phase 1 of this research. The researcher presented each slide

one at a time, along with the activity theoretical model given in Figure 3.1. A blank flipchart centred between the mirror and the model was used to record participants' responses and comments on the mirror data, an example of this is given above in Figure 4.41.

Figure 4.41 also demonstrates how the concept of dual or double stimulation was used in the Developmental Work Research. The first stimulus or mirror data was presented alongside the second stimulus the activity theory framework. This enabled the team to consider and reflect on an aspect of the multidisciplinary team activity using the activity theory framework.

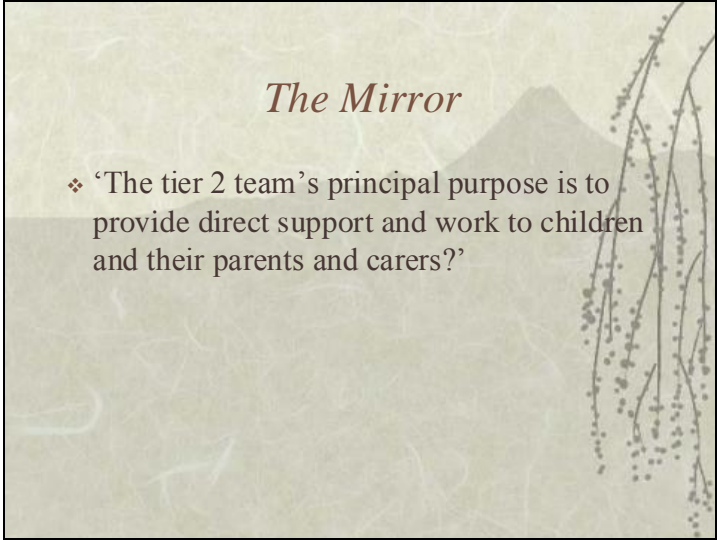
The approach helped the team to examine and question the use of certain team activities and tools. For example, the participants used the approach to identify contradictions between the tool of First Response and the community's awareness of it (see Figure 4.41). In addition, the team began to consider what learning actions were needed to promote this early intervention service more actively. Moreover, the team began to question whether there was consistency in the decision making around who gets a First Response visit. Finally, participants began to question the divisions of labour between different professional groups in the team and the impact this had on the use of First Response.

It should be acknowledged that not all stimuli generated as much discussion (see Appendix 6v). This may have been due to the time constraints of the session or that the stimuli were not sufficiently dilemmatic to generate debate and discussion. That said, the examples below (see Figure 4.42& 4.43) lead

participants to discuss and work on the dilemma of offering direct and indirect work. They further consider how this relates to the principal purpose of the team to employ direct work to promote positive behaviour of children, cited in the team's development plan (see Appendix 2)

Figure 4.42. Mirror data 2 – Direct work

Mirror Data Stimulus 2 Direct work



The Mirror

❖ 'The tier 2 team's principal purpose is to provide direct support and work to children and their parents and carers?'

Notes of comments made by participants on flipchart

- Involves indirect as well as direct work
- The principal activity of the team is direct work.... but the principal purpose was to promote the positive behaviour of children and young people and as a consequence their mental health.

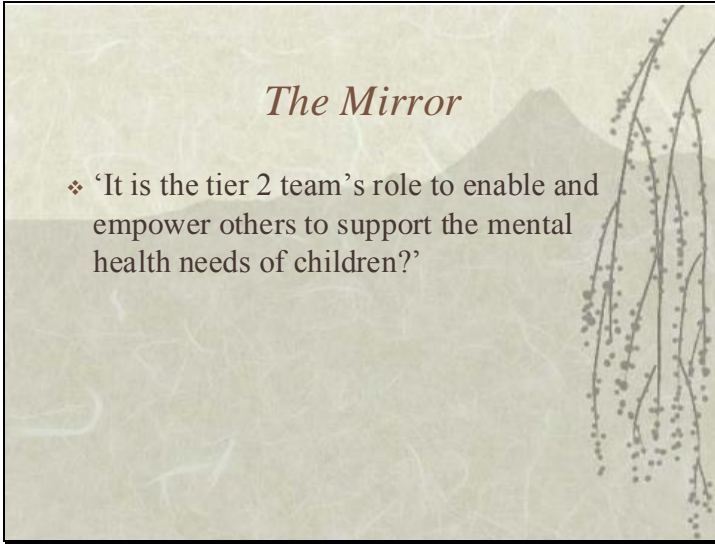
The next stimuli or mirror data on the team's indirect work led the team to appear to expand the object of the team's activity into addressing 'adult mental health and wellbeing' too as an outcome they were seeking to achieve.

The ideas generated in the DWR session only considered the team's current and future activity, drawing on an actual-empirical approach. It did not explicitly address the historical aspects of the activity, as in Engestrom's (2007) Change Laboratory approach. These aspects were assumed by the

researcher to be embedded in the cultural tools and the current context of the team.

Figure 4.43 Mirror data 3 – Indirect work

Mirror Data Stimulus 3 Indirect work



The Mirror

❖ ‘It is the tier 2 team’s role to enable and empower others to support the mental health needs of children?’

Notes of comments made by participants on flipchart (below)

- To enable and empower parents to be confident and competent in managing their children’s behaviour and therefore supporting positive mental health
- It addresses adult mental health and well being too.
- Others in the statement needs to be further developed and defined and should include professionals, parents etc.

However, the approach used may be criticised for not presenting sufficiently dilemmatic situations or double binds and for not explicitly seeking to undertake a historical analysis of the mirror data. As discussed above, the approach used was an actual-empirical rather than the historical-temporal approach to analysis of the activity system (Engestrom, 2000). Further examples of the stimuli and mirror data used, and the responses given are presented in Appendix 6v. Further discussion of the learning outcomes and the potentially expansive learning activity stimulated by this session will be offered in Sections 5.6.2 and 5.6.3

4.6.4 Small group work on team objects and activity systems.

The final session of the DWR day involved three small multidisciplinary groups working on the main object themes identified within the team's activity system. It should be noted there were no members of the PMHW group within each of these groups, as they had to leave early due to the demands of another aspect of their role, which again create a limitation to these findings.

The objects themes identified included direct work, training, group work, team processes and management (see Table 4.6a and 4.6b). Each of the three small multidisciplinary groups selected one theme to work on. The groups were also given the activity theory framework and flipchart paper to use as tools. Each group then discussed and defined the object they would work on within their chosen object theme. For example, the team processes group chose to focus on team meetings, as this was considered to be a fundamental process of the team. The other two groups worked on the team's direct casework with children and their families and multiprofessional training and development work of the team. The products and outcomes of their respective discussions are given in Figure 4.45, 4.46 and 4.47 and each is discussed in detail below.

4.6.4.1 Direct work

The 'direct work' group highlighted some key outcomes of the team's direct work including improvements in children's behaviour and parents' confidence

and competence. They further identified the tools the team used to work on the object of direct work including information gathering tools e.g. questionnaires and observation along with their experience and knowledge and skills of, for example, solution focused approaches. Consideration of these aspects of the activity system led the group to reflect on a contradiction found between the tools – community and the suggestion that the direct work approaches or tools used with children seemed to vary depending on the profession and the person involved.

The group also highlighted the diversity in the needs of the families they were working with in the community, and the associated risks this involved. They discussed a tension between community and division of labour and the processes by which labour was divided in the team and, in particular, the importance of different disciplines engaging in initial joint assessment visits. An associated contradiction was also found between community and rules in that there was an expectation that the FSWs would do First Response visits alone but that there was often a need for two workers. The group also found a tool – division of labour contradiction between the way cases were allocated and how individual professionals managed their own casework visits and times. Other things discussed included the object of direct work itself and how to define direct casework, and its beginning and end. Finally, a contradiction was identified between subject and community in that some team members could be anxious about selecting another professional from the team to work with. The precise reasons for this were not given but may relate to the uncertainties that professional groups have about each other's roles discussed earlier in this chapter in Sections 4.2.8, 4.3.8, and 4.5.8.

4.6.4.2 Training.

An extensive discussion of the team's training and development work took place and the group began by expanding its object to include the development of group work (see Figure 4.45 below). A detailed discussion of each element of the activity system is not possible here, however some of the key features of the activity system will be examined and discussed.

Firstly, Figure 4.45 shows that an exploration of the training activity system led the group to identify a number of contradictions. For example, a primary contradiction was observed in the divisions of labour, in that tier 1 staff attending training were often left to carry forward the training alone and were not explicitly supported by the tier 2 team members. A further tool-rule contradiction was found between the priority given to casework in the team and professionals finding time to contribute to training. Indeed, this and other contradictions highlighted how consideration of the activity system helped participants to surface issues and raise questions about aspects of their activity system. Indeed, the group raised some rhetorical questions e.g. 'how do we let stakeholders know the range of training on offer?' These questions appear to be aimed at stimulating the team's own thinking and learning action. Indeed, in some areas the group goes further and implies a possible development in the team's work e.g. 'recruitment tools are in need of development.'

Finally, the group considered a significant tension between the training activity of the team and their involvement in citywide multidisciplinary training. They

pointed to a tool and object/outcome contradiction, where the citywide brief for training superseded the team's own training priorities. The group queried how the objects of these different activity systems could be reconciled. This may be an example of a quaternary contradiction i.e. a tension between the objects of the two different training activity systems.

4.6.4.3 Team processes

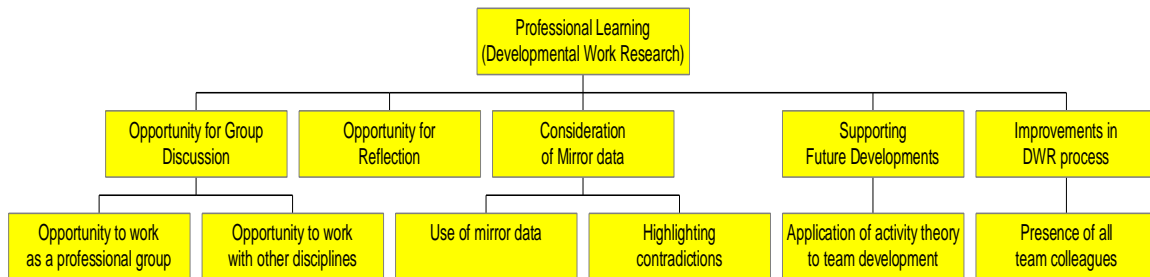
The group examining team processes decided to ground their discussion in a concrete practical activity of the team, that is, its team meetings. They used this as a basis for considering the team meeting activity system and the contradictions therein. Each element of the team meeting activity system and its contradictions were discussed. This led the group to question aspects of the activity system and surface a number of contradictions. One such division of labour–community contradiction was that support staff, whilst crucial to the team's operation, did not attend team meetings. The group also highlighted a possible contradiction between tools-rules in the team meeting activity system and, in particular, the amount of quality time team members spent together. Finally, the group queried aspects of the current team meeting process and alluded to contradictions within the divisions of labour and tools used in the meeting including its format, and the clarity and relevance of the agenda. Again, the group identified contradictions within and between elements of the activity system, and used this as basis to question their current practice. As a consequence, the activity system was taken to a full team meeting for further discussion of the contradictions highlighted and changes were made to the process as a result. Again, this appeared to suggest that learning actions and some potentially expansive learning activity had taken place.

4.6.5 Overview of developmental work research session.

The five-part process described above, demonstrates how activity theory was used in a range of ways to stimulate learning actions and some potentially expansive learning activity in professional groups and the multidisciplinary team. The process involved the use of activity theory analysis of individual, professional group and whole team activity systems. It described how activity theory analyses were used to support professional group and team learning and, in particular, to surface and work on the contradictions found within the different activity systems. Furthermore, it illustrated how double or dual stimulation could be used to mediate professional learning and to stimulate some potentially expansive learning activity in the professional groups and multidisciplinary team involved in this study.

4.6.5.1 Team member's evaluative comments on the DWR .

Figure 4.44. Professional Learning in Developmental Work Research Session



The objective of the DWR process was to allow the whole team to be consider and reflect on the MDT activity system, as a way of stimulating expansive learning activity. Each team member was asked to make evaluative comment on the Developmental Work Research Session. The thematic map presented in Figure 4.44 above provides an overview of the comments made by participants. Please see Appendix 7ii for details of the data linked to each of these themes.

The comments received suggest that the professionals involved in the DWR, for the most part, found the process helpful in supporting learning at both an individual, professional group and whole team level. In particular, participant feedback suggested that the process was helpful in stimulating learning through examination of contradictions and mirror data. It was also useful in providing the professionals involved with an opportunity to discuss, reflect and consider development and change as a work group and team.

Furthermore, comments indicated that the session had achieved, in part, its aim, which was to stimulate reflection and learning in individuals, professional

groups and the whole team. For example, positive responses received were typified by the following comment on the DWR session as:

‘an excellent opportunity to share ideas, thought and suggestions’
(PMHW)

However, some participants found elements of the process challenging offering the following comment:

‘I felt that a more positive approach would have been more in keeping with the style and work of the [Team]’ (FSW)

This led the researcher to reflect on whether there were aspects of the approach or his implementation of it that had influenced this outcome.

However, since the conclusion of this phase of the research the service concerned has commissioned the researcher to undertake further developmental work with the team to support it in taking forward the learning stimulated by this study. This is reflected by comments received on the day such as:

‘It will be useful to have a couple of additional sessions which would enable the team to develop further in terms of cohesiveness and awareness of each team’s role and responsibilities.’ (EP)

4.6.6 Summary of section

The three levels of analysis used in this study provided an opportunity to generate learning action and expansive learning activity at the level of the individual professional, professional group and whole team activity system. These learning actions and activity were supported by a range of approaches including individual activity theory analyses, focus group discussion with professional and multidisciplinary groups, and DWR sessions with the whole team. Moreover, the findings of the study suggest that surfacing and working on contradictions within these activity systems appears to stimulate learning

actions and some potentially expansive learning activity within individuals, groups and the whole team, creating the potential for expansive learning in the activity system of whole multidisciplinary team. Further work is planned to follow up the findings of this research and to support the ongoing development of the team and to see if expansive learning can be fully realised.

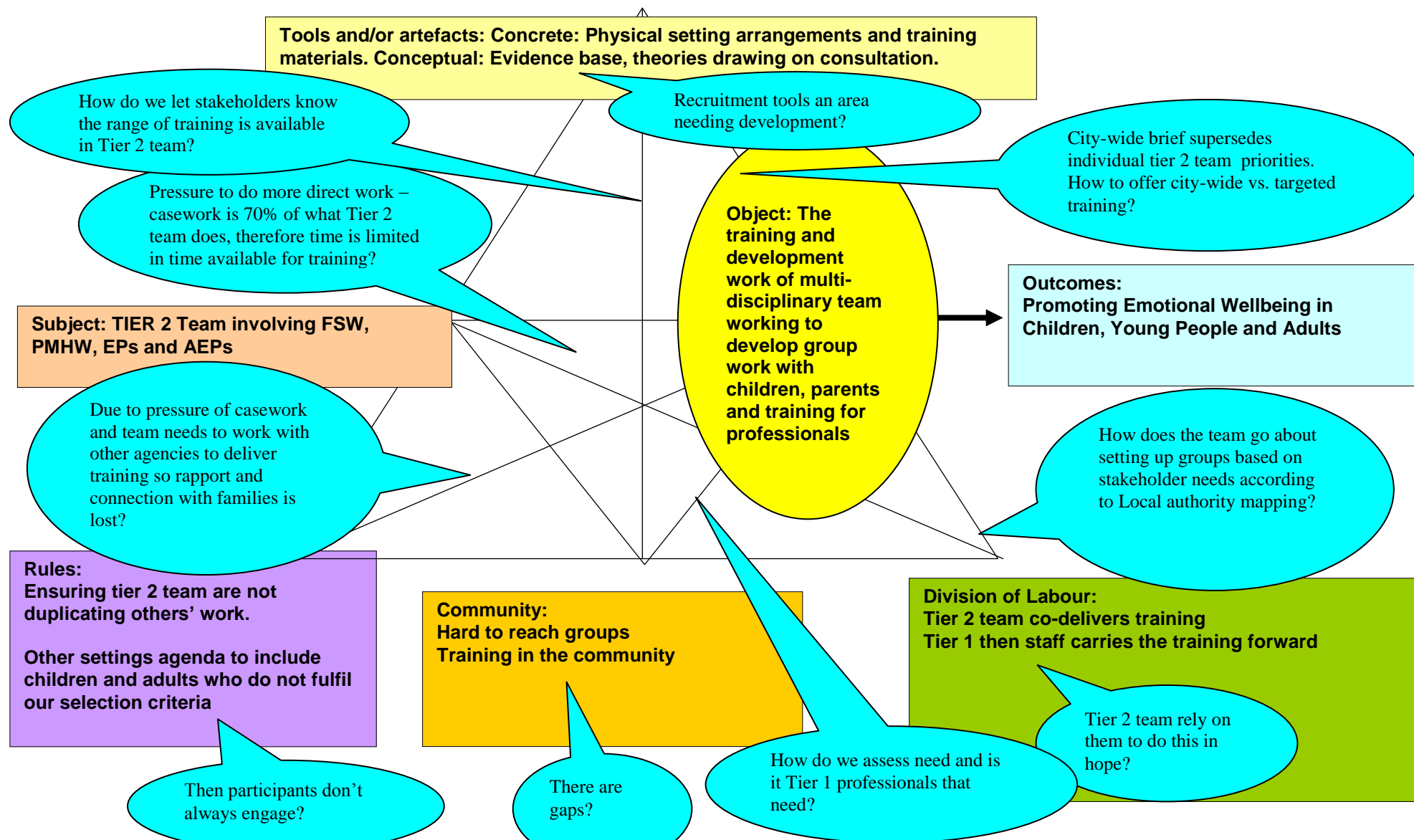


Figure 4.45 An activity theory analysis of the team's training activity system

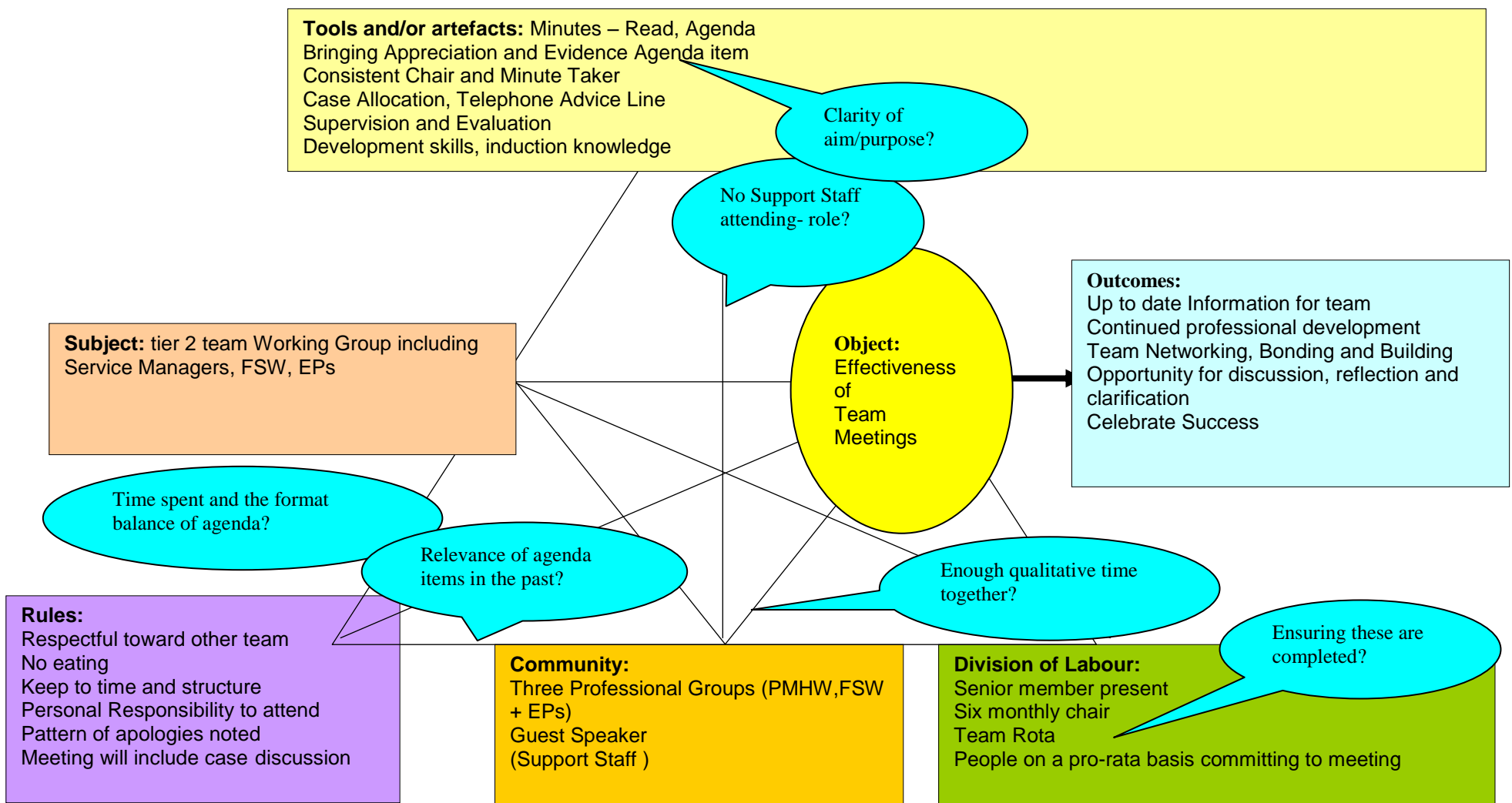


Figure 4.46 An activity theory analysis of fortnightly team meetings.

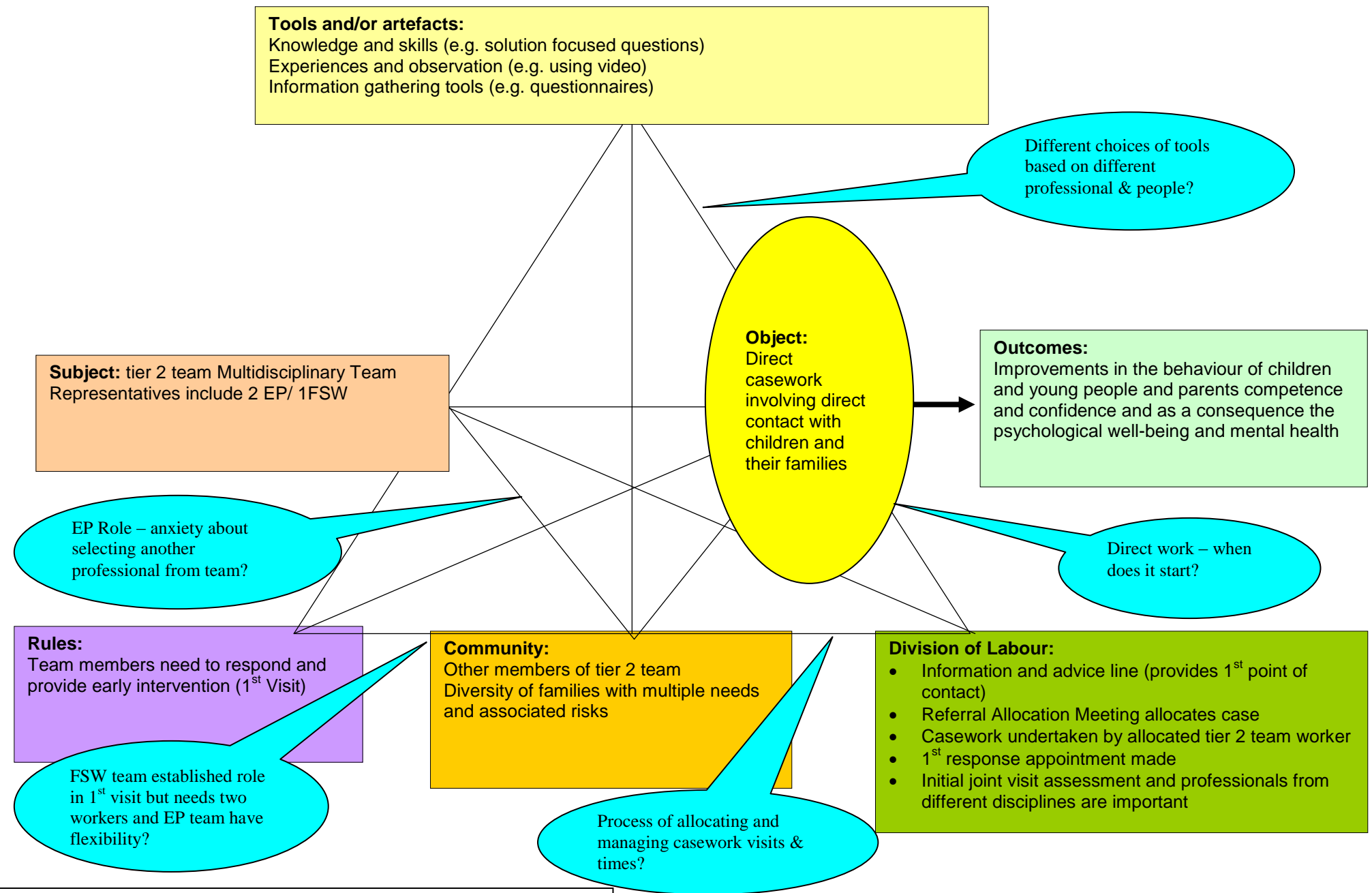


Figure 4.47 An activity theory analysis of the team's direct casework.

CHAPTER 5 DISCUSSION

5.1. Introduction to chapter

The findings outlined in the previous chapter illustrate the complex and interrelated nature of each profession's work. This chapter discusses these findings in relation to what is known about each profession's contribution to promoting mental health and psychological wellbeing in children and young people. In doing so, it considers the outcomes, tools used and the rules that support and constrain their work. This is followed by discussion of the contradictions and potential areas for expansive learning in each profession. The chapter concludes with consideration of the multidisciplinary team's activity as a whole, and discussion of how professional learning was supported by the sociocultural activity theory analysis and methodology employed.

Research Question: What do different professionals contribute to promoting the mental health and psychological wellbeing in children and young people?

5.2. Educational psychologists' contribution

5.2.1. Outcomes

The findings outlined in the previous chapter in Section 4.2.3. of this study suggest that educational psychologists aim to promote mental health and psychological wellbeing in children by:

- 1) building their skills and confidence through individual and group work; and

- 2) offering consultation and training on issues of mental health and wellbeing to significant adults with the aim of improving their awareness, skills and confidence in meeting the needs of children.

EPs' use of individual and group work relates back to the therapeutic and child psychology role emphasised by MacKay (2007) and Farrell et al (2006) and discussed in Chapter 2 of this thesis. The use of group work within EP professional practice is not particularly prominent in professional discussions about the EP role, although the sociocultural history of the profession has seen the understanding and use of group work as an essential component of EP practice. For example, Thacker (1987) pointed out that application of group work in professional practice could be aimed at supporting learning, developing classroom practice or as a therapeutic intervention.

More recently, the application and efficacy of group work, as a therapeutic intervention, has been discussed by Squires (2001) who pointed to the value of group work based on cognitive behavioural principles in EP practice. In addition, Burton (2004, 2006) employing a more eclectic approach to group work suggested it can have benefits in raising self esteem and reducing exclusion in children and young people. EPs in the present study appeared to undertake a psycho-educational role in group work with children and young people, which was aiming for both learning and therapeutic benefits. This study also suggested that the development of group work with children in schools was an area where EPs sought to make a distinct professional contribution to promoting mental health and psychological wellbeing (see Section 4.2.3 in the previous chapter).

The present study highlighted that EPs, in the context of this MDT, aimed to use a collaborative and consultative approach in their work (see Section 4.2.3). This relates to the work of Wagner (2000) who defined consultation as a:

‘voluntary, collaborative, non-supervisory approach, established to aid the functioning of a system and its interrelated systems.’ (Wagner, 2000, p11)

Wagner (2000) argued that EPs could employ different methods and models of consultation within this broad definition. She further emphasised the importance of consultative dialogue between EPs and others based on collaborative, and recursive processes. Wagner (2000) further posited that consultation offers an egalitarian approach where EPs positional authority and gate-keeping role are minimised. However, Leadbetter (2006b) pointed out that consultation as an approach in EP practice is problematic in that it was difficult to define and has come to be understood and used in a variety of different ways by EPs. Nevertheless, EPs preference for consultative and collaborative approaches and work aimed at empowering and enabling others was highlighted in the present study (see Section 4.2.3). Indeed, Cameron (2006) also emphasised the importance of empowerment in EP work.

The present study also indicates that EPs seek to demonstrate the impact and outcomes of their involvement through evaluation. Demonstrating and evaluating the outcomes of EP work activity has been a challenge for the profession for some time and subject to considerable professional discourse (see Section 4.2.3). Frederickson (2002) and Fox (2003) have both argued that there is an urgent need for the development of an evidence-base for EP

practice. Matthews (2003), however, pointed toward the difficulties created by different professional views of what constitutes good evidence and the different forms of knowledge that stem from positivist, constructionist and realist perspectives. These tensions are particularly evident in a profession whose practices tend to be constructivist but who are increasingly being encouraged to adopt more positivist quasi-experimental and experimental research. Norwich (1998) argued for the co-existence of these approaches in EP research and practice. The profession, exemplified by the EPs in this study, appears caught in the horns of a dilemma as to what constitutes an adequate evidence-base for EP practice (Fox, 2003) and the relative value it gives to positivist, constructionist and realist approaches to research (Matthews, 2003). Differences in the qualitative and quantitative evidence generated by each of these paradigms led Fox (2003) to point out that:

‘educational psychologists..... are increasingly likely to be asked to articulate the evidence base for professional practice. How we do this will depend on our view of what is good quality research and ultimately, therefore, on our view of knowledge. (Fox, 2003, p100)

A further challenge for EPs is how they demonstrate a link between their activity and the outcomes achieved for children’s mental health or psychological wellbeing in both the short and long term, particularly when the service is delivered indirectly through consultation. Cameron (2006) pointed to the additional difficulties that EPs had in establishing a clear link between EP activity and outcomes for children and in providing evidence of EPs particular contributions in the complex multidisciplinary teams around the child. One possible consequence of this difficulty is that EPs may find it more politically expedient to seek to work directly with individual and groups of children, as found in this study (see Section 4.2.3), enabling them to demonstrate the

efficacy and effectiveness of their work more clearly and straightforwardly. However, Leyden (1999) and more recently Cameron (2006) argued that there was little evidence to demonstrate that EP work at individual child level leads to long term improvements and systemic changes in the practices of adults, the wider organisation and system around the child.

5.2.2. Rules

The principal rules, outlined in the previous chapter in Section 4.2.5, that seemed to constrain EP work in this study were the very different expectations and understandings that EPs and others had about the EP role (see Section 4.2.5). This is consistent with the findings of Ashton and Roberts (2006) that there was a considerable discrepancy between how EPs view their own role and how school SENCOs viewed it, for example. EPs in this study, seeking to promote mental health and psychological wellbeing, viewed their own contribution as being 'community-orientated' working on child and family issues, while other professionals, inside and outside the team, and service users viewed the role as being 'school-orientated' working on educational issues (see Section 4.2.5). One possible consequence of this difference in expectations for the profession is that EPs contribution to promoting psychological wellbeing in children and young people might be narrowly defined and misunderstood.

MacKay (2006) and Stringer et al (2006) argued that the profession is uniquely positioned to work as community child psychologists and that there are considerable constraints created by EPs working solely with and through schools on learning and educational issues. In particular, considering whether

a child, school or community need should be the paramount determinant of the work of the profession. As a consequence, some in the profession have sought to develop and introduce a more community focus to their work due to the constraints of working with, and through schools recognised in this and other studies. However, EP practices over the last three decades have emphasised and involved a strong sociocultural tradition of school-orientated practice. In addition, schools remain at the centre and constitute a strong part of communities that EPs serve (MacKay, 2006).

The differences in role expectation observed in this and other studies suggests that it would be beneficial for EPs to have an increased dialogue with those outside the profession about their role. In particular, they needed to negotiate their role in promoting mental health and psychological wellbeing of children and young people in family and community settings with the other professions working within multidisciplinary teams. Furthermore, this study's findings, given in the previous chapter in Section 4.2.5, indicate that the profession may need to promote and explain its developing role within children's services and demonstrate how its activity as community educational psychologists in school or other settings promotes child mental health and psychological wellbeing.

A further constraint to EP practice was the way EP time was allocated (see Figure 4.1 and 4.12 and Appendix 10viii, for example). Time allocation was introduced as a method of managing EPs' time, and to ensure EP time was fairly and equitably distributed to schools with different levels of need. The EP profession developed a tradition of time allocation in its recent history in

response to an overwhelming number of referrals of individual children and the subsequent long waiting times for EP involvement. Imich (1999) noted that 74% services had a system of allocating time to each of its functions and that 78% had a system for allocating time for school visits. Whilst there were many benefits to the approach (See Imich (1999) for a full list), two unintended consequences of this approach highlighted in this study and other studies was that EPs' flexibility and responsiveness could be limited (see Figure 4.12).

Indeed, Imich (1999) highlighted the disadvantages of time allocation as the lack of flexibility it creates and the lack of control and autonomy that EPs feel they have over their work. This finding was further supported by Leadbetter (2000) who found that 67% of Principal EPs reported that their services had systems of time allocation and that those using the approach saw it as giving less flexibility in EP service delivery. This lack of flexibility was particularly emphasised in the current study where EPs worked in two different systems; one that was a referral-based and the other a time allocation system (see Figure 4.1). This suggests that further consideration needs to be made by EPs, and others, as to whether the profession's contribution to promoting mental health and psychological wellbeing is supported by the rules and expectations associated with time allocation or referral based systems. The benefits and pitfalls of the proactive and pre-planned approach created by time allocation would need to be weighed against the benefits and pitfalls of the reactive and responsive nature of referral-based approaches.

5.2.3. Tools

When asking the question - What tools do EPs bring to the object of promoting psychological wellbeing and mental health in children and young people? - This study's findings, outlined earlier in Section 4.2.7, indicated that no particular paradigm or theoretical model dominated their work. Indeed, it was evident that EPs drew on a range of theoretical approaches and artefacts, adopting an eclectic and integrative approach to their work rather than a single 'pure' theoretical approach. The theories EPs used varied and included behavioural, cognitive behavioural, humanistic, constructionist, positive and systemic psychological theory (see Figure 4.12 in Section 4.2.7). The recent history of the profession has emphasised an eclectic approach within EP practice. Cameron (2006), for example, suggested that educational psychologists have a:

'research and theoretical database in psychology to recommend evidence-based strategies for change.' (p.293)

EPs in this study drew heavily on theoretical tools to inform their work and activity (see Figure 4.1 in Section 4.2.7). They also appeared to place great emphasis on the use of theoretical knowledge rather than practical or practice-based knowledge in their work (see Figure 4.12). So when answering the question - What is it that EPs contribute to promoting mental health and psychological wellbeing? - This study suggests that EPs contribute an in-depth knowledge of a range of psychological theories and the ability to use them to support their work with children and young people and their families (see Section 4.2.7. and Figures 4.1 and 4.12). As Cameron (2006) argued EPs:

'draw on a research and theoretical knowledge base which seeks to understand the complexity of human experience and eschews simple answers to complex questions.' (p.301)

Clearly, theoretical knowledge is not the exclusive and unique property of EPs. However, this finding also relates to the views of Booker (2005) who suggested that EPs typically had a greater breadth and depth of understanding of psychological theory and its application than others working in integrated children's services. The finding may be significant in the quest of the profession to identify what EPs offer that is distinctive. The current study suggests that the distinctiveness of the EP contribution may come from a 'difference of emphasis' rather than 'difference in kind'. In other words, EPs appeared to draw more heavily on theoretical tools in support of their work than the other professions sampled in this study (see Figure 4.1 and Figure 4.12). This finding may explain, in part, why EPs have found it so difficult to identify and highlight to others what it is they offer that is unique and distinctive and warrants further exploratory research.

EPs also brought an understanding of 'process' or process knowledge to their work. This included an understanding and awareness of interpersonal and group skills and in particular the process of consultation (see Section 4.2.7). Fox (2003) emphasised the use of process skills alongside seeking evidence of outcomes as important to EP work. EPs use their own interpersonal and group work skills and their knowledge of what supports successful transactions between individuals and groups developed in their training. It appears that process skills used alongside theoretical knowledge help EPs to empower and enable people to meet children's needs. This suggests that a further contribution that EPs make to promoting psychological wellbeing and mental health is in their knowledge of interpersonal and group processes and skills.

Finally, the present study indicated that EPs tended to adopt a psychosocial view of mental health and psychological wellbeing (see Figure 4.1 and Figure 4.12). They were reticent in engaging unconditionally with work that emphasised the medical-diagnostic approach. It appeared that EPs had a basic knowledge and awareness of mental health concepts and drew on concepts such as risk and resilience to support their work. However, they were cautious in their use of, and work within, other paradigms (see findings in Section 4.2.7). Therefore, it could be argued that the most significant tool that EPs use in promoting mental health and psychological wellbeing within MDTs is the 'psychosocial' lens with which they typically view mental health concerns. This lens enables EPs to question and challenge the assumptions of those adopting a medical-diagnostic approach, which Tew (2005), has pointed out currently dominates much of child mental health work.

It should be acknowledged that in the current study some professionals within other disciplines shared a very similar lens to the one used by EPs. However, Tew (2005) indicated that the psychosocial and social perspectives remain minority views and perspectives in work around mental health issues and it is important that they are represented and expressed. So, it seems that a principal contribution that the EP profession might make to promoting mental health and psychological wellbeing in children and young people is to draw on its knowledge of psychological theory and processes and to express a psychosocial view of mental health. This might help EPs to ensure that children's mental health and psychological wellbeing are promoted and not unnecessarily and prematurely pathologised. As Cameron (2006) stated:

'educational psychology is concerned with understanding how individuals and groups learn and develop and how this informs the development of society: Most certainly, it is not about putting people into pigeonholes or labelling people. (p.301)

5.2.4. Contradictions

Whilst working to promote mental health and wellbeing in children and young people, EPs in this study appeared to face four main contradictions (see Section 4.2.8). First, a tool–community contradiction was found between the paradigms, explanatory theories and models held by EPs and those used by other professionals within the MDT and comprehensive CAMHS (see Figure 4.1 and Figure 4.18). As highlighted in Section 4.2.7 of the previous chapter, EPs appeared to draw on a psychosocial view of children's mental health needs, whereas other professionals emphasised models, such as the medical-diagnostic model. This is related to the findings of Anning et al (2006) that different explanatory models often existed within multidisciplinary teams and that dominant and complimentary models were evident within teams. Such differences in models could create a healthy tension in which EPs and other professionals may challenge one another's perspectives, opening up the possibility of expansive learning activity and development in the MDT. Indeed, Tew (2005) asked for a more balanced consideration of medical, social and psychosocial perspectives on children's mental health needs. A diversity of viewpoints within a multidisciplinary team, on what promotes children's mental health and psychological wellbeing may, therefore, be viewed as helpful rather than problematic.

A second tool–community contradiction appeared to be between EPs view of their own role and others' view and understanding of it (see Section 4.2.8 and

Figure 4.12). Indeed, a number of writers and professional observers have emphasised the importance of EPs promoting and marketing their role, so that it is better understood (see for example, Baxter and Frederickson, 2005; Cameron, 2006; Farrell et al, 2006). This contradiction may stem from the long cultural-historical tradition within the EP profession of working directly with children to assess and address the needs of individual children in schools (see MacKay, 2007, for example). This is in contrast to the profession's recent historical preference for indirect service provision, offering consultation to significant adults to empower and enable them to make the changes needed to promote the mental health of children in family and community settings (see for example Wagner, 2000; Dickinson, 2000; Munro, 2000). The contradiction also reflects the current dilemma in the profession about whether EPs should place more emphasis on being child, educational, school or community-orientated psychologists (see Farrell et al, 2006; MacKay, 2006; Stringer et al, 2006, for example).

A further tool–outcome contradiction found in this study appeared to indicate that EPs were torn between responding to the needs of children, building relationships with adults and responding to the needs of organisations (see Section 4.2.8 and Figure 4.12). MacKay (2006), Farrell et al (2006) and Stringer et al (2006) have all highlighted how EPs work at a variety of levels with individual children, groups and organisations. This contradiction is reflective of the profession's debate over a number of years about the most effective level at which to apply EPs skills (see Farrell et al, 2006, for example). The professional dilemma is further exemplified by Leyden (1999) who argued that EPs needed to work strategically and proactively within local

authority and school systems, rather than by just responding to a string of individual children's problems which may have, in part, been caused by the system and organisation.

Finally, a striking contradiction was found between the community and division of labour of EPs in this study, in that EPs were seeking to maintain a single disciplinary identity at the same time as working with, and for, a multiagency team (see Section 4.2.8 and Figures 4.1 and 4.12). There was evidence of joint work and a culture of collaboration between EPs and other professionals in casework and training (see Figure 4.10 and Appendix 10i -10viii, for examples). However, the EP profession also sought opportunity to work as a single professional group within the multidisciplinary team (see Section 4.2.8 and Appendix 10iii, for example). This seems to reflect the current national picture, where EPs are seeking to maintain their professional identity within integrated children's services, and relates to the views of Booker (2005) who observed that EP professional identity was frequently challenged in integrated multidisciplinary team working.

5.3. Primary mental health worker contribution

5.3.1. Outcomes

The primary mental health worker (PMHW) profession is a relatively new one. In the early years of the profession's development, Lacey (1999) highlighted four main aspects of the PMHW's role as consultation, joint assessment, direct work and training. This links with aspects of the PMHW role found in the present study, outlined earlier in Section 4.3.4, which included activities aimed at raising awareness and understanding of children's mental health needs and

building the skills and confidence of parents and professionals in meeting these needs. These findings relate to Gale and Vostanis's (2003) suggestion that the principal role of the PMHW was to provide specialist knowledge of child and mental health at early stages in tiers 1 and 2 of comprehensive CAMHS.

A further outcome sought by PMHWs in this study was in helping children with a mental health needs and their families access the appropriate type and level of support and provision within comprehensive CAMHS (see Section 4.3.4). This involved the PMHW acting in a gate-keeping, liaison and sign-posting role within and between tiers, as illustrated in Figure 4.17 and 4.18 in Section 4.3.4. However, Gale and Vostanis (2003) have cautioned against PMHWs becoming gatekeepers to specialist CAMHS and urged others to see them as a resource rather than just a way to access specialist CAMHS. The evidence from this study would suggest that PMHW were, in fact, trying to perform all of the functions outlined by Gale and Vostanis (2003) (see Section 4.3.4).

Finally, PMHWs' work also appeared directed toward demonstrating evidence of improved outcomes through evaluation (see Section 4.3.4). This relates to the wider culture within health services where there is an expectation that the interventions recommended should be evidence-based (see for example, Wolpert et al, 2006). It further highlights the importance to PMHWs of demonstrating outcomes and evidence of the impact of their work through use of common 'objective' measurements of progress such as those suggested within the CAMHS Outcomes Research Consortium (CORC) Initiative (see Wolpert et al, 2007). However, Herbert (2006) has suggested

‘perhaps the dream of an absolute and thus uncompromising scientific objectivity in the study and mitigation of young people’s mental health is chimera.’ (Herbert, 2006, p23)

for PMHWs and other allied professions.

5.3.2. Rules

Service criteria were seen as both supporting and constraining the PMHW role in this study (see Section 4.3.3). On the one hand, the criteria appeared to create a clear definition and understanding of the extent and limit of the PMHW role. On the other hand, it constrained the role as the criteria to access the PMHW and other services were not always clear and coterminous. This meant that some children and families appeared to fall between services. Furthermore, some other CAMHS services could be reluctant to become involved whilst a PMHW or other tier 2 team member was working on a case. This hindered the smooth transition of a case from one service to another (see Appendix 9iii, for example). It suggests that there is a tension or contradiction between the rules of the different tiers and activity systems within comprehensive CAMHS. Moreover, it suggests that further developmental work between teams and tiers within comprehensive CAMHS would be beneficial to ensure a more co-ordinated, joined up service provision in the locality studied.

This study further showed the importance of managing risks associated with child mental health in the PMHW role (see Section 4.3.3). This included an expectation that risks associated with mental health concerns were carefully identified, assessed and managed at an early stage and children sign-posted

to an appropriate service based on these assessments. It was evident from the present study that service protocols, procedures and record-keeping systems underpinned PMHW work (see Figure 4.22). These appeared to help PMHWs to ensure risks were managed and their practice was safe (see Appendix 9iii, for example). The importance of assessing risk in the PMHW role is one that was not explicitly addressed in other studies. However, MacDonald et al (2004) noted that PMHW undertaking consultation at tier 1 and 2 needed to use different skills outside their traditional clinical roles including the use of consultation. Further research is required to ascertain how PMHW assess and manage risk associated with mental health issues when performing consultation in a more community orientated role within tier 2 CAMHS services.

5.3.3. Tools

Gale and Vostanis (2003) highlighted the importance of PMHW's specialist knowledge of child and mental health, in providing for and promoting child mental health in family and community settings. This study's exploratory findings also suggest that knowledge of mental health, its assessment and treatment were key tools for PMHWs (see Section 4.3.7). In addition, PMHWs had appeared to use a clear conceptions of their own role, extensive knowledge of CAMHS service provision and knowledge of factors that promote mental health in children and young people, using concepts such as risk and resilience (see Section 4.3.7 and Figures 4.17, 4.18 and 4.22). This finding resonates with the PMHW knowledge bases identified by Bradley et al (2009) which included knowledge of development, psychopathology, treatment techniques and CAMHS service provision.

The PMHWs in this study, in contrast to EPs, appeared to place slightly less emphasis on theoretical models and knowledge (see Section 4.3.7 and 4.2.7 respectively). They appeared to place much greater emphasis on practice-based knowledge and the use of evidence-based approaches to meet particular mental health needs. On top of this PMHWs, much like EPs, brought an understanding and knowledge of process to their work (see Figure 4.22). PMHWs also emphasised, the importance of consultation, supervision and support processes in underpinning their work and practice (see Section 4.3.7). This finding relates to the three level model of service delivery proposed by Gale and Vostanis (2003) which identified key aspects of the PMHW role as providing consultation, supervision and training for frontline professionals.

5.3.4. Contradictions

The detailed thematic analysis of PMHW work identified a number of contradictions from which the PMHW service, its managers and professionals may learn and develop (see Section 4.3.8). Firstly, a contradiction between tools and community appeared to indicate that PMHWs had a key role in mediating understanding between the different cultures and models of mental health held by different agencies and services, but that this role may not have necessarily been supporting wider interdisciplinary working (see Section 4.3.8). Indeed, Gale and Vostanis (2003) proposed an integrative approach to PMH work that draws on biological, psychological and sociological paradigms and models. In the present study, PMHWs appeared to have a key role bridging understandings between different paradigms, professionals and tiers

and, in particular, linking with other health professionals and services including specialist tier 3 CAMHS (see Figures 4.18 and 4.22).

Gale and Vostanis (2003) further observed, within the Leicestershire context, that PMHWs have an important role to play in creating a link between specialist CAMHS and maintaining the interface between tiers one, two and three. However, in the present study there was some evidence to suggest, from PMHW's community and division of labour (see Section 4.3.5 and 4.3.6), that PMHW role hadn't necessarily improved links between other disciplines in the MDT and health colleagues in the comprehensive CAMHS community, as was intended. If anything, there appeared to be an over-reliance on the PMHWs to make the links to health colleagues(see Section 4.3.5 and 4.3.6). This meant that improved understanding and wider collaboration between professionals at tier 2 and tier 3 in comprehensive CAMHS was less apparent (see also EP and FSW community in Sections 4.2.4 and 4.4.5 respectively). The precise reason for this finding warrants further investigation.

Whilst it was evident that PMHWs had facilitated improved links between tiers, it is also possible that the role had inadvertently helped to bypass, rather than resolve, the barriers to communication that existed between different professionals, services and agencies across comprehensive CAMHS in this locality (see Section 4.3.8). This exploratory finding may have implications for those seeking to develop and introduce new roles to work at the interface between existing services. It also appears consistent with Anning et al (2006) and Edwards et al's (2009) observation on the importance of boundary working for professional learning within multidisciplinary teams.

Whilst the PMHW's role appeared clearly understood by those in the role, it was less well understood by those they worked with. This created a tool – community contradiction between PMHW's knowledge and understanding of their own role and the expectations of it held by others (see Section 4.3.8 and Figures 4.18 and 4.22). MacDonald et al (2004) also identified that differences in understanding existed between other professionals and PMHWs about their role. In particular, they found that many tier 1 staff and clients expected direct clinical work but PMHWs themselves favoured consultation. These differences in perspective were highlighted as a potential barrier to effective liaison-consultation work with tier 1 staff. The findings of both the current study and MacDonald et al (2004) are perhaps unsurprising given the newness of the PMHW role but they represent a significant challenge for the profession. It suggests that further work is required by PMHWs in promoting understanding of the role and negotiating their contribution to promoting mental health and psychological wellbeing with those they work with, and for, in multidisciplinary teams and comprehensive CAMHS.

A further rule–division of labour tension was found in the time use of PMHWs, affecting their opportunity to collaborate and work with other tier 2 MDT team colleagues (see Section 4.3.8). PMHWs were the minority professional group and also had the least amount of time available to work in the tier 2 MDT (see Section 4.5.1). Their time was split three ways and given in roughly equal proportions to work with tier 1, tier 2 and tier 3 services (see Figure 4.18 and Figure 9i, for example). This created huge time and work pressures for those

performing the role. MacDonald et al (2004) suggested that there were three main types of organisation of PMHW services. These are as:

- an outreach service for Specialist tier 3 CAMHS;
- working as a team in tier 2; and
- based within primary care.

It was evident that the PMHWs, in the present study, were trying to deliver services not just in one of these ways but in all three, creating a significant rule –division of labour contradiction in the demand for, and use of, PMHWs' time.

Finally, a community – division of labour contradiction was observed between the PMHW service criteria and those held by other services within comprehensive CAMHS (see Section 4.3.8). PMHWs found that involvement of the tier 2 team could sometimes preclude involvement of the specialist tier 3 CAMHS team. It was expected that a case would be closed to the tier 2 team before the specialist CAMHS service could take it on (see Section 4.3.8, Figure 4.22 and Appendix 9iii, for an illustration). This appeared to be an example of what Engestrom (2001) terms a quaternary contradiction i.e. contradiction between the objects of two related activity systems. The consequence of the contradiction was that it was difficult for PMHWs to ensure a proper hand over of a case and to achieve joint working between services, when this was needed within comprehensive CAMHS. It also appears to be an example of the gaps in communication that can be found between CAMHS services, first highlighted by Health Advisory Service (1995) and more recently by the independent CAMHS (2008) review. It suggests that

further work is still required on the interface between the tier 2 MDT and specialist CAMHS tier 3 team in this locality.

5.4. Family support worker contribution

5.4.1. Outcomes

In this study it appeared particularly important for those in a FSW role to develop and follow common team protocols and procedures (see Section 4.4.3). This appeared to have stemmed from the tradition in social care services of rigorous record keeping in child protection cases, in line with the recommendations of the Laming Report (Laming, 2002) and other serious case reviews. As discussed in Chapter 2, the family support worker (FSW) role has its origins within the Children Act (1989) and the development of social service provision for children in need including day nursery and family centre provision. The other main outcomes sought by FSWs in this study included the provision of support for parents to help them meet the needs of vulnerable children through offering early support, facilitating parent – child interaction and helping them to access information and services (see Section 4.4.3 and Figure 4.33).

Underpinning all of these outcomes was a desire by FSWs to ensure the quality and consistency of service provided (see Figure 4.33). This has its roots in the ‘Quality Protects’ -Framework for the Assessment of Children in Need and their Families’ adopted by social care services in the 1990s (Department of Health, 1999). This framework emphasised the need for quality and consistency in assessment and decision-making about children in need and the provision they received. These approaches have been more

recently endorsed through the Every Child Matters (Department for Education and Skills, 2004): Change for Children proposals, including the development of Common Assessment Framework (CAF), Information Sharing Protocols (ISP) and 'Contactpoint' (a directory of services). These appear to represent a significant contribution that those from a social care background typically bring to multidisciplinary teamwork.

5.4.2. Rules

Linked to the findings above, the present study appeared to indicate that FSWs felt more obliged to work within the parameters set out for the team through the team business plan (see Section 4.4.4 and Appendices 8ii, 8iii, 8vi and 8x). For example, in offering time-limited direct work for children and performing evaluation of casework (see Figure 4.33). Also underpinning the FSW role was an expectation that they had a common core of knowledge and skills, such as a basic understanding and competence in Solution Focussed Brief Therapy (SfBT) approaches (see Appendices 8v and 8x, for example). FSW were supported in developing their role by a culture and expectation of collaboration and co-operation within the team. Indeed, FSWs appeared to particularly benefit and value the training offered by the other professional disciplines in the team (see Section 4.4.4 and Figure 4.33). This appeared consistent with the suggestion of Edwards et al (2009) that expertise becomes distributed in multidisciplinary teams through a process of professionals working together, sharing practice and learning from each other.

FSW were the largest professional group and the only full-time members of the team and therefore represented the hub and engine of the team (see

Section 4.5.1). Other professionals were often part-time making their availability an issue for FSWs. FSW reported being constrained in their role by the time and availability of other professions as well as the service criteria held by these professions (see Section 4.4.4. These rules sometimes prevented FSWs from accessing support, supervision and joint work from other professions when it was required (see Figure 4.33 and Appendix 8i, for example).

5.4.3 Tools

The tools that FSW used can be categorised into five or six main areas. First, was their understanding and awareness of the team and the wider social care procedures (see Section 4.4.7). This emphasis on child protection procedure supports the view of Vostanis et al (2006) who argued that the FSWs have a key role to play in the interface between CAMHS and child protection services, and in responding to child protection concerns.

Second, an emphasis was placed on the use of policy and procedural knowledge in their work, in particular when determining and accessing support for children and families (see Section 4.4.7). This relates to Gray's (2002) observation that a principal aspect of a FSW's role was to deal with the needs of families as they arise in the family home, and then to refer them on to other health and social services as appropriate to the need.

Third, Gray (2008) highlighted the importance of the emotional engagement shown by FSW when they were supporting families with child protection concerns. The role of the FSW bringing both practical and emotional support

tools to parents was also evidenced in the present study. FSW, unlike the other professions, had much of their knowledge grounded in practical childcare experience and hands on work with children and families. They used this understanding to show empathy to, and support for parents (see Figure 4.33). Gray (2002, 2008) observed that FSW often had a befriending role, establishing trusting relationships and engaging practically and emotionally with families. Moreover, Gray (2002) pointed out that FSWs

‘engaging emotions with families helps to smooth the upsets to provision and ‘oils the wheels’ of social care’ p.20.

Furthermore, this finding is consistent with ideas put forward by Vostanis et al (2006) that FSWs had an important role in supporting positive outcomes for children and families by offering parent support as part of tier 2 CAMHS service. Indeed, Vostanis et al (2006) found that parent support offered by a Family Support Service using Solution focussed Brief Therapy (SfBT), had a greater impact on child behaviour and family life than did parent support provided by a specialist CAMHS service.

The tools used by FSWs in this study appeared to be mainly of a practical, emotional and procedural nature rather than a theoretical, research or evidence-based kind. That said, the theoretical knowledge that FSW did use included knowledge of child development, childcare and parenting and to a lesser extent disability issues (see Figure 4.31 and 4.33). This is consistent with the observations of Walker (2003) who indicated that FSWs used an eclectic mix of practical, therapeutic and activity based approaches in their work. The use of different knowledge links to ideas of Eraut (2004) and Anning et al (2006) who observed that professionals had two types of knowledge they used in practice. That is, professional, codified knowledge

that stems from professional training and personal knowledge that stems from personal experience. The latter was very much in evidence in the work of FSW in this study.

5.4.4. Contradictions

The present study suggests that several contradictions exist for FSWs seeking to promote mental health and psychological wellbeing in children and young people. Firstly, a contradiction between tools – outcomes appeared to exist for FSWs when trying to meet the needs of parents and children at one and the same time (see Section 4.4.8). FSWs indicated that sometimes there was a tension between what was in the best interests of children, and their parents/carers and wider families (see Section 4.4.8 and appendices 8ii and 8vii, for examples). This tension is recognised in the government's recent 'think family' initiative (see Department for Children, Schools and Families, 2009), which recommends a holistic consideration of family needs by social care and other professionals. Secondly added to this, there appeared to be a further tool – outcome contradiction between FSWs offering parent support using solution-focused approaches and in performing a child protection role, where it may be necessary to take a more problem-orientated approach (see Figures 4.23 and 4.33).

Next, FSWs in this study found a significant rule –outcome contradiction in meeting the complex needs of families within the short time-limited interventions permitted (see Section 4.4.8 and Figures 4.23 and 4.33). Indeed, Walker (2003) noted the time-limited nature of FSW intervention, and Gray (2002) pointed to FSWs' key role in undertaking initial assessment and

referring children and families on as necessary. This was problematic for some FSWs who felt that some families' needs were complex, long-term and required further support (see Section 4.4.8 and Appendices 8ii, 8vii and 8xi, for examples), but they couldn't always access the support required from within the comprehensive CAMHS services (see Appendix 8iv, for example). A further related community-division of labour tension was identified in the collaboration between FSW and other professionals working in CAMHS. This was often borne out of the time limitations and criteria of other services, meaning that FSW were not always able to obtain support in appropriate and timely ways, when they felt at the limit of their knowledge, skills and confidence (see Figure 4.28 and 4.29, for examples).

Finally, a notable rule–tool contradiction was found between FSWs' desire for consistency of service and their ability to have professional autonomy and flexibility in the role (see Figure 4.33). Indeed, many FSWs reported being guided by the service plans, protocols and procedures. However, some felt they needed to have more opportunity to respond flexibly to the needs of individual families (see Section 4.4.8 and Appendices 8i, 8iv and 8viii, for examples). Moreover, it appeared that experienced practitioners felt more confident in working outside team expectations and breaking team rules when this was in the best interests of children and families (see Figure 4.28 and 4.29, for example). These findings relate to the observations of Anning et al (2006) and Edwards et al (2009) who found that professionals in MDTs rule bend and risk take in ways that support children's needs being met. However, FSWs also seemed more likely to refer to and follow service expectations than other professional groups (see Section 4.4.4 and Appendices 8i to 8xi, for

examples). The precise reasons for this contradiction and why some FSWs appeared reluctant to rule bend and break would benefit from further consideration. It may relate to the sociocultural history of the profession in child protection and the procedural rules and constraints on practice this entails.

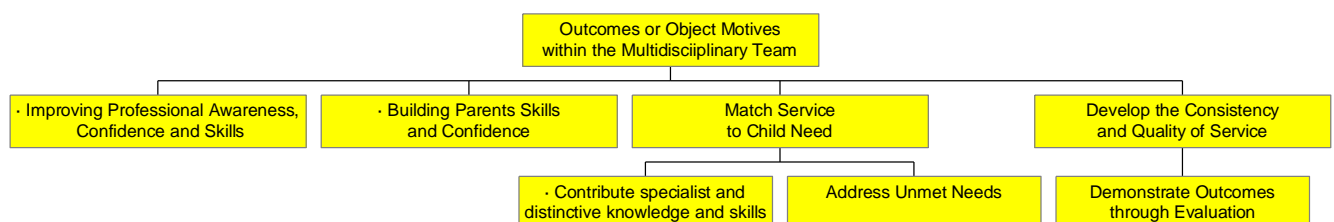
5.5. Multidisciplinary team contribution

Having considered the contribution of each profession in turn, the discussion now moves on to consider and provide overview of the contribution the multidisciplinary team as a whole.

5.5.1. Outcomes

The study found four principal outcomes that the whole team's work seemed directed toward. These are illustrated and summarised in the thematic map in Figure 5.1 below

Figure 5.1. Thematic Map of the Multidisciplinary Team Outcomes or Object Motives



First, a principal aim of the team's activity appeared to be to ensure that the service offered was matched to both child and family need (see Section 4.5.1). Indeed, the team had many internal processes to ensure its decision-making was clear and effective (see Section 3.8.7). This included consideration of what the team and each profession could contribute via

multidisciplinary case allocation and team meeting discussions. Where the team was unable to meet the needs highlighted they sought to identify other services or provision in comprehensive CAMHS that could (see Table 4.7 and Figure 5.1 above). Research by Walker (2003) with another MDT stressed the importance of a team's context, position and links with other support services, as well as its capacity to meet needs and the flexibility in the support offered as being key to the team's effectiveness.

However, it was evident that team members experienced considerable frustrations in accessing other services when the needs of a child and family were complex and appeared beyond the capacity of a tier 2 team. These difficulties were usually a by-product of differences in criteria or interpretation of need held by the tier 2 team and other services in comprehensive CAMHS (see Appendices 8i, 8iv, 8vii, 8xi and 9iii, for examples). It appeared that criteria were set independently of each other in different parts of the comprehensive CAMHS and as a consequence some children, young people and their families could fall between services. This relates to the observation of the recent CAMHS Review (2008) that many difficulties in communication between services and in children accessing CAMHS services remained.

The next outcome the team aimed to achieve was in building parent's skills and confidence (see Section 4.5.3). In this study each profession involved felt it had a contribution to make to parent support (see Table 4.7). Indeed, the development of parenting skills is a priority of National Government (see Every Parent Matters, Department for Children, Schools and Families 2007) and many services are involved in developing and delivering support for

parents. Local authorities responding to this national priority have been required to develop a local parenting strategy and are expected to co-ordinate parenting support across children's services. This study, however, indicated that different professionals might offer slightly different things to parent support. For example, FSW typically provided practical and emotional support, befriending parents and supporting them with information and access to services, in line with the findings of Gray (2002, 2008). On the other hand, PMHWs offered advice on how parents could access services and knowledge of evidence-based parenting programmes, whereas EPs appeared to use their theoretical knowledge and consultation skills in working with parents. Again, it should be said that no one professional group had an exclusive right to these forms of knowledge or support, rather it was a question of the emphasis that each profession appeared to place on the different knowledge bases.

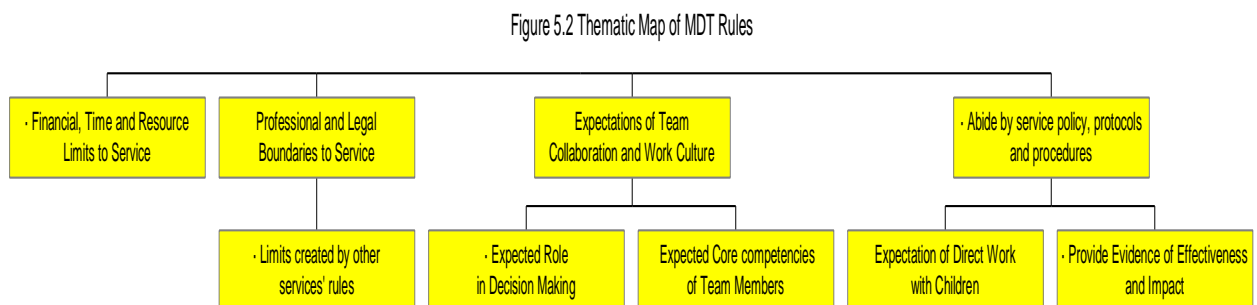
This study indicated that another outcome that the team was striving to achieve was in the increased knowledge, skills and confidence of other professionals around mental health issues (see Section 4.5.3). The emphasis on 'capacity building' has been an aspiration of those trying to build a truly comprehensive CAMHS for sometime. Indeed, the emphasis in recent policy and practice has been on making the promotion of mental health and psychological wellbeing 'everybody's business' (see Department of Health, 2004).

Finally, underpinning all of these outcomes was the desire in the team to provide quality and consistent services that demonstrate the effectiveness of

the work through positive evaluation of outcomes for children and families (see 4.5.3). The latter finding relates to Walker’s (2003) observation that it was important to demonstrate the positive impact of a team or service for all concerned. The importance given to evaluation was a particularly strong feature of the team in this study (see Table 4.7).

5.5.2. Rules

The rules that appeared to support and constrain the work of the multidisciplinary team’s activity are summarised and illustrated in Figure 5.2 below



As might be expected; time, funding and resource limitations were identified as constraining factors by all professions in this study (see Section 4.5.5). It also reflected the fact the team had relied on ‘project’ funding for its survival and growth over the last 10 years. Additional constraining factors included the statutory responsibilities of each agency, professional codes of conduct and different services’ criteria (see Figure 4.38 and Appendices 12v, 13v and 14v, for examples). Indeed, Eraut (2007) noted that professions tended to define themselves by their professional standards, frameworks of competence and qualifications. In contrast, national and local government frequently defined

professional knowledge and practice quite differently and seek evidence of the demonstrable outcomes and impact of a profession's work (Eraut, 2007).

A largely supportive rule for the team was the expectation of a collaboration and equality in relationships in the team culture (see Section 4.5.5). It appeared that each member of the team had a role in decision-making and contributed their specialised professional role and expertise as appropriate (see Appendices 12v, 13v and 14v, for examples). This was in line with the expectations of the current workforce development policy (see Department for Children, Schools and Families, 2008), which emphasised the importance of a common core skills within the children's workforce followed by the development of specialised knowledge.

There was desire within the team to share practices, develop common approaches and to establish collaborative working (see Table 4.9 in Section 4.5.5). Indeed, Barclay and Kerr (2006) noted that professionals viewed communication and understanding as being key to effective multidisciplinary work. They further suggested that this was achieved by professionals sharing information, developing common processes and working collaboratively. In this study it was evident that the team had common processes, which all in the team were expected to follow including use of common initial assessment and evaluation procedures (see Appendices 12v, 13v and 14v, for examples). This further relates to findings by Barclay and Kerr (2006) that common processes, practice and policies were important to MDT functioning. In addition, Watson (2006) and Hymans (2006) highlighted the importance to

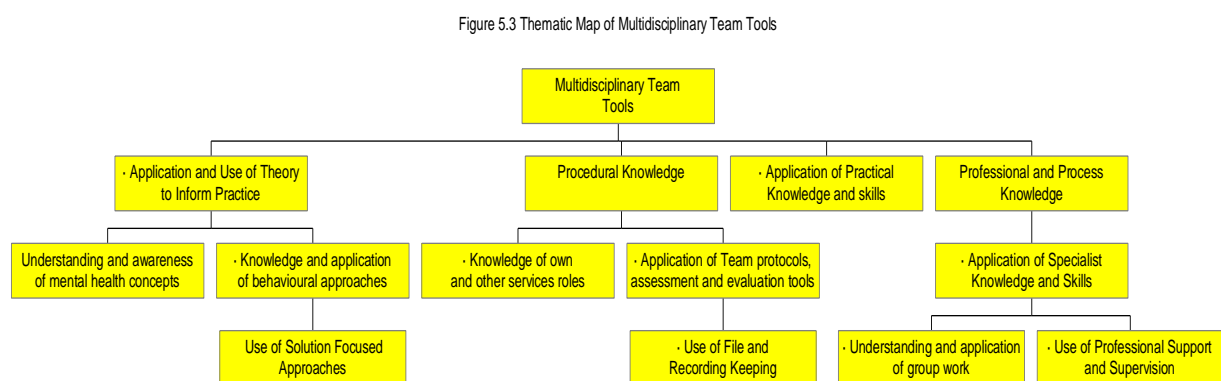
team members of developing a shared vision, priorities and team strategy in MDT work.

In contrast to this, other professionals wanted a greater degree of professional autonomy and freedom in their work, particularly in the approaches that they used in assessment and intervention. For example, there was an expectation that professionals in the MDT would do, for example, direct work with children (see Section 4.5.5). The latter appeared to create a tension for some in the team who felt that indirect consultative support was the most effective and best use of their limited time (see Figures 4.33 and 4.38). This relates to an observation of Hymans (2006) that professionals within the MDT wanted an opportunity to show what they can contribute, and to have their expertise and diversity of role acknowledged.

The contradiction between developing common and consistent processes and allowing professionals the autonomy and flexibility to make independent judgements and decisions is a recurrent and strong theme in this study and warrants further research and development work in this and other MDTs in comprehensive CAMHS. It relates to Anning et al's (2006) observation that in some MDTs there was a tension between those in activity systems seeking a 'community of practice' more in line with Wenger's (1998) 'model and those dealing with conflict through what Engestrom calls 'knot-working' model. It also relates to a finding of Edwards et al (2009) who suggested that professionals develop processes for knowledge sharing and pathways for practice in MDTs (Edwards et al, 2009). This will be returned to later in this chapter in Section 5.5.4.

5.5.3 Tools

The tools and artefacts used in the work of the tier 2 multidisciplinary team can be classified into four main types of knowledge/skills. These are theoretical knowledge, procedural knowledge, practical knowledge/skills, process knowledge/skills and professional knowledge and are illustrated in the thematic map in Figure 5.3 below.



Professionals seeking to promote mental health and psychological wellbeing within this multidisciplinary often drew on theoretical knowledge to inform what they did and the approach they took. This study would suggest that professionals use a range of theories and approaches (see Table 4.8 in Section 4.5.4) and which they used depended on the particular case, the situation and their own knowledge base, skills and values (see Appendices 8, 9 and 10, for examples). The latter point links with the views of Williams and Fulford (2007) that personal values are important in professional decision-making and work activity. Moreover, Edwards et al (2009) noted the understanding of one's self and professional values as an important concept

underpinning professional learning within multiprofessional teams. It also seemed to relate, in part, to Eraut's (2003) view that professionals' use of theory depended

'not only on the range of theories which they 'know and understand', or even on the range of theories they have used, but also on the range of contexts in which they have used them'. (Eraut, 2003, p63)

Edwards et al (2009) further suggested that the ability of a professional to interpret the sociocultural context of their activity, and to know when to draw on, and apply, their professional knowledge and learning are important to professional contributions and learning in MDTs. This would suggest that professionals in MDTs need to know not only what to apply and how to apply it, but also why, where, when and with whom to apply a particular theoretical approach or tool. This relates to Engestrom's (1999b) classification of tools and the idea that there are different types of tool and purposes to which these can be put.

The degree to which professionals deployed and emphasised each type of knowledge or tool appeared to depend on their professional role and training. For example, theoretical knowledge seemed to be much more a feature of EPs work (see Appendix 13vii) but less so FSWs (see Appendix 14vii). This could suggest that 'why' tools are more feature of EP work, 'what' tools being more a feature of FSWs and 'how, where, when and with whom' a feature of the work of PMHW (see Appendix 12vi). Moreover, Eraut (2003) suggested that the theories professionals use do not derive solely from empirical evidence but from the ideology of the profession itself. This also links to Edwards et al's (2009) suggestion that professional learning in

multiprofessional teams is influenced by a profession's pedagogic stance to their work. It is also consistent with Eraut's (2003) view that the personal theories of the practitioner and the culture of the profession itself influence professional practice and identity.

Edwards et al (2009) argued that professional knowledge and identities are bound up with the expectations held of them by others. They further suggest that the sociocultural view of learning does not make a distinction between what is learnt by individuals, on the one hand, from how they act in and on their world, on the other (Edwards et al, 2009). In other words, professionals both shape, and are shaped by the sociocultural context in which they work. There is a constant interaction or dialectic between an individual and their sociocultural world (Edwards et al 2009). For example, procedural knowledge appeared important in professional decision-making and supporting collaborative working in the team i.e. each professional group brought knowledge of its own agency procedures and could help parents and other professionals with this (see Table 4.8 in Section 4.5.4). The emphasis placed on procedure, and the amount and type of procedural knowledge held by each professional group varied considerably. For example, PMHWs' understanding of care pathways and CAMHS procedures was a key aspect of their role in comprehensive CAMHS (see Appendix 12vi). FSWs, however, drew on their knowledge of child protection and social care procedures (see Appendix 14vii), but EP's knowledge of SEN procedures was far less evident in a CAMHS context.

Other types of knowledge base and skills in evidence were practical knowledge and skills. As discussed earlier in this chapter, these tended to be the domain of the FSWs in the team. FSW brought practical hands on childcare, parenting and befriending skills as well as emotional support grounded in their own work and life experience. Practical skills were far less evident and emphasised in the other disciplines (see Table 4.8 in Section 4.5.4).

The next type of tool found in the team was process knowledge and skills. Process knowledge related to the practices that underpinned and supported the successful application of theory and practice including understanding and application of interpersonal and group work skills, processes to support professional practice such as consultation and professional supervision (see Table 4.8 in Section 4.5.4).

Finally, professional knowledge related to the specific areas of expertise, topics or work not found in other professional groups. In fact, the current study indicated that the areas where professions made a specific and unique contribution to the MDT were few, and far between (see Section 4.5.4). This finding appeared, in part, to be supportive of Eraut's (2003) view that a profession is best understood as an applied field rather than a discipline:

'because its rationale derives from its social purpose and not from any distinctive form of knowledge.' p62.

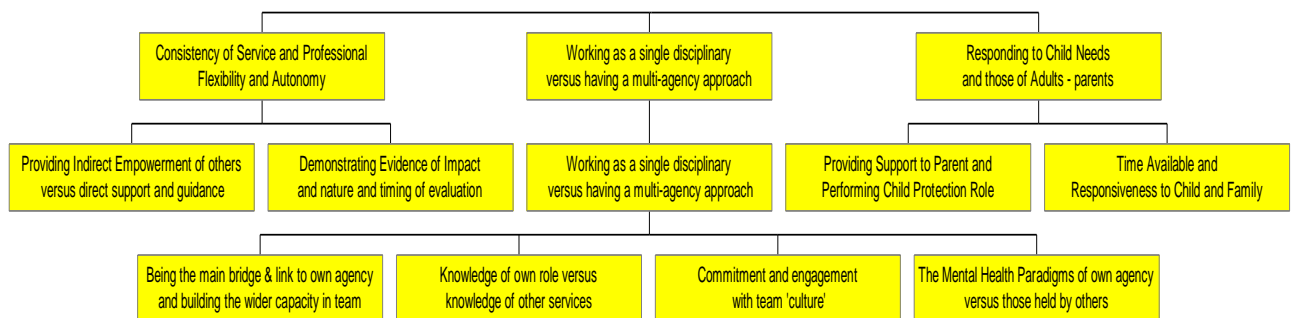
Research Question: What contradictions and opportunities for innovation exist within the activity system whose object is to promote

mental health and psychological wellbeing in children and young people through multidisciplinary teamwork?

5.5.4. Contradictions

The contradictions identified within this multidisciplinary tier 2 team's work can be categorised into three main themes. These include a rule–tool contradiction between developing a consistency of service and allowing professional flexibility and autonomy; a community –division of labour tension in working as a single discipline within a multiagency approach and finally, a tool – outcome contradiction in responding to child versus adult needs. These themes and linked sub-themes are illustrated in Figure 5.4 below.

Figure 5.4 Thematic Map of the Multidisciplinary Team Contradictions



This study highlighted a desire in team members to achieve consistency and quality standards across the whole team. However, tensions existed between the rules-tools in the MDT activity system, when considering how much professional flexibility and autonomy team members had within these service expectations and standards (see Figure 4.38 and Section 4.5.8). Indeed, some staff found the consistency of service helpful but others found it

constraining (see Section 4.5.8). There were, however, team members who appeared prepared and confident in working outside service requirements, when the child's need or situation required this (see section 4.5.8 and Appendices 8, 9, 10, for examples). For example, some in the team found a rule –tool contradiction between the required approach to evaluation and the needs of a particular case, and so chose not to apply or use the team's evaluation procedure (see Appendices 8i and 8iv, for examples). This links with the Edwards et al (2009) finding that professionals in the teams they examined were prepared to rule-bend and risk-take. As Edwards et al (2009) argued:

'professionals are knowledgeable and active decision-makers who work within existing social practices, which in turn shapes the sources of knowledge they use and possible courses of action they take in any given situation.' (Edwards et al, 2009).

The challenge for this, and other, multidisciplinary teams is how to establish a common core of principles, values and practices, whilst still supporting difference, diversity and development of new approaches. This resonates with the observations of Hymans (2006) that diversity and difference in MDTs was important to the people working within the team. How multidisciplinary teams create inclusive cultures that accept, incorporate, celebrate and use diversity and difference in professional perspectives is a key learning point from this study, and an area worthy of further exploratory research. As Eraut (2003) suggested:

'the effectiveness of a team is highly dependent on the interactions embedded in the performances of its members, which cannot be judged in isolation from each other.' (Eraut, 2003, p64).

A further rule–tool tension in the MDT's activity system appeared to be between a team expectation that direct work would be provided and the view

of some professionals that a more indirect consultative approach would be a more appropriate and effective use of their time (see Section 4.5.8). This debate echoes a similar debate in the EP profession who have considered the relative benefits of working directly with individuals by offering therapeutic approaches (MacKay, 2007), versus the adoption of an indirect consultative approach (Wagner, 2000) empowering and enabling others to own a problem and its solutions.

How much each profession worked as a single discipline versus how much they contributed to the multidisciplinary processes was another contradiction identified between community and divisions of labour within this MDT.

Underpinning the contradiction was the expectation in the MDT that each professional group would act as the principal link to its own discipline and agency (see Section 4.5.8). However, it was not clear whether this promoted or hindered wider linkage and understanding between the different professional disciplines, agencies and tiers within comprehensive CAMHS (see Section 4.5.6 and 4.5.7). For example, if EPs were the main link to other educational psychologists and education professionals this was not necessarily helping to build the skills and capacity of the other disciplines in the MDT to do work within education settings (see Section 4.2.8 and 4.5.8). This was linked to a further tool–community contradiction that a profession’s knowledge of its own role could sometimes be at odds with others’ knowledge of the role, as was found with EPs and PMHWs in this study (see Section 4.5.8). This discrepancy may relate to Eraut’s (2003) observation that professions created their own theories about their own practice. These theories may be based on empirical evidence or conceptual frameworks

peculiar to the field or simply the preferred view or ideology of the profession (Eraut, 2003). Furthermore, it relates to Edwards et al (2009) view that professional status is earned in negotiation with other professionals and service users and that professionals working in MDTs 'need to be clear about what they can contribute to local systems of distributed expertise.' (Edwards et al, 2009, p.84)

A further tension for professionals working across different teams and tiers in comprehensive CAMHS was how much to commit to and engage in work as part of the whole multidisciplinary team (see Section 4.5.8). This was, in part, due to the time constraints, and the pressure and demand created from other work and teams. However, it could also be related to Eraut's (2003) suggestion that practitioners zealously guard their personal and professional autonomy and that:

'contributions of their practice and knowledge acquired from their diverse previous contexts of work and formal training are bound to have a significant effect.' (Eraut, 2003, p.64)

A further tool–outcome contradiction was found in the team attempting to provide support for both children and their parents (see Section 4.5.8). Sometimes when doing joint work professionals divided their labours to ensure a clear demarcation of roles and responsibilities (see Section 4.5.8). This was needed in cases where professionals were providing a support for parents as well as performing a child protection role for children. At times, professionals were required to switch roles and move from support to making protection of children their paramount concern. For example, a FSW listening to a parent and offering support on the team's telephone information and advice line hears a disclosure of possible harm. This required the FSW to shift

from a support to a protection role. At other times, team members worked together to help overcome any role conflict felt, for example, by one team member offering support and the other performing a challenge role (see Section 4.2.6, for example). This relates to a key concept identified by Edwards et al (2009) as supporting professional learning in MDT, namely, a team's responsiveness to both professional and clients' needs.

The models, paradigms and explanatory frameworks used to understand mental health concerns within, and between, professions was the final contradiction identified (see Section 4.5.8). A tool–community tension was found between those in comprehensive CAMHS drawing on the medical – diagnostic paradigm and the psychosocial paradigm used, in particular, by EPs and social care professionals in the tier 2 team (see Figure 4.38). This links and relates to the ideas of Anning et al (2006) who observed that:

‘the existence of internal variations in explanatory models suggests there are dilemmas for our teams in achieving cohesion, through negotiated shared practice models, while at the same time embracing and celebrating complexity and diversity.’ P.59

Anning et al (2006) further argued that multiprofessional teams ‘socially construct’ problems and interventions through a particular combination of professional perspectives or ‘gazes’ and that sharing expertise was often required in the work of multidisciplinary teams.

Research Question: What professional learning comes from a collaborative sociocultural activity theory analysis of multidisciplinary teamwork aimed at promoting psychological wellbeing in children and young people?

5.6. Professional Learning within multidisciplinary teams

This aspect of discussion considers three levels of professional learning generated by this study. First, it considers the learning stimulated by the activity theory analysis of an aspect of individual professional's activity, where its object was to promote mental health and psychological wellbeing in children. Second, it discusses the learning stimulated in professional groups through group work within a DWR session. Finally, it reflects on the learning that was stimulated by a DWR session with the whole multidisciplinary team and the ongoing work planned for the team.

5.6.1. Professional Learning within Individual Interviews

Figure 5.5 Thematic Map of Professional Learning in Phase 1

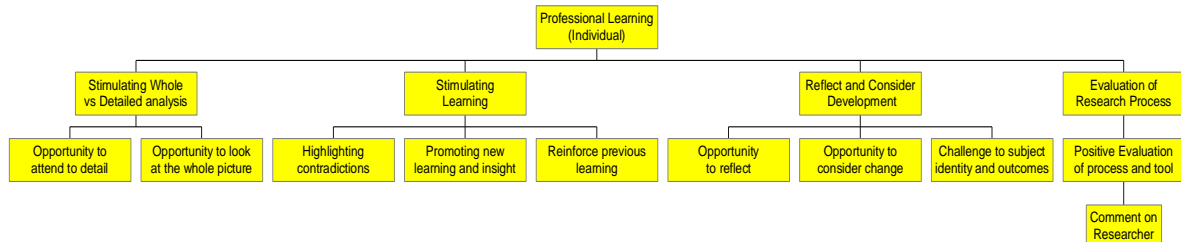


Figure 5.5 shows a thematic analysis of participants' comments on what mediated their learning during individual activity theory interviews and analysis with professionals. Participants' responses suggested four main ways in which an individual activity theory analysis stimulated their learning (see Section 4.6.1 and Appendix 7i.).

Firstly, participants found that the approach created new learning and insight by highlighting contradictions and, in some cases, by reinforcing previous 'tacit' knowledge or informal learning (see Appendix 7i, for examples). The

former supports Engestrom's (1999b) contention that it is the contradictions in an activity that promote learning actions and potentially expansive learning activity in individuals as well as workgroups. Furthermore, it supports Edwards et al's (2009) argument that helping professionals to examine the contradictions in their work can provide a way of stimulating 'expansive' learning and development of the work and practice within multiagency teams. The latter point also relates to the observations of Eraut (2003) who found that informal learning in the workplace was important in promoting professional development and that much of what professional's learn and apply in practice is 'tacit' knowledge.

Secondly, using an activity theory analysis with individuals appeared to allow these professionals to consider an activity in both a detailed and holistic way (see Section 4.6.1). It also offered some professionals opportunity to verbalise, reflect on their role and practice, and to consider what changes they could make. All participants were universally agreed that the application of the activity theory framework was a useful process and helpful in supporting their professional development and learning. Moreover, they emphasised the value of the activity theory triangle as a tool to support both their own and service development (see Appendix 7i). This fits with the Edwards et al (2009) contention that in sociocultural learning there is a constant interaction or dialectic between an individual and their activity and that individuals both shape, and are shaped by the world.

Finally, participants also observed that the process used and the researcher's mediation supported their reflection and learning (see Section 4.6.1). Indeed,

it was interesting to note that when the process did not involve the presence of the researcher, for example when feedback was offered remotely via e-mail (see Appendix 5 for example and Appendix 7iii for all other responses), this created problems in relation to the researcher being able to:

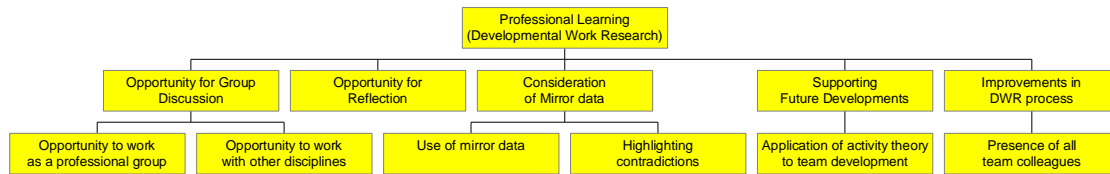
1. mediate the analysis offered; and
2. obtaining further comment from participants about the learning that came from the process.

This links with an observation made in a previous study by Durbin (2007) that activity theory can provide a useful framework to support an in-depth analysis and understanding of an aspect of practice by an individual professional within a supervision or appraisal process. It further suggests that the skills of the activity theory research-practitioner are important in mediating this analysis, and supporting successful outcomes for professional learning and development.

5.6.2. Professional Learning in Developmental Work Research

The feedback on professional learning received from participants in Phase 3 of the project, which involved Developmental Work Research with professional and multiprofessional groups, can be summarised under three main themes or aspects of the professional learning. These are illustrated in Figure 5.6 below. See Appendix 7ii for the data linked to these themes.

Figure 5.6 Thematic Map of Professional Learning in Developmental Work Research Session



The principal themes identified indicated that the DWR provided:

- an opportunity for group discussion and reflection, including an opportunity to work as a professional group and MDT;
- an opportunity to consider and learn from the mirror data presented including the contradictions highlighted; and
- the value of the DWR process and the use of the activity theory methodology in supporting future team development.

A fourth theme commented on how the researcher could improve the process, and the inclusiveness of, and participation in, future DWR sessions.

These findings support Engestrom's (1999b) contention that DWR sessions provide work groups with opportunity to discuss and reflect on their work group activity. In particular, by having a 'metaphorical' mirror held up to their work and an opportunity to work on the contradictions highlighted as a way of stimulating potentially expansive learning activity in individuals, groups and the whole service. Moreover, it seems to support Engestrom's (1999b) view that expansive learning activity may be stimulated in individuals and work groups by surfacing and working on inner contradictions within activity systems. The DWR session encouraged participants to consider the ways the team could develop. Indeed, the multidisciplinary team used the activity theory approach to do further work on some of the key MDT objects identified in this study, such as the team's direct work (see Figure 4.47), the team's training

activity (see Figure 4.45) and team meetings (see Figure 4.46). This suggested that some learning actions and some potentially expansive learning activity had taken place.

The criticisms offered by participants of the DWR were that it could have:

- provided more detail on the method of analysis used;
- given more time for discussion of individual analyses;
- adopted a more 'positive' approach; and
- included all team members (some team members were absent due other work commitments).

It should be said that these views represented a minority of participants but nevertheless it led the researcher to review the initial analysis and to undertake a more detailed analysis of the activity triangles. This detailed analysis, summarised earlier in the thesis in Figure 4.38, has provided the raw material and stimuli for the researcher's ongoing work with the team.

A further interesting observation came from a FSW who mentioned in passing that some team members had interpreted the approach as having a 'negative' tone rather than the 'positive' solution-orientated approach, which was more keeping with the team's ethos. This may have been misunderstanding of the process or the researcher's explanation of the approach. However, a few participants and team members found examining the contradictions a challenging experience. It should be said that this was not the view of the majority but it was clear that some in the team were seeking to build a 'community of practice' through participation and reification in line with the

ideas of Wenger (1998) drawing on the team's solution orientated approach. Others, however, saw the value in examining contradictions as a way of stimulating development and expansive learning activity in the team, in line with Engestrom's theories (1987, 1999b). This relates to the finding by Anning et al (2006), discussed earlier, about how practice is shared and developed in teams. It is also consistent with the view that all teams carry the sociocultural histories of both the individual workers and the institution of which they are a part (Anning et al, 2006).

5.6.3 Evidence of expansive learning activity?

As highlighted in Chapter 3, Engestrom (2000) suggested that there are four dimensions by which an object and therefore activity system can be considered to have expanded. These are across socio-spatial, anticipatory-temporal, moral-ideological and systemic-developmental dimensions. He further highlights some key questions that could be used to indicate whether expansion has occurred on these dimensions or not. These are the:

- Socio-spatial dimension – i.e. 'Who else should be included?'
- Anticipatory-temporal dimension – i.e. 'What previous and forthcoming steps should be considered?'
- Moral-ideological dimension – i.e. who is responsible and who decides?
- Systemic – developmental dimension – i.e. How does this shape the future activity?

This section of the thesis discusses and considers these dimensions, drawing on data collected at each of the phase of the research as illustrative examples. It should be stated that the evidence considered here is drawn from a case study and as such has limitations in its transferability to other

localities and research of this kind. Nevertheless, the researcher aimed to consider whether there was any evidence of potential expansive learning activity stemming from the work with the multidisciplinary team.

5.6.3.1 Socio-spatial dimension.

Engestrom (2000) suggested that the key question in considering whether an object and activity system had expanded within the socio-spatial dimension was 'Who else could be included?' For example, at an individual professional level, a team manager considered who else might support the development of the team through their participation and contribution to the team's steering group. This, in turn, led to a consideration of the wider purpose of the team (see section 4.6.1.1. and Appendix 10iv). Moreover, at the professional group level, the educational psychology group described how they were actively considering including other professions in aspects of their work aimed at promoting wellbeing in children (see Section 4.6.2.3 and Appendix 6iv). Furthermore, FSWs reflected on the need to include the team's support staff in the objects and activity of the team (see Section 4.6.2.2, Table 4.15). In addition, at the whole team level, the team actively considered, during the DWR, who else might contribute to; for example, First Response visits (see Section 4.6.3.1). These examples provide some illustrative evidence of expansion of individual professional, professional groups and multidisciplinary team's object within the socio-spatial dimension.

5.6.3.2 Anticipatory-temporal dimension

Engestrom (2000) suggests that the key question in the anticipatory-temporal dimension is; what previous and forthcoming steps should be considered?

Again, there are some illustrative examples of individuals reviewing and questioning the steps involved in their activity. For example, a member of the EP group involved in multidisciplinary group in a school on domestic violence began to reflect on the multidisciplinary nature of the work (see Appendix 10v). She reflected on how the planning and development phase of the work was collaborative and joint, but that the implementation and reporting stage was very much more individual and independent. This led her, drawing on a division of labour –community contradiction, to reflect on the previous steps of her involvement and to use these as a basis for planning her future engagement with an activity and object of this kind. For example, she noted that her knowledge and skills of working with schools had not been fully used, and that she had not participated in reporting the evaluation of the project. As the project work was ongoing, it led her to consider how she might take the learning from her previous activity into current and future contribution to the project work i.e. by seeking to share her knowledge and skills of work in future planning, delivery and evaluation of the work. (see Appendix 10v)

At the professional group level, the FSW group reflected on whether its previous activity had led the team to have a shared vision. In particular, they reflected on the need to revisit the business plan and to use this as a basis to reconsider the team's core business and what it might offer in the future (see Section 4.6.2.2, Table 4.15).

As far as work at the whole team level is concerned. The team made the following observations following its developmental work research session (see Appendix 6v):

- 'The session has highlighted lots of thoughts and areas for consideration.
- The team needs to think how to take forward these.
- How to enable the team to have time to share perspectives and come to a shared understanding?
- It is helpful share and to look at similarities and differences.
- Further work is required on individual and team roles including role definition and boundary' (see Appendix 6v).

This suggests that, after reflecting on its previous activity system, the team was considering what further steps it might take to change its object and activity system and, in particular, individual and team role definitions and boundaries and creating opportunity for the team to work on these issues.

5.6.3.2. Moral-ideological dimension

In the moral-ideological dimension Engestrom (2000) considers the key question is: Who is responsible and who decides? In phase 2 of the project, questions of responsibility and decision making within individual professional activity systems were highlighted by a tool-rule contradiction between professional autonomy and consistency of service. In particular, the extent to which professionals had flexibility, and could use their own professional discretion, to make decisions and determine their actions. For example, a FSW observed that, whilst it was a team expectation that certain forms of initial assessment and evaluation should take place, she needed to have the freedom to decide what was suited to a particular case (see Section 4.4.8 and Appendix 8i, for example). Moreover, a similar tension was found within other rule-tool contradictions, such as the team requirement for direct work and a short time-limited intervention, when FSWs felt they needed to take

responsibility for decisions affecting the length and type of intervention used (see Section 4.4.8). FSWs indicated that they wanted responsibility to decide what was in the best interests of children and families they were supporting (see Section 4.4.8; Appendices 8i to 8xi).

There was also some evidence within the whole team activity system, that the contradiction identified between consistency of service and professional autonomy was important to the ongoing development and expansion of multidisciplinary team's object and activity system (see Section 4.5.8, Figure 4.38 and Table 4.12).

5.6.3.4 Systemic–developmental dimension

The key question Engestrom (2000) suggests for systemic-developmental dimension is: How does this shape the future activity? This is particularly evident in PMHWs discussion of their activity system (see Section 4.6.2.1: Table 4.14). Here PMHWs are observed actively considering how the contradictions identified might be addressed and worked on in the future by the group and team. For example, they actively consider how they could develop their object to include greater participation and involvement in team training activity. They pose the question:

‘How do we ‘cross the divide’ and have a PMHT involvement in tier 2 team activities when the PMHT capacity of the team increases’

They are also observed actively questioning how they might develop their pivotal role linking tier 2 and 3 CAMH services. They state:

‘How can we join tier 2 team and specialist CAMHS up to feel more of a whole team/service?’

At the whole team level, the team was observed considering how the activity theory analysis and developmental work research might inform their future activity and object . For example, at the end of the DWR (see Appendix 6v) the team concluded that:

‘Further work is required on individual and team roles including role definition and boundary’

Finally, a multidisciplinary group when reviewing the team’s activity system (see Section 4.6.3) observed that there was a need for the team to review its vision and business plan, which suggests the team was considering a review of the core objects and activity of the team. This illustrates how the multidisciplinary team was considering the shape of its future activity and considering an expansion of its object across the systemic-developmental dimension.

5.6.4 Summary of section.

The above examples illustrate how individual professional, professional group and multidisciplinary team activity systems and objects appeared to be expanded across Engestrom (2000) socio-spatial, anticipatory-temporal, moral-ideological and systemic-developmental dimensions. The examples provide further illustrative evidence of learning actions and potentially expansive learning activity at the level of the individual professional, professional group and multidisciplinary team activity system. Nevertheless, it should be noted that Engestrom’s (2000) dimensions were not evident and identified in all data sets. This is consistent with Engestrom and Sannino (in

press) observation that expansive learning is not easily identified or achieved, and that a sustained involvement with a work group is often required.

5.7. Methodological considerations and learning

The British Psychological Society (2009) provides some helpful pointers in relation evaluating the use of qualitative research. It suggests that it is important to consider the research reflexively, as well as the transferability and the utility of the findings. A research log (see Appendices 4 and 5iii, for examples) was kept throughout the study by the researcher to support a reflexive analysis of the research and to highlight any learning that came from the process. This highlighted a number of methodological issues and learning points that came from applying the activity theory approach. These indicate that sociocultural activity theory offered:

- a mediated process between the researcher and the researched;
- a dynamic rather than static process in which the activity systems of participants changed during the research;
- an intervention and a way of promoting learning at individual, group and whole team level; and finally
- an opportunity to look at professional activity in both a detailed and holistic way.

5.7.1 SCAT research: A mediated process

It was apparent from the outset that the individual interview using a sociocultural activity theory was not a passive but dynamic process. It involved a mediated discussion in which the researcher supported the researched in obtaining insight and understanding of their activity system (see Appendix 3, for an example). The researcher used the activity triangle and

research skills as tools to facilitate the participants' understanding and learning from the activity. It was further evident that alongside the framework and research tools used, the activity researcher's interview, questioning and facilitation skills, were important to the outcome of the discussion. This led the researcher to reflect on the mediation they used through questioning, summarising, paraphrasing and probing the professional's work as a way of highlighting any contradictions and stimulating expansive learning.

The researcher took care to ensure they questioned, prompted and probed in ways that facilitated reflection in the researched and used a process which combined the skills and knowledge base of the researcher with those of the researched. The tools used by the researcher in this study were imbued with the cultural and historical tradition of the activity theory research. In sociocultural activity theory research, it is the researcher who uses their knowledge of activity theory, and the researched that offer knowledge and experience of their work activity and practice. The approach used therefore assumes that those experienced in the culture and tradition of sociocultural activity theory use it as a tool to mediate the learning of those new to the process. Furthermore, it is the interaction between the two that mediates and contributes to the object and outcome achieved. In other words, all those involved in the research both shaped, and were shaped by it.

In activity theory research it appeared that the skills, knowledge and experiences of the researcher as a mediator were as important as the other tools used. It should therefore be acknowledged that the researcher as an educational psychology practitioner had a range of professional experiences

and personal interests that may have influenced outcomes of this research. The researcher was aware of this possibility and attempted to work against it by ensuring that data was owned and checked by participants, to confirm the accuracy of the researcher's analysis and interpretation. However, the researcher acknowledges that in mediating professionals' reflections and analysis he was drawing on his own knowledge and experience in other local authority and CAMHS activity systems as tools to mediate and support professional learning.

5.7.2. SCAT as an intervention

At one point in the process it became evident that the research was itself a dynamic intervention. It seemed that the SCAT approach facilitated change and the ongoing development of the team whilst the research was taking place. Indeed, this relates to Leadbetter (2005) description of the approach as an 'interventionist' methodology. Following the individual interviews it became apparent that changes had been made or occurred in individual, team and service practice. For example, one contradiction highlighted in discussion with a service manager led to a reconsideration of the composition of the steering group and the need to have a specialist CAMHS tier 3 presence. The approach appeared to facilitate an action-orientated and emancipatory approach amongst its participants.

This fits with the dialectic philosophy underpinning the approach and the suggestion that participants both shape the research and are shaped by the research activity. Indeed, the links and relationship between action research and sociocultural activity theory were highlighted by Edwards (2000), who

suggested that the SCAT approach placed professional action within its sociocultural and historical context, increasing the likelihood that any change or intervention being sustained. Edwards (2000) observed that

‘Systemic analyses are not seeking equilibrium. Instead, the contradictions and turbulence identified within the systems are characterised as points of systemic adaptation and expansive learning. As part of the process of expansive learning the analysis is fed back to participants in the system so that they might interrogate the evidence, and ultimately seek and test alternative ways of operating.’ (Edwards, 2000, p.201)

This, of course, creates a challenge for the researcher in researching and reporting on a dynamic and constantly changing activity system.

5.7.3. SCAT: A multilevel and multi-layered approach

The focus of this research was human activity and its sociocultural context. However, those interviewed often shared their thoughts, feelings and interpretations of the activity system based on their previous cultural and historical experiences. This relates to criticisms offered by Toomela (2000) and Roth (2007) who suggested the SCAT approach didn’t take sufficient account of thoughts and feelings. However, as Engestrom (1987) argued sociocultural activity theory (SCAT) provides a means by which the interaction between the individual (with all their thoughts, feelings, behaviours and constructs) and society (with its dynamic social, cultural and historical features) can be understood. In the current study SCAT supported the analysis of individual perspectives within a multidisciplinary activity system whose object was to promote the mental health and psychological wellbeing in children and young people. This enabled both individual, group and team perspectives on the activity system to be considered and worked on. As Edwards (2000) pointed out:

‘SCAT research is multilayered and consciously weaves together relationships between culture, mind and action ...knowledge is accordingly constructed dialectally in interaction with cultural tools that mediate the knowledge in use in that community.’ (Edwards, 2000, p.198).

5.7.4. SCAT: A holistic and detailed approach

One potential criticism that might be offered of some of the research undertaken by activity theorists is that it doesn’t always make the processes of analysis and interpretation explicit. As Daniels (2007) suggests an effective ‘language of description’ is yet to be found by those applying the approach. Indeed, the author found few papers that gave a detailed outline of the methodology and analysis used. This makes verification of findings and assessing their empirical basis challenging and problematic. In an attempt to overcome this as a potential criticism the researcher has undertaken and provided details of the steps of analysis used in this study.

There was a significant challenge for the researcher in undertaking such ambitious research and analysis alone in terms of time, capacity and ensuring alternative professional perspectives on the work were considered. Time and capacity issues, and the ambitious nature of the research remained a constant challenge. Indeed, many of the projects using this approach involve multidisciplinary teams of researchers. There was a particular challenge for the researcher in running the DWR alone. As Edwards et al (2009) argued, DWR provides:

‘an interventionist methodology where researchers work with research participants to reveal contradictions and to promote the use of the tools of activity theory to enable practitioners to work on the contradictions. (p.174).

Unfortunately, a lone researcher could not be involved in facilitating or mediating the discussion of each professional group in the study, as these were run simultaneously. The discussions were therefore, by necessity, facilitated by the professional leaders of each group using a semi-structured process provided by the researcher. The process and outcomes were, therefore, in part dependent on the professional group leader's knowledge of the process, their skills of mediation and recording of the outcomes. The power differential between the professional leader and those they manage may also have had some influence on the outcome. Some of the richness of the data may also have been lost in this process. The researcher tried to work against this by providing a semi-structured process, visiting each group to take any questions about the process and supporting the discussion when necessary. The process did, however, allow each group to own the activity theory analysis generated and to have unfettered discussion about the interpretation offered by the researcher (see Table 4.14, Table 4.15 and Appendix 6iv, for outcomes of these discussions).

That said, the DWR session led the researcher to reflect on whether the initial analysis of the data had actually captured the full sociocultural picture of the team's activity. Indeed, one participant asked what steps had been used in the analysis. The researcher, therefore, undertook a further process of analysis to create specific links between the data extracts taken from individuals to the professional group themes. Professional group themes were then grouped to create the overall MDT themes as outlined in Chapter 4 of this thesis.

These steps provided further detailed analysis and verification of the interpretation and findings made. However, there was also a risk that the

more detailed but in-depth analysis used could lose some of the richness and dialectical nature of the data by breaking it down into different parts of the each activity system and then to specific data extracts. The researcher attempted to overcome this possibility by bringing the parts of the more detailed analysis back into a holistic form of the final activity triangle for each professional group and the whole team, and then by sharing this with the service. The benefits of this approach were that it provided a rigorous and detailed analysis of all elements of the activity triangle. It also more explicitly linked individual's data to group and team themes and provided an audit trail of the analysis and interpretation made.

5.7.5. SCAT: A collaborative or contradictory process

As discussed earlier some participants felt a little discomfort or threat when considering contradictions in the DWR and at other stages of the research process. Consideration of contradictions created a certain degree of 'turbulence' in individuals and professional groups. It appeared that these participants preferred a positive and solution-focused orientated approach, based on professionals working together and sharing practice through a collaborative process. This led the researcher to reflect on whether some staff or professional groups were feeling threatened or insecure in the process or whether the researcher's perceived power, position and status as an educational psychology practitioner and trainer was influencing this outcome. The researcher worked hard to avoid any perceived power differentials and political influences on the research. However, it could be that the researcher's relationship with one profession in the study and the managers of the team may have influenced participant engagement and perceptions of the process

and its outcomes. This observation possibly relates to criticisms offered of the SCAT approach by Avis (2007) who suggested that activity theory approach gives insufficient recognition of the socio-economic and political context in which an activity takes place. That said, most participants did find that exploration of contradictions supported their reflection, learning and development and as Cole et al (1997) observed.

‘Contradictions are the engine of change and development in an activity system as well as a source of conflict and stress.’ (p5).

5.8. Overview of chapter

This chapter has discussed the contribution that each professional group and the multidisciplinary team make to the promotion of mental health and psychological wellbeing in children and young people. It has further considered the sociocultural processes that mediate the contributions within the related activity systems and contradictions found within. It also discussed the professional and methodological learning that occurred as a result of the research process. Each of these will be summarised in detail in the conclusions that follow.

CHAPTER 6 CONCLUSIONS

6.1. Overview of chapter

This chapter summarises the main findings of the research outlined in Chapter 4 and considers the original contribution to knowledge the research makes. In doing so it attempts to answer the principal research questions set for this

study. Each question is taken in turn, summarising and briefly discussing the study's main findings. Finally, the thesis concludes with consideration of the implications of this study for multidisciplinary work and future research of this kind.

Research Question: What do professionals contribute to promoting mental health and psychological wellbeing in children and young people when working within a multidisciplinary team?

6.2. Summary of main findings

6.3. EP contributions

As highlighted and discussed in Chapters 4 and 5, this study suggests that the EP contribution to promoting mental health and psychological wellbeing appears to be mediated by EP use of theoretical knowledge and process skills. The research further indicated that the awareness and application of psychosocial models of child mental health are another potentially important part of an EPs' contribution, and mediates their work in multidisciplinary teams (see Section 4.2.8). Furthermore, these tools supports their work in family and community contexts and may enable them to question the predominant medical-diagnostic model used in these settings (see Tew, 2005). Moreover, EPs use tools such as collaborative consultation help them to consider not only the needs of a child but also the system around the child, and to support and challenge this system where necessary. EPs use of a psychosocial model of mental health may also help them to question the assumptions of those holding an alternative view in the team and wider community, in line with the suggestion of Tew (2005) discussed in Chapter 2. The study further indicated

that the rules that support or constrain EP work includes those created by EP time allocation and work in school contexts (see Section 4.2.5). Despite this, the division of labour between EPs and others in the multidisciplinary team suggested that EPs are still viewed as 'school' orientated practitioners working on educational issues (see Section 4.2.4 and 4.2.6), rather than the 'community' psychology practitioners to which some in the profession aspire (see for example, MacKay, 2007 Stringer et al, 2006).

Finally, the study identified a number of contradictions from which learning actions and some potentially expansive learning activity could take place for the EP group involved in this research and possibly for the wider profession (see Section 4.2.8). These include:

- 1) a tool –community contradiction between EPs use of psychosocial perspectives of mental health and other professionals use of medical diagnostic perspectives and paradigms;
- 2) a community –division of labour contradiction between EPs seeking to maintain and develop their own distinctive contribution, whilst also working collaboratively with, and alongside, others in a multidisciplinary team context;
- 3) a tool –community tension exists in ensuring clarity in the EP role, at the same time as promoting its wider contribution to promoting mental health and psychological wellbeing across a variety of community settings; and finally
- 4) a community –division of labour contradiction was identified stemming from differences in the understanding of the EP role by the profession and other people. This highlights the importance of the profession pursuing a

discussion about the EP role beyond the profession itself with those EPs work with, and for, in community settings. It also highlights the importance of EPs negotiating a contribution that is meaningful not only to the profession but also those they seek to serve.

Further exploration and examination of these contradictions may help to ensure that EPs' future contribution to the promotion of mental health and psychological wellbeing of children and young people in family and community settings is properly understood, complements what other professionals offer and is effective in supporting positive outcomes.

6.4. PMHW Contributions

The PMHW role was created to help make specialist mental health knowledge available at an early stage within comprehensive CAMHS and to facilitate communication between tiers 1, 2 and 3. This study found that whilst this certainly was the case for PMHWs and other health colleagues, the wider linkage and collaboration envisaged between other professionals within the comprehensive CAMHS community has been more difficult to achieve (see Section 4.3.5 and 4.3.6). This study suggests that work at the interface between tiers cannot depend on the efforts of the PMHW professional group alone (see Section 4.3.8). Other professionals need to be encouraged to work at the interface and across the boundaries between different professional groups, tiers and services.

The study further indicates that PMHWs have a key role to play in assessing the mental health needs of children and associated risks and advising on

evidence-based interventions and provision for children with mental health needs (see Section 4.3.7). However due to time, resource and service constraints the PMHW role in this study didn't appear to include a significant amount of direct work, as envisaged by Gale and Vostanis (2003). Opportunities for joint work with other professional groups were also restricted. A considerable amount of the PMHWs' contribution appeared to be focused on assessing and determining the level of need, and facilitating access to appropriate support, at tier 1, 2 or 3, through gate-keeping and sign-posting to services, and in liaising with other professionals (see Section 4.3.5 and 4.3.6). PMHWs' opportunities to undertake direct and joint work are areas that warrant further discussion within the PMHW professional group, multidisciplinary team and wider community.

A number of contradictions were highlighted within and between the activity systems in which PMHWs work. In particular, a tension was found between the rules – divisions of labour in that the criteria and procedures needed to access one service did not always correspond or link with others. Criteria set did not always facilitate the smooth transfer of cases and responsibilities between PMHWs and other specialist CAMHS services, such as might be expected within a co-ordinated care pathway (see Section 4.3.8). This finding suggests that further development work would be beneficial with those responsible for, and working at, the boundary between the tier 2 and tier 3 CAMHS activity systems. This would also allow further exploration of the division of labour between PMHWs and other professionals working at the interface between tier 2 and tier 3 CAMHS communities.

6.5 FSW Contributions

This study found that the FSWs' contribution to promoting mental health and psychological wellbeing appeared to be mediated by their practical skills, knowledge of parenting and experience of childcare and behaviour management. A particularly strong feature of the tools used by FSWs was in providing emotional support, befriending and supporting parents to improve their skills (see Section 4.4.7). This is in line with the findings of Gray (2002, 2008), Walker (2003) and Vostanis et al (2006) all of whom found that FSWs made a significant contribution to parent and family support, across a range of different localities and settings.

FSWs in the present study also appeared to be supported in their role by the use of team protocols and procedures (see Section 4.4.4). They also appeared to benefit from learning skills and knowledge from the other disciplines in the team. Other studies indicate that FSWs often implement interventions they have learnt from other disciplines very successfully and effectively. For example, Vostanis et al (2006) indicated that community FSWs support for parents using solution focused methods was more effective at improving parenting skills than the support provided by specialist CAMHS services.

A contradiction found between the tools and outcomes in FSWs' activity systems included attempting to ensure the child protection needs of children were met at the same time as providing emotional support to parents. FSW were challenged by the need to build relationships and offer emotional support to parents, in the ways outlined by Gray (2002), at the same time as ensuring

that parents were fully aware of the paramount importance given to child protection (see Section 4.4.8).

A further community–division of labour contradiction was highlighted in FSWs' collaboration with other professionals, where the criteria and availability of these professionals and services hindered joint working, effective case supervision and professional support (see Section 4.4.8). This relates to the earlier observations about the time constraints on these professions, differences in referral procedures and criteria and differences in understanding of each other's roles (see Section 4.2.8 and 4.3.8). This suggests that further development work with the FSW group and other professionals in the multidisciplinary team is required to support improved understanding of each profession's role, improve the co-ordination of care pathways and to ensure FSWs access appropriate supervision and support as, and when, it is required.

Finally a significant contradiction was found between tools and rules in FSWs' activity system, FSWs appeared to rely on procedural knowledge as a tool (see Section 4.4.7), but they also sought room for greater professional autonomy and flexibility in their work with individual families (see Section 4.4.7). FSWs seemed to desire greater professional freedom in making judgements about particular cases (see Section 4.4.8). They wanted to rule bend and rule break in the ways that they considered beneficial to the case and family. This relates to the findings of Anning et al (2006) and Edwards et al (2009) that suggested that risk taking and rule bending in the best interests of children and families supported professional learning in multidisciplinary

teams. However, the tool-rule contradiction between wanting professional autonomy and having consistency in service delivery was a particularly strong feature of FSWs' activity systems (see Section 4.4.8). This contradiction would benefit from further exploratory work with the FSW group and wider team, to see if expansive learning can be generated for the professional group and the team.

Research Question: What professional learning comes from a collaborative sociocultural activity theory analysis of multidisciplinary teamwork aimed at promoting psychological wellbeing in children and young people?

6.6 Professional learning

Responses from participants in this study outlined earlier in Section 4.6.1 suggest four main ways in which an individual activity theory analysis stimulated expansive learning in the professionals involved. Firstly, they indicated that the approach stimulated new learning and insight through highlighting contradictions or by reinforcing prior knowledge and learning. Secondly, the approach appeared to support professionals to consider an activity holistically, at the same time as facilitating detailed analysis of aspects of the activity. Thirdly, it offered some professionals opportunity to verbalise, reflect on their role and consider what changes they wanted to make to their practice. Finally, all participants were agreed that the application of the activity theory framework to an aspect of their work was a useful professional development experience. Moreover, they emphasised the value of activity theory triangle, the processes used and the researcher's questioning in supporting their reflection and learning (see Section 4.6.1).

Finally, responses from participants in this study, outlined previously in Section 4.6.2, suggest that Developmental Work Research (DWR) provided them with the opportunity:

- to have professional group discussion and reflection both as a single discipline and a MDT;
- to consider and learn from the mirror data presented and the contradictions highlighted; and
- to consider the use of DWR in supporting future team development and the application of the activity theory methodology to other team and service development activities.

6.7. Methodological Learning

As far as the researcher can ascertain, this study represents the first attempt to undertake an activity theory analysis of a tier 2 community CAMHS team whose object was to promote mental health and psychological wellbeing in children and young people in family and community settings. The methods of data collection and analysis used in this research also provide an original way of applying sociocultural activity theory approach to multidisciplinary tier 2 CAMHS work.

Furthermore, the research addresses one of the potential criticism of this and other studies is the lack of specific procedures in the activity theory approach (Murphy and Rodriguez-Manazares, 2008) and therefore the methods of data collection and analysis may not always be made clear and explicit . This study attempted to overcome this by offering a detailed outline of the methodology,

and analysis used. However, the researcher's analysis could be criticised for breaking the activity systems down into their different parts, and in separating each element from its sociocultural context. This might also have hindered the consideration of the dialectic relationship between the different elements of the activity system. The researcher attempted to work against this by moving from the whole activity system to its parts and then back again, building the data up into a holistic view of the activity system.

Drawing out the key themes from the analysis using a process of data collection, reduction, display and conclusion drawing/verifying as recommended by Miles and Huberman (1994) also supported a detailed sociocultural analysis of professional and team activity. However, inevitably it also meant that some of the detail and richness of the activity system was lost in the process. Nevertheless, the size and complexity of the data set collected and the detailed analysis undertaken allowed a thorough sociocultural activity theory analyses of each professional group and multidisciplinary team's work to be made. Indeed, the challenge for this, and other studies, using detailed analysis of activity systems, is how to ensure they continue to show fidelity to the sociocultural activity theory approach, at each stage of the analysis and research process. As Daniels (2007) suggested those using activity theory in research need to ensure that the language of description and approaches used are compatible with the underpinning principles of the activity theoretical approach.

6.8. Multidisciplinary team contribution

To conclude, this research suggests that this tier 2 MDT strive to ensure that children and families access and receive appropriate and timely support matched to their particular needs. Moreover, the MDT seeks to build parent and professional knowledge, skills and confidence and their capacity to meet children's mental health needs. The MDT underpins these aims by the use of internal team processes and procedures to ensure the consistency and quality of services it provides (see Section 4.5.3).

This study further indicates that the rules that constrained the MDT include finance and resource limitations, legislative and professional codes and service criteria and care pathways, which were not always co-ordinated. However, it further suggests that the MDT's activity was supported by the use of collaborative processes and procedures within the team (see Section 4.5.5)

This research also suggests that professionals within the team used different types of knowledge as tools to mediate their work in promoting mental health and psychological wellbeing in children and young people. These knowledge-based tools included theoretical knowledge, procedural knowledge, practical and experiential knowledge, process knowledge and professional knowledge. These different knowledge bases were not unique to one profession. However, each profession appeared to place different emphases on them as tools to mediate their work. Practical skills and experiential knowledge appeared to be a key aspect of a FSW work within the MDT. Process skills and procedural knowledge in CAMHS seemed to be an important feature of

the tools that PMHW brought to the team and theoretical knowledge appeared to be more apparent as a tool in the work of EPs (see Section 4.5.4).

The significant contradictions highlighted in the multidisciplinary team activity system in this study (see Section 4.5.8) were between:

- tools and rules in achieving service consistency and allowing professional flexibility and autonomy;
- community and divisions of labour in allowing work as a single discipline within a multiagency approach; and
- tools and outcomes when responding to the needs of children, and supporting adults and organisations.

Each of these, and the other contradictions highlighted, is worthy of further Developmental Work Research (DWR) with the multidisciplinary team. Indeed, further work was commissioned to take forward the learning that came from this research with the multidisciplinary team concerned. This allowed further consideration of the contradictions highlighted and created further opportunity and potential for expansive learning activity within the MDT activity system, whose object is to promote the mental health and psychological wellbeing of children and young people in family and community settings.

Finally, this study highlighted the benefits of using sociocultural activity theory analysis as a way of promoting expansive learning in individual professionals, professional groups and a multidisciplinary team. It is hoped that the expansive learning activities generated in this research can be taken forward by its participants, the researcher, the commissioners and others into other activity systems.

“Opening up possibilities for changing work practices within the context that the system is operating in.” (Engestrom, 1987, p.24-25).

6.9. Overview of original contribution to knowledge.

This study contributes to knowledge and research in the following ways.

Firstly, it represents a unique application of Sociocultural Activity Theory (SCAT) to a tier 2 multidisciplinary team whose aim is to promote mental health and psychological wellbeing in children and young people.

Secondly, it offers an in-depth analysis of a multidisciplinary team activity system by drawing together the individual analysis of twenty-five professionals' activity systems into the collective activity system for each professional group and the multidisciplinary team. Thirdly, it employs a comprehensive use of qualitative data collection methods and analysis within the SCAT approach, in order to create a rich description of the activity systems of each professional group and multidisciplinary team. Fourthly, through the application of the SCAT approach it has identified a number of exploratory findings in respect of the objects, tools, outcomes, rules, community and divisions of labour for individual professionals, professional groups and the full tier 2 multidisciplinary team activity systems. Finally, the research highlighted a number of dilemmas or double binds within these activity systems; which were taken to be indications or manifestations of the inner contradictions in the activity systems of individual professionals, professional groups and the multidisciplinary team. The contradictions were highlighted and used as a way of transforming the activity systems of the individual professionals, professional groups and multidisciplinary team involved in this study.

The findings of this research are particularly relevant to the multidisciplinary team and local context in which the study took place. However, it is hoped that the detailed outline of the research and its findings provided within this thesis, allows other researchers and practitioners to consider its applicability to their own context and multidisciplinary settings. Further research of this kind is needed in a range of other CAMHS and multidisciplinary settings to see if the exploratory findings, emergent themes and learning generated in this study can be replicated elsewhere

In conclusion, this study represents a novel and comprehensive application of SCAT approach to a tier 2 CAMHS team. It links an exploratory activity theory analysis to a formative developmental work research intervention. It combines the perspectives of individual professionals and professional groups, in order to create a detailed description of a tier 2 CAMHS multidisciplinary team activity system. Furthermore, the contradictions surfaced and worked on within these activity systems provided the raw material from which individual professionals, professional groups and multidisciplinary team could learn expansively.

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LIST OF APPENDICES.	PAGE
APPENDIX 1i. Research briefing	371
1ii. Activity triangle	375
1iii. Participant consent form	376
APPENDIX 2 Team business plan	377
APPENDIX 3 Interview transcript extract	389
APPENDIX 4 Extract from the researcher's diary	390
APPENDIX 5i. Letter accompanying e-mail feedback	391
5ii. An example e-mail response	392
5iii. Researcher's log after DWR	392
APPENDIX 6i. Professional group record form	393
6ii. Whole team activity discussion record form	394
6iii. MDT Group 2 feedback on activity system	395
6iv. EP Group feedback on activity system	396
6v. Developmental work research record	398
APPENDIX 7i. Thematic grid of comments on activity system	406
7ii. Thematic analysis of comments within DWR	411
7iii. Thematic grid of e-mail responses	414
APPENDIX 8 FSW individual activity triangles	416
8i. Senior FSW	417
8ii. FSW	418
8iii. Team Manager (FSW)	419
8iv. FSW	420
8v. FSW	421
8vi. FSW	422
8vii. FSW	423
8viii. Senior FSW	424
8ix. FSW	425
8x. Senior FSW	426
8xi. FSW	427
APPENDIX 9 PMHW Individual activity triangles	428
9i. PMHW	429
9ii. PMHW	430
9iii. SPMHW	431
9iv. Temp PMHW	432
APPENDIX 10 EP individual activity triangles	433
10i. EP	434
10ii. Senior EP	435
10iii. EP	436
10iv. Principal EP	437
10v. Assistant EP	438

10vi EP	439
10vii EP	440
10viii Senior EP	441
APPENDIX 11 Support staff activity triangles	442
11i. Service Office Manager	443
11ii. Support Officer	444
APPENDIX 12 PMHW group thematic grids	445
12i. Subjects	445
12ii Objects	445
12iii Community	447
12iv Division of labour	446
12v Rules	447
12vi Tools	448
12vii Outcomes	450
12viii Contradictions	451
APPENDIX 13 EP professional group thematic grids	452
13i. Subjects	452
13ii. Objects	452
13iii. Community	453
13iv. Division of Labour	454
13v Rules	457
13vi Outcomes	459
13vii Tools	461
13viii Contradictions	464
APPENDIX 14 FSW group thematic grids	467
14i. Subjects	467
14ii. Objects	467
14iii. Community	468
14iv. Division of labour	469
14v. Rules	472
14vi. Outcomes	474
14vii Tools	476
14viii Contradictions	480

APPENDIX 1i: RESEARCH BRIEFING

Professional contributions and learning when working to promote psychological wellbeing in children and young people in multi-disciplinary team contexts and settings.

Research Aims

The research is a small-scale exploratory study which aims to consider the contribution that different professionals, working within multi-disciplinary teams, make to promoting the emotional and psychological wellbeing of children and young people in schools, community and other children's services settings.

This research aims to examine the professional contributions in a multidisciplinary team whose object is to promote psychological wellbeing in children and young people. The purpose is explore the similarities and differences in the 'tools' or 'artefacts' that each professional used, and to consider how professional and team culture mediate the work. The study further aims to explore the contradictions that exist in this area of work, and to stimulate learning in the professionals and the multidisciplinary team involved.

Research Questions

- What do professionals contribute to the process of promoting mental health and psychological wellbeing in children and young people whilst working within a multidisciplinary team?
- What are the sociocultural processes that mediate these professional contributions within multidisciplinary teamwork?
- What contradictions and opportunities for innovation exist within the activity system whose object is to promote mental health and psychological wellbeing in children and young people through multidisciplinary teamwork?
- What professional learning arises from a sociocultural activity theory analysis of individual professional, professional group and multidisciplinary teamwork in this area of work?

Subsidiary Questions

- What are the objects that the different professionals' and the team's work is directed toward?
- What are the hoped for, and actual, outcomes of the different professionals and team's work?
- What knowledge bases, skills and experiences do the different professionals bring to this work?
- What are the tools or artefacts used by the different disciplines in the team?
- What are the rules that support or constrain the work of the different professionals in the team?
- What is the community with which the professionals and team work?
- How is labour divided between the different professional disciplines within and outside the team?

Research Methods

Socio-Cultural Activity Theory (SCAT) will be used as the theoretical framework to investigate the different contributions that professionals make to promoting mental health and psychological wellbeing and the learning that comes from working within a multi-disciplinary team context. The methodology employed will include the use of Engestrom's (1995) second-generation activity triangle and aspects of his Development Work Research (DWR) techniques.

Data collection

The project will initially involve team members being interviewed using Engestrom's theoretical framework. Each participant's responses will be recorded on an activity triangle (see attached) and a back up digital tape recording will be made in order to help the researcher fill any gaps. It is expected that the interviews will take about an hour each. The interviews will require a small room to ensure the confidentiality of the process

An iterative process will be used in which individual responses will be fed back to participants for comment. A theme analysis using grounded theory approaches will be undertaken to allow individual, professional group and whole team level analyses. These analyses will then be used to support individual, group and team learning and development. A development session will be used to feedback the analysis with the aim of promoting further learning and development in individuals and the team. The process aims to generate reflexive and expansive learning in the participants, team and service involved.

Research Outcomes:

It is hoped that the process outlined will create a rich picture of the work those different professionals and team does in promoting psychological wellbeing. In particular, it is hoped that the research will illuminate the socio-cultural historical context in which professionals' work to promote psychological wellbeing in children, family, schools and community in XXXXXX.

Each participant will be given a copy of his or her individual transcribed activity triangle. The researcher will analyse the emergent themes from the completed activity triangle and feed this back to individuals, professional groups and teams. An iterative process will be used to generate further hypotheses, potential further research questions and conclusions. The team analysis and findings will then be shared with the whole team and consideration given to the learning it generates. A resume of the findings of the research will be shared with all the participants and commissioners of the research. The learning and development from the study will also be shared with wider audience through the dissemination of the research findings via a doctoral level thesis and publication in professional journal. It is hoped that the study and the learning that comes from it can be used to inform the application of the approach in other multi-disciplinary teams and settings.

Ethical Considerations

The information collected from the study will be used for the purposes of the research project and its publication only. Every effort will be made to ensure that individual's identity and responses remain confidential. It is likely that the study will be published and the outcomes of the research shared with a wider professional audience. The information collected from individuals will be maintained confidentially and efforts will be made to ensure that individual, groups of professionals and teams are not identified or disclosed without their prior agreement and consent.

Practical and Resource Considerations

A single quiet and confidential room will be required to conduct individual interviews and any individual feedback sessions.

The development sessions will require the use of a larger room that can hold all group or team members. Basic training equipment will be needed including flipchart, paper and pens, OHP or PowerPoint projector.

Timeline for Research.

Activity	Date
Manager /Steering Group Meeting	June – July 2008
Preparation for Fieldwork	August 2008
Individual Interviews	September and October 2008
Analysis of Data	November and December 2008
Feedback and Development Session	January 2009
Write up of thesis and publication	February to December 2009

Participant Consent

All participants will be given a research briefing to explain the research and will have opportunity to ask questions of the researcher prior to being asked to make informed consent. All participants will be informed of their right to withdraw from the project and to ask for the data collected from them to be destroyed at any point in the project. It is hoped that this will ensure all managers, team members and individual professionals understand the confidentiality of the process, what is entailed in the research project and make an informed decision about whether to participate or not. It is hoped that most of the team will participate. The time commitment involved will be explained, likely to be an hour.

Information about the Researcher

Nick Durbin, B.Sc. (Hons) PGCE, M Ed (Psych) C. Psychol.

I am currently Joint Programme Director on the University of Nottingham Doctorate in Educational Psychology (Professional Training). I am also undertaking Postgraduate Research at the University of Birmingham for which this study will be used.

My current interests include professional learning within multi-disciplinary teams and networks. The contribution different professionals make to organisational change, school improvement and promoting psychological wellbeing.

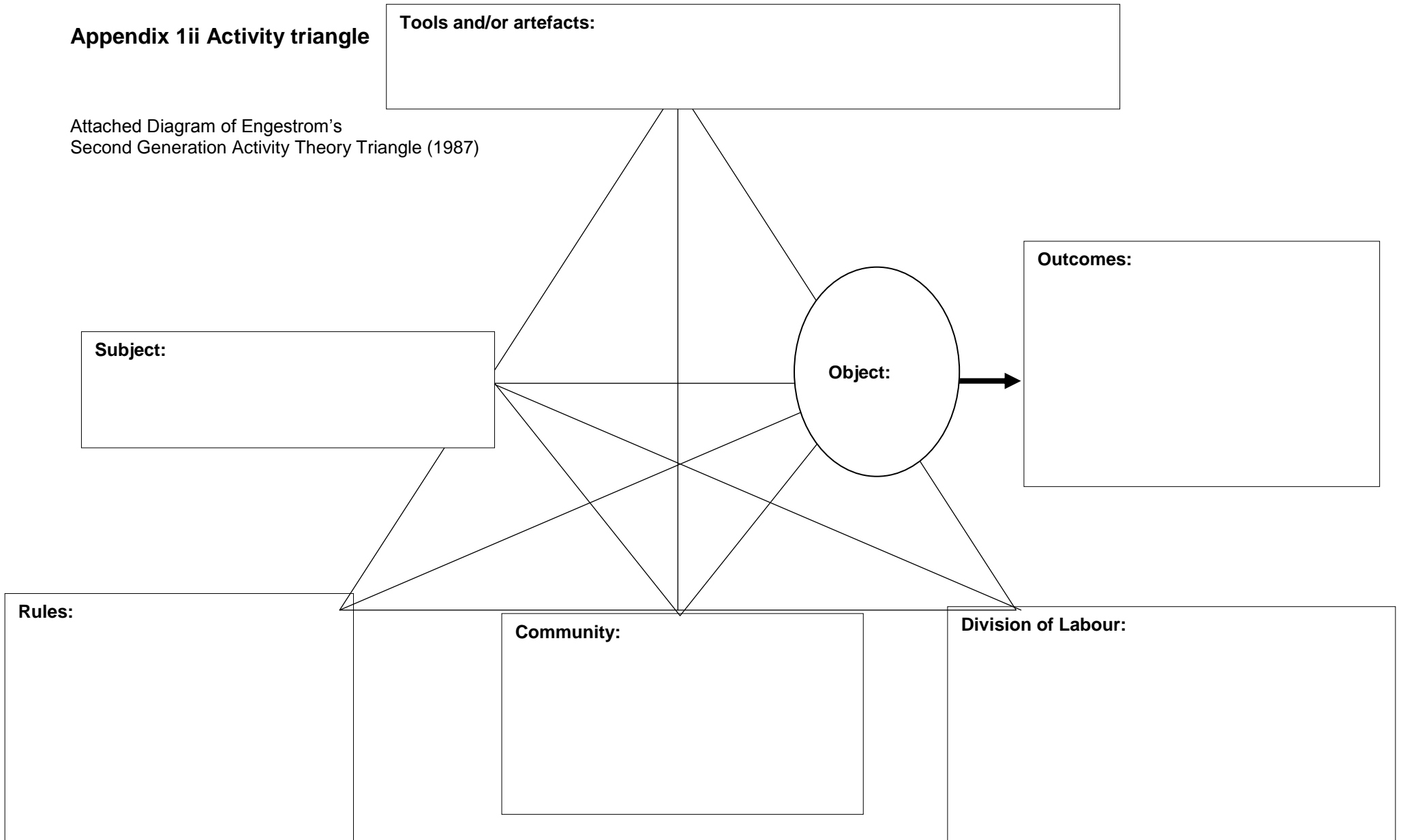
I am a former Principal Educational Psychologist, Senior Educational Psychologist and Educational Psychologist (with a social services specialism). In my recent past I have managed and developed a multi-disciplinary Tier 2 community children's mental health team. I have worked within a multi-disciplinary team settings within social services settings and have more recently developed, managed and lead a multi-disciplinary Children's Emotional Health Team. I have also managed English language, behaviour and learning support teams and worked as the co-ordinator of a critical incident team.

I am currently acting as a consultant to a critical incident support team and working as a Senior Educational Psychologist with an interest in promoting psychological wellbeing in schools and children service settings. I am currently responsible for managing and developing the professional training for educational psychologists and looking at links between academic and professional training of psychology professions and in promoting professional learning in applied settings. In the recent past I have been responsible for professional, team and service development across a range of teams and have extensive experience of facilitating development activities.

Nick Durbin
Joint Programme Director
University of Nottingham
And
Postgraduate Research Student
University of Birmingham
1st July 2008

Appendix 1ii Activity triangle

Attached Diagram of Engestrom's
Second Generation Activity Theory Triangle (1987)



Appendix 1iii. Participant Consent Form

Professional contributions and learning when working to promote psychological wellbeing in children and young people in multi-disciplinary team contexts and settings.

Consent Form

Research Briefing and Information

Thank you for agreeing to participate in this research project. In order that all those who are participating in the research make properly informed consent, I have outlined the project purposes, aims and methods (see attached Appendix 1i research briefing). I have also outlined issues of confidentiality and ethics and provided a place for you to give written consent below. read the research briefing provided above. Please feel free to ask the researcher any questions you may need for clarification. When you are satisfied and would like to participate in the project please indicate this by signing below.

Informed Consent

I understand that the information I share will remain confidential (as long as it is safe and legal to do so). The information and data collected will be used for the purposes of this research, and the researcher's doctoral thesis to be submitted to the University of Birmingham and any consequent publication that stems from this.

I understand that the researcher will check with me before revealing or disclosing information that might identify me. All responses will be anonymised so that I, and the people I work with, will be not identified in anyway. I understand the researcher will seek my further consent if he feels it will be beneficial to share data that may reveal my identity to others. I understand that I have the right to withdraw and to ask for the data collected from me to be destroyed at any time during the research process.

I consent to the information collected as part of this interview being taped, used for the purposes of this research and if needed in a published research paper. I agree for the anonymised information collected to be shared with a wider audience in the local authority and elsewhere in order to promote good and effective practice in promoting psychological wellbeing within multi-professional teams, services and local authorities.

I have read and understand the research briefing and the time and other commitments involved. I have had opportunity to ask the researcher any questions and wish to give my consent.

I, the undersigned, have read the information above and consent to participate in the project and to the information and data collected from me to be used as part of this research study.

Name:

Signed:

Appendix 2 Team Business Plan

XXXXXXXXX CITY Tier 2 team **STRATEGIC BUSINESS PLAN: 2007 – 2010**

CONTENTS:

1. Service Purpose
2. Aims
3. Aims, Key Tasks, Major Activities
4. Resources
 - a) staffing
 - b) budget
 - c) access and locations
5. Policy Drivers and Principles
6. Governance, Management and Accountabilities
7. Appendices

1. SERVICE PURPOSE

To provide a city-wide early intervention and preventative service for children and young people aged 0 – 11 years at risk of social exclusion, and underachievement because of their psychological, behavioural or mental health needs.

Summary of service provided: -

- Consultation and advice to parents
- Screening for “vulnerable children”.
- Direct casework with children and families
- Group support for children in schools and other settings
- Group support for parents especially in relation to positive behaviour management
- Consultation and co-working with universal professionals
- Training and development work for universal professionals
- Production of educational resources and materials
- Representation on a variety of appropriate steering groups

The XXXXXXXX City tier 2 team Strategic Business Plan 2007-2010 will have three aims. Each aim will have associated Key Tasks and Major Activities that will contribute to fulfilling the aims. The major activities and action plan will change year on year to reflect the evolving landscape within which the TIER 2 service will be delivered.

2. AIMS

Aim 1 – Direct Work.

To provide direct work with children and families from diverse communities to enhance parenting skills and capacity in managing common emotional and behavioural concerns and thereby promoting psychological/emotional wellbeing, and positive mental health.

Aim 2 – Emotional, Wellbeing and Mental Health Training, Promotion and Education

To raise awareness, build skills capacity and confidence of staff within universal services, by promoting the importance of positive Mental Health and Emotional Wellbeing for all children and young people across XXXXXXXX City, and enabling staff to develop a repertoire of universal prevention and early intervention approaches.

Aim 3 – Sustaining Service Quality

To maintain an evaluated, effective, responsive and proactive service

Responsibility for collation of data has been assigned to the Team Leaders of each partner agency team, who may delegate responsibility for each key task to a team member Collectively this will assist with delivery of the service , monitoring ,and evaluation.

3. TABLE OF AIMS, KEY TASKS, MAJOR ACTIVITIES AND SUCCESS CRITERIA

AIM 1 – DIRECT WORK

To provide direct work with children and families from diverse communities to enhance parenting skills and capacity in managing common emotional and behavioural concerns and thereby promoting psychological/emotional wellbeing, and positive mental health.

RELEVANT POLICY DRIVERS: eg ECM, CYPP, NSF,LAA, and others

LEAD AGENCY:

KEY TASKS	MAJOR ACTIVITIES	SUCCESS CRITERIA	RESPONSIBILITIES Allocated by management group:- work in progress
1.To work directly with families to deliver planned and structured input, which builds on the strengths and capacities of families.	<p>Cross agency assessment and direct casework across the city with children and their families aged 0 -11, (year 6 and below) in any setting Programmes of work delivered within community settings most comfortable to families including the family home, school/early years settings or other community facility.</p> <p>tier 2 team to work proactively alongside parent agencies to ensure that children and families are seen within the appropriate tier of service and particularly at points of transition where children are moving between services.</p>	<p>Up to 200 cases per year</p> <p>Use of a range of community settings across XXXXXXXX city</p> <p>tier 2 team to monitor the movement of its cases between the ties of service and report back on a yearly basis.</p> <p>All staff trained in CAF/LP protocols.</p>	
2. To provide and promote early intervention services across the city for parents, carers and children in crisis.	<p>Maintain First Response appointments/advice service across the city</p> <p>Active participation to support groups in community venues across the city.</p>	<p>Service to be available in different geographical (in more then 4 areas of the city)</p> <p>Support sessions to be offered in up to 5 Sure start Centres.</p>	
3. Contribute to the delivery of a city wide parenting strategy in collaboration with other professionals in voluntary and statutory sectors	<p>tier 2 team to be involved in the delivery of parenting groups and offer a wide range of Parenting Support to develop skills and confidence in managing challenging behaviour in under 11's.</p> <p>To deliver parenting groups in partnership with other</p>	<p>Run up to 4 groups a year</p> <p>2 parenting groups to be delivered.</p>	

KEY TASKS	MAJOR ACTIVITIES	SUCCESS CRITERIA	RESPONSIBILITIES Allocated by management group:- work in progress
	agencies/professionals.		
4. To offer advice and consultation to parents, carers and professionals.	To jointly staff, monitor, and evaluate the current provision of the Telephone Information and Advice Line.	Service available as specified (4days a week). User feedback collated. Track outcomes for sample of callers.	

AIM 2: TRAINING ,PROMOTION and EDUCATION

To raise awareness, build skills capacity and confidence of staff within universal services, by promoting the importance of positive Mental Health and Emotional Wellbeing for all children and young people across XXXXXXXX City, and enabling staff to develop a repertoire of universal prevention and early intervention approaches.

RELEVANT POLICY DRIVERS: E.G. ECM, CYPP, NSF, LAA, OTHERS

LEAD AGENCY

KEY TASKS	MAJOR ACTIVITIES	SUCCESS CRITERIA	RESPONSIBILITIES Allocated by management group:- work in progress
1. . tier 2 team to contribute to the local multi agency training strategy on Child Mental Health	<p>tier 2 team to provide a range of training and education opportunities in relation to child mental health for all staff working with children and families, including:</p> <ul style="list-style-type: none"> • Contribution to the local foundation course on child mental health • Topic based e.g. risk and resilience, emotional literacy • Skill training e.g. solution focused working • Areas of specialism e.g. To provide appropriate training on psychological and mental health needs of recently arrived children needs of refugee/newly arrived • Responding to emerging needs of local professionals and the voluntary sector in universal services in relation to child mental health 	<p>=To be involved in 4 city wide programmes per year.</p> <p>=Up to 10 Training, workshops in any settings per year.</p> <p>=2 x 2.5 day work shops to be facilitated by tier 2 team Staff Per Year</p> <p>=5 locality wide workshops to be offered</p> <p>= Training delivered to agency/ team / network and to be evaluated</p>	
2. To provide consultation services to	tier 2 team to provide a consultation service to individuals and teams	Numbers of consultations	

KEY TASKS	MAJOR ACTIVITIES	SUCCESS CRITERIA	RESPONSIBILITIES Allocated by management group:- work in progress
city professionals working with children and families.	working with children and families – will include some “co-working” with other professionals.	offered + number of co-worked cases with different professionals.	
3. To offer advice to professionals where there are concerns regarding child mental health problems	PMHW to provide a CAMHS Professional Advisory Service which offers advice to city professionals regarding concerns about child mental health issues.	Numbers of contacts per year from city professionals	
4. To promote partnership arrangements with relevant agencies within diverse communities of XXXXXXXX City, in order to improve access to service.	Seek out key partners and representatives from communities and to promote tier 2 team work in order to meet jointly identified needs. Responsive to locally expressed needs/preferences.	Participate in 3 CAMHS/CYPS Information Events targeting diverse communities.	

AIM 3 – SUSTAINING SERVICE QUALITY :

To maintain an evaluated, effective, responsive and proactive service

RELEVANT POLICY DRIVERS: EG ECM, CYPP, NSF, LAA, others

LEAD AGENCY

KEY TASKS	MAJOR ACTIVITIES	SUCCESS CRITERIA	RESPONSIBILITIES Allocated by management group:- work in progress
1. To evaluate all tier 2 team progress against its aims and key tasks	To monitor and summarise progress against the success criteria for key task using a range of relevant evaluation formats. To maintain relevant databases.	Annual Report to include outcome measures eg. improved scores on SDQ scaling tools etc and to be submitted, using JSG format, to relevant partner agencies . Data reports identified and available	
2. To ensure effective functioning: To support inclusive practice To promote identifiable outcomes for	To ensuring effective team meetings which promote multi-professional work To ensure engagement of all staff in the tier 2 team Business Plan	Management and steering group meetings receive regular reports on	

KEY TASKS	MAJOR ACTIVITIES	SUCCESS CRITERIA	RESPONSIBILITIES Allocated by management group:- work in progress
children To support Community Cohesion and diversity	To ensure good Performance management and supervision within professional groupings To maintain proficient mechanisms for managing referrals and sustaining good professional practice To identify and meet Individual and whole team training needs	progress including agreed action points. Supervision/appraisal records show staff have received training.	
3 To build and sustain effective collaborative partnerships across services for children including research activities • Engagement and communication with relevant agencies and others	To promote the work of Tier 2 Team across universal, voluntary and statutory service providers by undertaking promotion events. ¹ To sustain effective working relationships with BST, EWS, SNTS, EYST, PS, SELL, SED, (BMG) Safe Guarding and Social Care to ensure seamless transition between tiers of service To organise and attend a 'market stall' information event. To use the expertise and knowledge of tier 2 team to inform and support the further development of effective early mental health provision by co-working on nominated projects. To keep abreast of developing priorities.	<ul style="list-style-type: none"> Develop a website with advice and activity sheets which can be downloaded by Summer 2007. Information about tier 2 team on XXXXX Website and updated regularly Have agreed protocols of referrals Devise new training package that are delivered and evaluated	
4..To ensure coherence with the key priorities of partner agencies and the voluntary sector eg. social inclusion, NSF and modernisation agenda, improved outcomes for children etc	Steering group to comprise members of partner agencies and the voluntary sector. tier 2 team regularly report to CAMHS JSG, and relevant agency and partnership meetings	Reciprocal attendance at appropriate meetings, and action/plans prepared.	
5.To provide good quality of information and resources	To maintain up to date information on early intervention services across the city and ensure dissemination of leaflets To run an annual market stall day	tier 2 team to have up to date information at bases	

¹ Key to abbreviations : BST, Behaviour Support Team; EWS, Education Welfare Service; SNTS, Special Needs Teaching Service; EYST, Early Years Support Team; PS, Psychology Service; Learning Services, SED, Social Emotional Development. (Behaviour Management Group)

KEY TASKS	MAJOR ACTIVITIES	SUCCESS CRITERIA	RESPONSIBILITIES Allocated by management group:- work in progress
6. To ensure evidence informed and effective evaluation, including collecting and reporting relevant data for planning and delivery of effective services.	<p>Accurate manual data collection on tier 2 team Advice and Information Line</p> <p>Ensure information is captured and recorded by inputting referral details onto tier 2 team database on receipt of referral forms at Collegiate House</p>	<p>Data base available on Telephone Advice Line, First Response, Sparks.</p> <p>Referrals and initial enquiries will be treated by relevant dimensions, (eg. postcode, ethnicity in order to monitor service provision.</p>	

4. RESOURCES

a) Staffing – April 07-March 08

The tier 2 team is a multi-agency partnership between the Local Authority and the XXXXXXXXshire Trust. The service comprises 17 FTE professional staff made up of Family Support Workers, Educational Psychologists and Primary Mental Health Workers from CAMHS. The service is supported by an Administrative Officer.
(See Appendix 1)

b) Budget

The tier 2 team budget is made up of funds from the CYPS base budgets, CAMHS Mental Health Grant, The Vulnerable Children Grant and XXXXXXXX Partnership NHS Trust base budget – see also Appendix 1.

c) Access and Locations

The tier 2 team is currently delivered from the following four administrative bases: XXXXX XXXXXXXXXXXX. Outreach appointments and support is offered in many community venues.

5. POLICY DRIVERS and PRINCIPLES

The work of the tier 2 team addresses national and local policy drivers as outlined (see Appendix 2) and is informed by the following principles:

a) Diversity.

TIER 2 partnership recognises the diversity of XXXXXXXX city and seeks to offer services to children and families from a wide range of backgrounds. The tier 2 team strives to offer a culturally congruent and sensitive service that is tailored according to the families needs.

b) Access.

Tier 2 Team is a key element of the Local Authority's local preventative strategy, offering early intervention to children and families struggling with behavioural and emotional difficulties, thereby improving access to mental health provision for the local population. The tier 2 team tries always to meet people in settings in which they are most comfortable. This means working in family homes, schools and early years settings, health centres and other local community facilities.

c) Building Capacity

Children's mental health is everyone's business. All professionals working with children and families have opportunities to enhance children's emotional and psychological wellbeing. The tier 2 team has a particular focus on building capacity and confidence in relation to mental health issues amongst professionals working with children. tier 2 team staff work in partnership with local professionals who are supporting families dealing with everyday problems.

d) Strengthening Families

Most children will experience some emotional ups and downs in the course of their childhood. Being a parent can be stressful and challenging at times. Children's resilience to these upsets can be significantly enhanced by their experiences both at home and within the local community. The tier 2 team believes that families have the necessary skills and resources to find their own solutions to difficulties. tier 2 team work to assist families to identify and harness these resources.

e) Safeguarding

tier 2 team is a preventative resource working at an early stage to improve the emotional and psychological wellbeing of children. However all staff are trained in safeguarding protocols, and accessing the Local Safeguarding Children's Board website

– www.xxxx.xxx

f) Communication

Effective communication has long been viewed as a key tool in the provision of high quality services for children and families. However for tier 2 team, collaboration and liaison with others, are critical elements going beyond standard good practice.

6. Governance, Management and Accountabilities

The governance and management of this multi-agency initiative team has five strands – strategic, budgetary, operational, professional and personnel.

A strong strategic direction comes from a multi-agency steering group, which holds the remit for the delivery of an agreed business plan, and represents all statutory agencies and the voluntary sector.

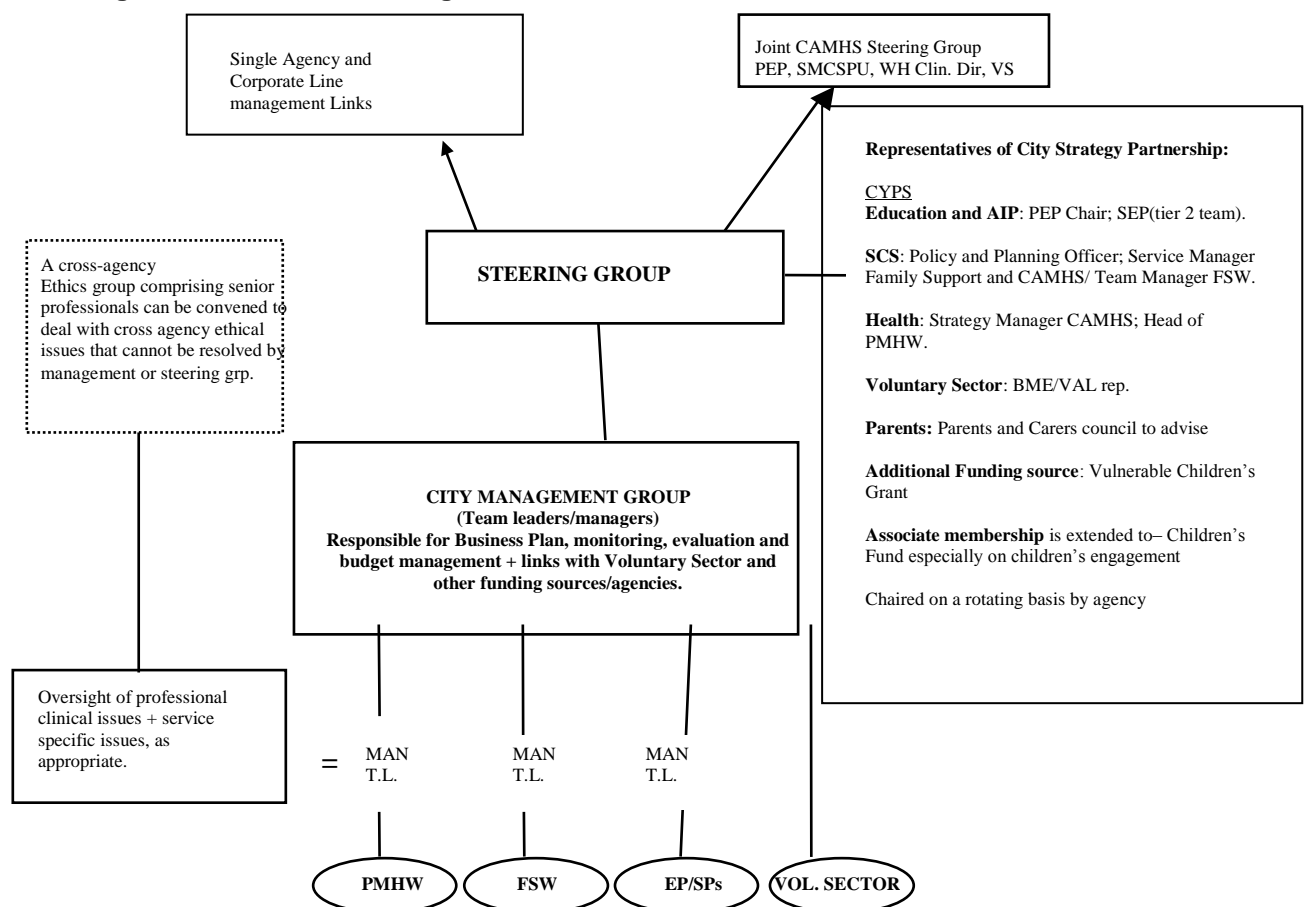
The management of the business plan is conducted via an inter-agency management group exercising day-to day budgetary and operational responsibilities in delivering the business plan through team leaders/representatives. The management of each element of the business plan continues to be the responsibility of each service provider.

Personnel issues and the varying terms of employment, require individual agency control for the differing professional groups, as do professional matters, particularly those involving professional/clinical supervision.

Evaluation for the City Council is undertaken through the Senior Educational Psychologist and the maintenance of effective liaison with the University of XXXXXXXX.

The Tier 2 Team Steering Group – at Response Line 2 reports to both the City Council through Service Directors in CYPS and to NHS Partners through the Joint CAMHS Steering Group.

Figure – Governance, Management and Accountabilities



7. APPENDICES

Appendix 1

STAFFING and FUNDING SUMMARY XXXXXXXX Tier 2 team **2007-2008**

<u>Family Support Workers</u>	<u>Educational Psychologists</u>	<u>Primary Mental Health Workers</u>
1 Team Manager	1 Tier 2 Team Admin Post	0.2 Senior PMHW
2 Senior FSWs	1 Senior EP	1.3 FTE PMHWs
8 FSWs	2.5 FTE EP- Senior Practitioner	
	2 Assistant EPs	
A) Total staff costs with on costs = £XXXXXXX All paid for out of Mental Health Grant.	B) Total staff costs with on costs = £XXXXXXX 1 admin, 1 SEP, 1 EP and 2 AEP's, all paid for out of Mental Health Grant. E) 1 EP will be paid for from Psychology Service Base Budget on-cost = £XXXXXXX F) (Additional 0.5 FTE EP paid for from 2007/08 Vulnerable Children's Grant – awaiting confirmation XXX approx	Total staff costs with on costs = £XXXXXXX Total 1.5 full time equivalent. Commissioned from LPT by City PCT (Health) G) Overall LPT costs ()= XXX
C) Training costs for FSW's and EP's also paid for from MHG = £XXXX.		
D) Running costs for FSW's + EP's also paid for from MHG = £XXXXXX		

- Total MHG costs (ie. A,B,C,D) = £XXXXXXX
- Total Psychology Service Costs (ie. E) = £XXXXXXX
- Total short-term funding cost 2007-08 (ie. F) = £XXXX
- Total PMHW cost (ie G) = £XXXXXX

Appendix 2

XXXXXXXXX City Tier 2 Team – Policy Drivers – Relevant Priorities
2007-2010

ECM	NSF	CYPP	LAA
<p style="text-align: center;"><u>Outcome - Be Healthy</u></p> <p>1) Aim: Children + Young People are mentally and emotionally healthy</p> <p>2) Priority National Targets Death rate from suicide and undetermined injury (DH)/ improvement in access to CAMHS (DH)</p> <p>Key Judgements and illustrative evidence for inspections</p> <p>3) Parents and carers receive support to keep their children healthy</p> <p>4) -Action is taken to promote children and young people's mental health</p> <p><u>Outcome- Make a Positive Contribution</u></p> <p>Aim:</p> <p>5) -Engage in law abiding and positive behaviour in and out of school.</p> <p>6) - Develop positive relationships and choose not to bully or discriminate</p> <p>7) - Develop self-confidence and successfully deal with significant life change and challenges.</p> <p>Priority and national targets</p> <p>8) % 10 – 19 year olds admitting to (a) bullying another pupil in the last 12 months (b) attacking, threatening or being rude due to skin colours, race or religion.</p> <p>Key judgements and illustrative evidence for inspections</p> <p>9) - Children and young</p>	<p style="text-align: center;"><u>Core Standards</u></p> <p>1) The health and well-being of all children and young people in is promoted and developed through a co-ordinated programme of action, including prevention and early intervention wherever possible, to ensure long term gain, led by the NHS, in partnership with local authorities. (P.44 – P.46 concentrates on children's mental health.)</p> <p><u>Standard 2</u></p> <p>2) Supporting parents (P.64 – P.85)</p> <p><u>Standard 3</u></p> <p>3) Children and young people + Family centred services. (Standard P.87)</p> <p><u>Standard 9</u></p> <p>4) The mental health and psychological well- being of children and young people.</p> <p>5) Standard- All children and young people from birth to their 18th birthday, who have mental health problems and disorders, have access to timely, integrated, high quality, multi- disciplinary mental health services to ensure effective assessment, treatment and support for them and their families.</p>	<p style="text-align: center;"><u>Priorities</u></p> <p><u>Being Healthy</u></p> <p>1) Promote emotional resilience and positive mental health</p> <p>Strategic actions planned to improve outcome</p> <p>2) -To develop multi- agency resilience Promoting Training Programme and implement a delivery plan to adapt mainstream practice to increase the emotional resilience and a positive mental health in children and young people.</p> <p>3) - Continue to implement the CAMHS Strategy with partner agencies to include the improvement of access to services and develop a clearer City Focus.</p> <p>Making a Positive Contribution</p> <p>Strategic Action Planned to Improve Outcomes</p> <p>4) -Improve multi- agency support in relation to behaviour in schools, including to reduce exclusions, particularly of over- represented groups i.e. some BME groups.</p> <p>5) - Develop strategies to enable children and young people to develop, sustain and repair relationships</p> <p>6) - Ensure that the issue of transition, turbulence and emotional resilience are adequately reflected in the multi- agency attendance</p>	<p style="text-align: center;"><u>Children and Young People's Block</u></p> <p>Children and young people 2.2 1) Promoting Positive Mental Health (Development Target)</p> <p><u>Healthier Communities and Older People Block</u></p> <p>2) Improving Mental Health -Substantially reduce mortality rate from</p> <p>a) Suicide b) Suicide and injury undetermined c) Development Target</p> <p>Development Target</p> <p>3) Develop and adopt well- being measure to provide a better indicator for mental health than</p> <p>a)Suicide b)Suicide and Injury undetermined</p>

ECM	NSF	CYPP	LAA
people are supported in developing socially and emotionally 10) - Children and young people, particularly those from vulnerable groups, are supported in managing changes and responding to challenges in their lives.		strategy, Developing young citizens of conscience and other strategic planning.	

ECM – Every Child Matters, Change for Children, Outcomes Framework. Version 2.0, 1st September 2005.

NSF – National Service Framework for Children and Young People and Maternity Services, 2004.

CYPP – XXXXXXXXX Children and Young People's Plan 2006-9.

LAA – XXXXXXXXX's Local Area Agreement 2006-9.

APPENDIX 3. Interview transcription extract.

P: No, it's amazing, very good, it was very interesting

R: So that's the final point we've got to then I think, Is just for you to comment on the process. How you found it, what learning has come from the process for yourself? I think you have talked about at different stages.

P: Yes, the reflection bits

P: Is there anything..... Firstly, the learning around this activity and the things that you are going to take away.

P: Yeah, I am going to take away the comment on the organisation of the programme, uhm...yes, and possibly as well about the fact that it was a piece of collaborative working which resulted in a report which wasn't... we weren't consulted as such, throughout that process, yes at the end but at that point ... you see, I suppose when I think about the report, as it was written, I would have done it differently, we would all have done it differently but together we have come up with something else which is probably.....

R: You didn't talk about how it was going to be written and what might be...what are the key points.

P: No

R: Its ...somebody has put it down. Okay, So there is that element of it

P: uhuh, uhuh, uhuh (indicating agreement)

R: So the learning about the activity. Your comments on the process, how you found that?

P: The actual, this process today? I've really enjoyed it and it been really interesting.

R: And how it's helped you?

P: It has.... It has helped me look at the things in a wider way because I've just I think ...within... being involved in that project, you're so involved with actual process of setting something up, oh my god always these things going on and I need to have ticked the boxes. To take a step back and look at the whole ... whole programme. How it would have come across to the children as well? Y'know In a different way... How we would do it differently next time? How would I want to be involved with it? Would I want to be involved in something that was perhaps a little bit chaotic at times?

APPENDIX 4. Extract from the researcher's diary.

Research Log:

3rd September 2008

Meeting with Whole Team

(The audience was 22 members of the team).

Agenda

- Explain purpose of research
- Introduce myself as a researcher
- Explain methods and methodology
- Take questions and comments
- Explain hoped for outcomes for the professionals and team
- Help team members to make informed consent
- Seek agreement to participate and share timetable for interviews.

It was explained that I had about ½ hour to do the above. I had re-drafted the research briefing for the audience. I then went on to outline the research, to introduce myself and to explain the rationale for the research. I then explained the theoretical framework and the method that I would use. In addition, I provided all present with a research briefing. I also shared the conceptual framework to be used giving a brief outline of the questions to be asked about aspects of their work activity and a blank triangle for them to make any notes and jottings on. I then left room after questions and comment.

The questions received were:

- 1) the type of work that might be suitable for the study;
- 2) whether the work needed to involve other members of the team;
- 3) whether joining the team recently prevented involvement;
- 4) clarification of my professional background and places of work;
- 5) clarification of the methodology and whether the study aimed to work from the 'bottom up.' and finally
- 6) the timeline for the research.

APPENDIX 5i. Letter accompanying e-mail feedback

To All Research Participants, Tier 2 Team
XXXXXX City Council
XXXXXX

Nick Durbin
Postgraduate Researcher
University of Birmingham

10th January 2009

Dear Colleague,

Thank you for taking part in my research. I have completed interviews with 25 members of the team and have now done the initial analysis of each activity using the activity theory framework. I hope you found our meeting helpful in supporting your reflections on the activity you chose to discuss with me. As promised, here is the written summary of our discussion provided as a record of our meeting. A written record can never do justice to the richness and quality of the discussion. Nevertheless, I hope the attached represents a fair and accurate record of our discussion.

The contradictions highlighted from our discussion are offered as speech bubbles with a question mark. Contradictions within activity theory are highlighted to stimulate further reflection and learning. They are deliberately presented with a question mark to reflect this and should not be interpreted as criticism but as food for further reflective thought, learning and development.

As part of the next stage of the research, I would be grateful if you would check the activity triangle and confirm by return of e-mail and if possible by 23rd January 2009, that:

- | | |
|---|-----------------------------------|
| 1) The triangle represents a true, accurate and fair record of the discussion. | Yes/No
(delete as appropriate) |
| 2) Is there anything you feel needs to be added or changed?
If yes, please state what below. | Yes/No
(delete as appropriate) |
| 3) Looking at the triangle now, does it highlight any further contradictions or issues for you about the activity? If yes, please can you say what these are and why below. | Yes/No
(delete as appropriate) |
| 4) Do you have any further comments you wish to make about the process used, any learning that came from our discussion or this record and any follow up activity or development that happened as a result?
If yes, please can you say what these are below. | Yes/No
(delete as appropriate) |

Following receipt of participants responses I will be undertaking a further team level analysis and hope to do a workshop with the whole team on the issues that have emerged and highlighted at this level.

I would be grateful if you could send your response by Friday 23rd January 2008 to enable me to do this analysis in a timely way. In the meantime, if you have any queries or questions about this, please do not hesitate to get in touch with me on 0115 84 67242 or nick.durbin@nottingham.ac.uk.

I look forward to receiving your e-mail by return and to meeting the whole team again. It has been a real privilege to meet you all and be given the opportunity to have a window on the team's work. The view I see is one which is rich and full of diverse, effective and interesting activities aimed at promoting mental health and psychological wellbeing of children and their families, from which will come a lot of learning for me as researcher, hopefully for you as professionals and team and others who are working on similar activities elsewhere.

Thanks once again for participating in the research.

Yours sincerely
Nick Durbin
Postgraduate Researcher

APPENDIX 5ii. An example e-mail response.

Example e-mail response of an EP on receipt of an activity triangle:

The activity triangle is a great way to provide an overview and capture the complexities of social activity – the discussion provides a systematic structure for thinking and the record supports further reflection.

The discussion has highlighted some ‘intervention drift’ in practice particularly around EP role in follow-up and contribution to formal evaluation. The discussion encouraged me to be more proactive in this area (addressing contradictions between the tools, object and DoL?) A worthwhile activity – I was glad I made time for this.

APPENDIX 5iii. Researcher’s Log after the DWR session

Reflection: It felt like a very successful day with some challenge and some further research data to confirm initial analysis, which needs to be consolidated. The key issues that emerged:

- 1) how to provide support and challenge;
- 2) how enhance the confidence and esteem of the team whilst working on the contradictions;
- 3) how to ensure an inclusive process that supports the minority professional group (should positive discrimination be used);
- 4) how to ensure that multi-disciplinary learning is stimulated.

I was left exhausted but with a rich source of confirmatory or contradictory data and felt that I had fulfilled my duty to feedback and stimulate development work in the team. The opportunity to follow this through is a bonus for which I am grateful and is comment in itself on how managers perceived the value of the research and my work. Many of the team also expressed a desire to have time to follow through some of the things highlighted.

Nick Durbin
Researcher

5/2/09

APPENDIX 6i. DWR professional group record form.

Promoting mental health and psychological wellbeing in children in family and community settings: An activity theory analysis of professional contributions and learning within a Multidisciplinary team.

Professional GroupRecord

- 1) The triangle represents a reasonably accurate and fair summary of your work within Tier 2 team?

Yes/Partially/No
(Delete as appropriate)

Please feel free to add comment below

- 2) Is there anything you feel needs to be added or changed? Yes/No
If yes, please state what below. (Delete as appropriate)

- 3) Looking at the triangle now does it highlight any further contradictions or issues for you as a professional group?
If yes, please can you say what these are and why below. Yes/No
(Delete as appropriate)

- 4) Do you have any further comments that you wish to make about the process, any learning that came from your discussion of this record and any follow up development work that is indicated?
Yes/No
If yes, please can you say what these are below. (Delete as appropriate)

Appendix 6ii. Whole team activity discussion record form.

Promoting mental health and psychological wellbeing in children in family and community settings: An activity theory analysis of professional contributions and learning within a multidisciplinary team.

List of Group Members (by role)

.....
.....

- 1) The triangle represents a reasonably accurate and fair summary of this aspect of Tier 2 team activity?

Yes/Partially/No
(Delete as appropriate)

Please feel free to add comments below.

- 2) Is there anything you feel needs to be added or changed? Yes/No
If yes, please state what below. (Delete as appropriate)

- 3) Looking at the triangle now does it highlight any further contradictions or issues for you as a group?

If yes, please can you say what these are and why below. Yes/No
(Delete as appropriate)

- 4) Do you have any further comments that you wish to make about the process, any learning that came from your discussion of this record and any follow up development work that is indicated?

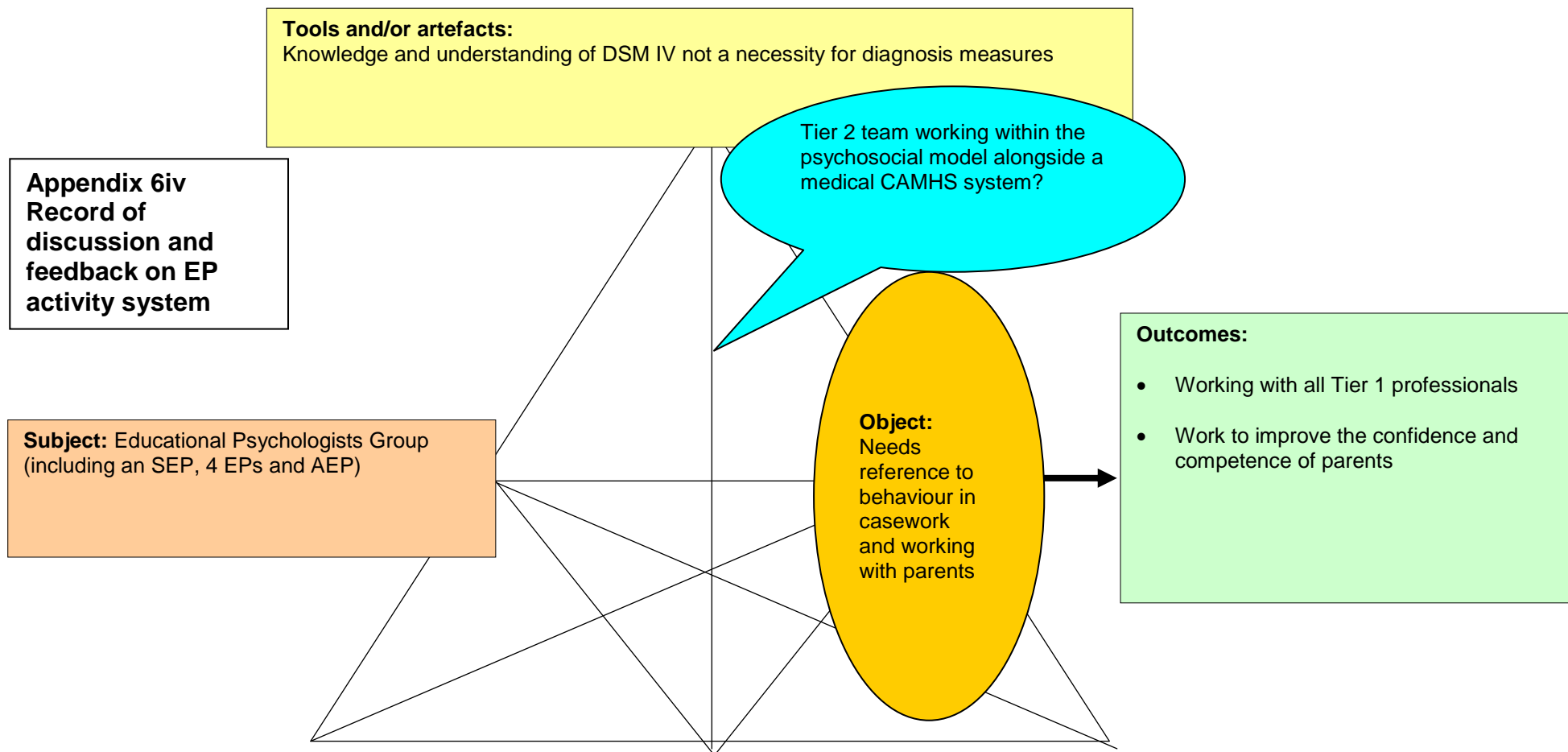
Yes/No
If yes, please can you say what these are below. (Delete as appropriate)

Appendix 6iii. Multidisciplinary group feedback on analysis of whole service activity system.

Multi-Disciplinary Group 2

Recorded comments of approximately 8 tier 2 team staff (including a Manager, PMHW, FSW and EPs and two professionals who hadn't participated in the earlier part of research) stimulated by whole service activity triangle feedback

- 1) Tools - No comments
- 2) Rules
 - Balance between all skill levels within team and availability to service users
 - Empowerment of all team members
 - Service for whole families
 - Tier 2 team provides support and consultation to all stakeholders at tiers 1 & 2
 - Early Intervention
- 3) Community
 - Consultation is first port of call, and the initial method of support
 - Links with comprehensive CAMHS are throughout all tiers (?)
 - Joint CAMHS strategy
- 4) Division of Labour
 - Two agencies
 - Voluntary sector input
 - All responsible for business plan aims etc
 - Training
 - Work within schools, groups and individually
 - Positive and negative aspects of staff team's commitment
- 5) Outcomes
 - Long-term follow up – 1 year, 2 years?
- 6) Object - Skills and resources involved in working with an extended age group
- 7) Subject - No comments
- 8) Contradictions – No comments



Appendix 6v. Developmental work research session.

Aims:

To examine and explore tier 2 team work aimed at promoting mental health and psychological wellbeing in children, young people and families.

Objectives:

To provide a mirror of the team's work using the lens and model of sociocultural activity theory in an attempt to promote thought, learning and development activity in professionals and the team involved.

Ground Rules

The following ground rules were agreed with the team:

All contributions are valid and valued.

All participants will:

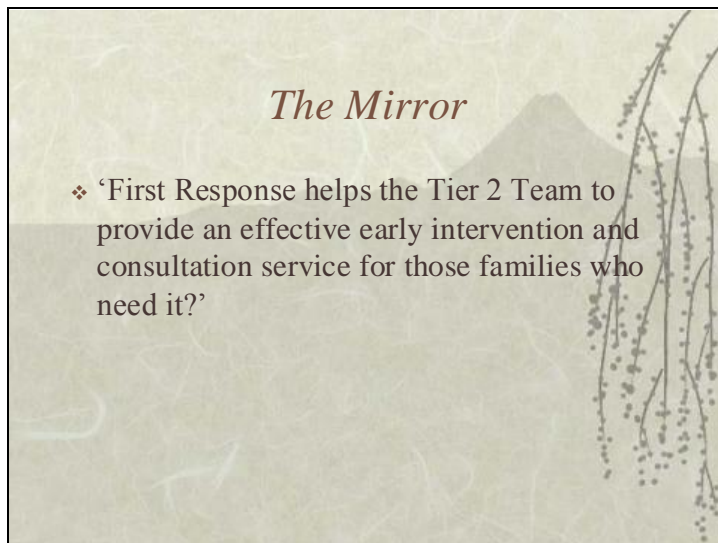
- Respect for diversity and difference.
- Respect the confidentiality of the process.
- Speak for themselves.
- Resolve any disagreements in a respectful and peaceful way.

Group Aims

The team set for itself the following hopes for the session:

- To begin to reconcile individual aims.
- To consider whole service 'espoused' theory versus 'theory in use' in service practice.
- To hear about the strengths and the effective and positive aspects of tier 2 team work.
- To look at the processes used in the multi-agency team to support children and young people.
- To reach a consensus & agreement on what approaches benefit children and young people and how the team can support positives outcomes.
- To identify and share contradictions with each other at an individual, group and service level.

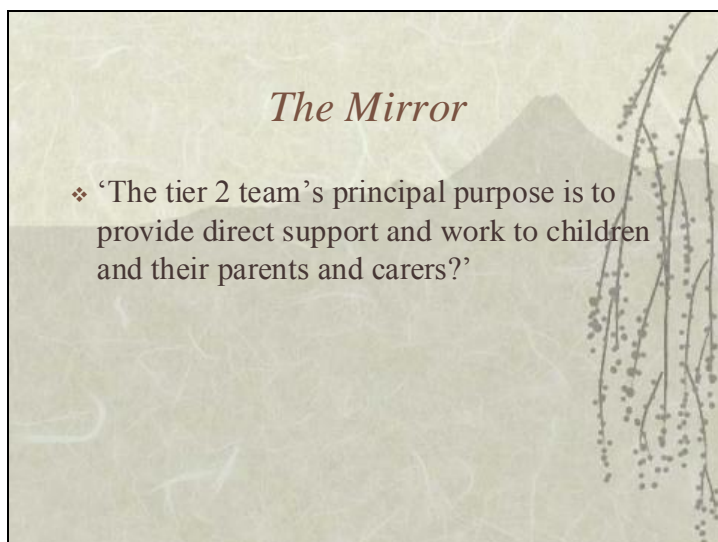
Mirror Data Stimulus 1



First Response

- How much is the first response (F-R) known beyond the service itself?
- Is F-R promoted as a part of the service offered by the tier 2 team to external agencies and bodies?
- Is there internal consistency in the decision making of who gets F-R?
- FSW are the only members of the tier 2 team to do F-R, and so other members of the service who do not deliver F-R might not fully understand and know about it?
- There has been a noticeable increase in uptake of F-R?

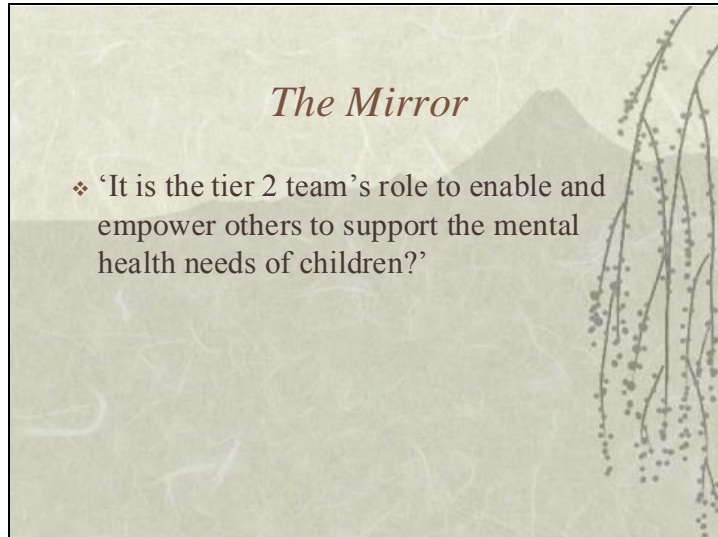
Mirror Data Stimulus 2



Direct work

- Involves indirect as well as direct work
- The principal activity of the team is direct workbut the principal purpose was to promote the positive behaviour of children and young people and as a consequence their mental health.

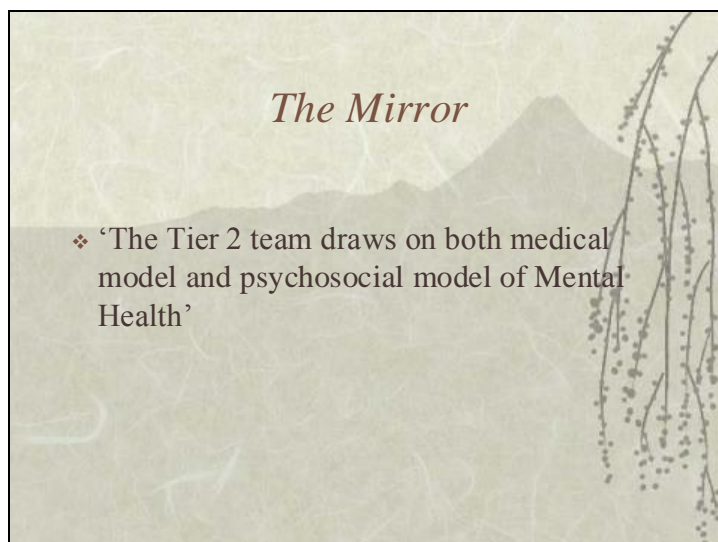
Mirror Data Stimulus 3



Indirect work

- To enable and empower parents to be confident and competent in managing their children's behaviour and therefore supporting positive mental health
- It addresses adult mental health and wellbeing too.
- Others in the statement needs to be further developed and defined and should include professionals, parents etc.

Mirror Data Stimulus 4

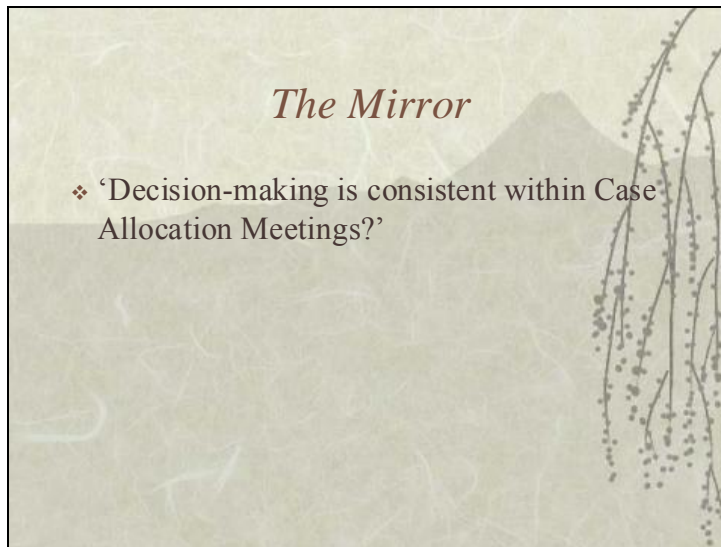


Paradigms and Models

- Should include sociological and community orientated models and paradigms

- The team's work understanding the cultural customs and influences on mental health and understanding

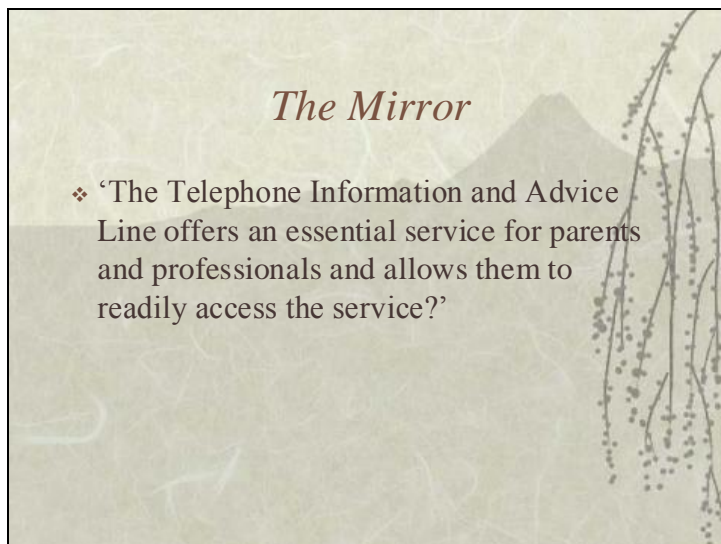
Mirror Data Stimulus 5



Case Allocation Meetings

- Approach can vary due to variations in group membership and group dynamics.
- A relatively consistent process with low numbers of decisions challenged. 95% cases allocated without difficulty.
- Allocation is a process of which the meeting is the start.
- There is a link between Case Allocation and Initial assessment visits.

Mirror Data Stimulus 6

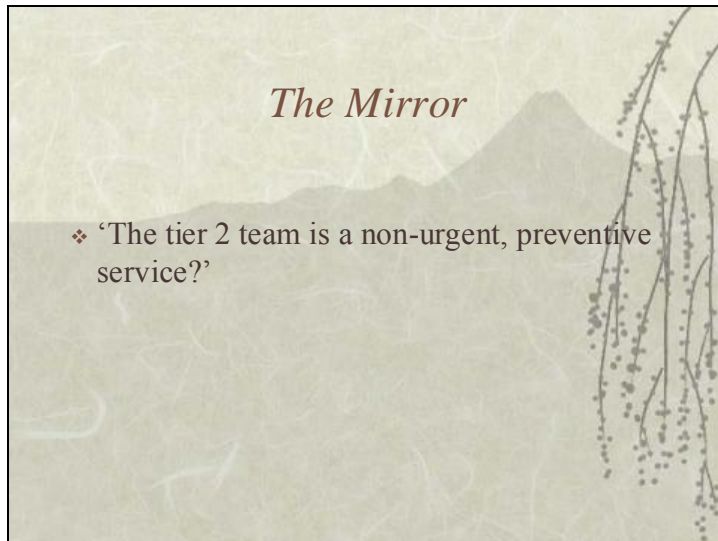


Telephone Information and Advice Line

- Is uniquely operated by professionals.
- It can offer early intervention and signpost parents to other services

- TIALs is a consultation service and empowerment
- TIALs workers offer listening skills and empathy

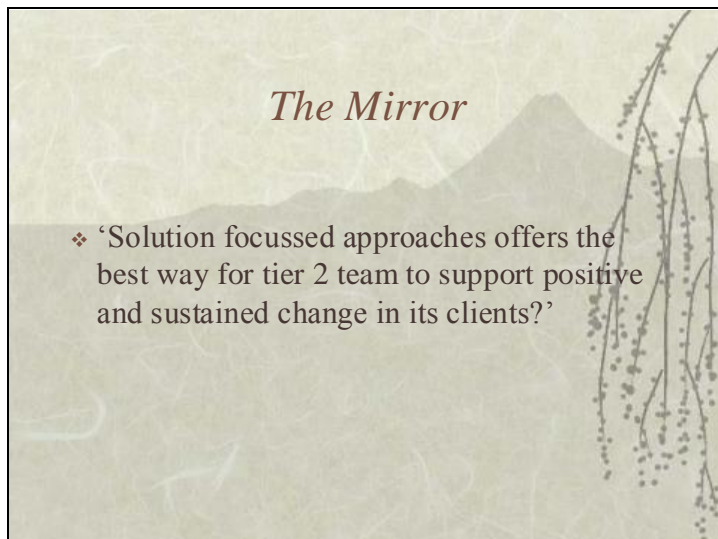
Mirror Data Stimulus 7



Nature of Service

- Tier 2 team is not an emergency service.
- Tier 2 team does, however, provide an early intervention service.
- Tier 2 team does respond to urgent need by signposting children to safeguarding services and helping parents to access a service.

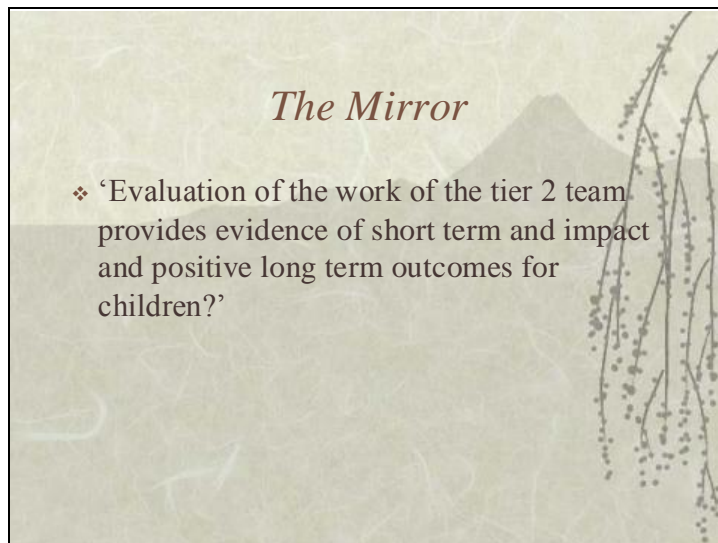
Mirror Data Stimulus 8



Solution Focused Brief Service

- A good starting point but some families do come back.
- We have evidence of short-term impact but we don't know if changes are sustained.
- What happens after 3 months?

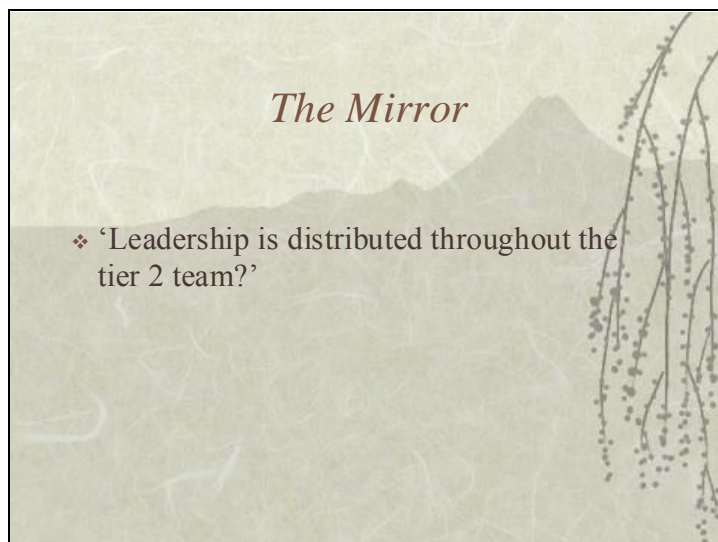
Mirror Data Stimulus 9



Service Evaluation

- Evidence of short-term outcomes
- Some positive long term evaluation between 2 and 5 years ago

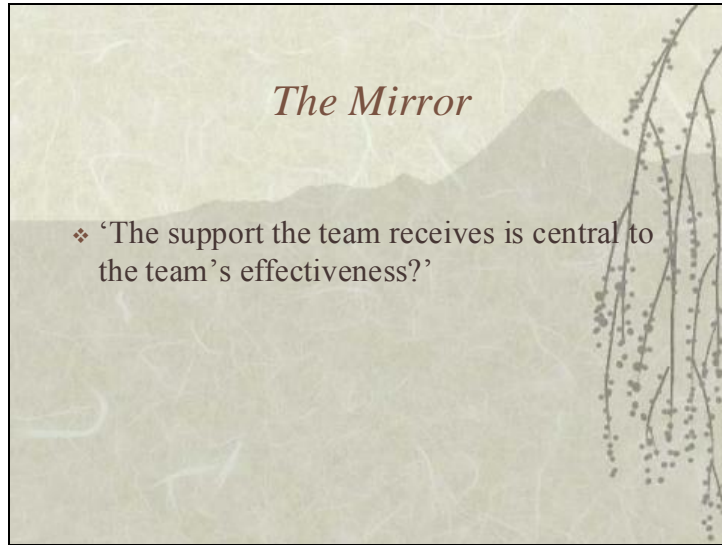
Mirror Data Stimulus 10



Service Leadership

- A general agreement with the statement
- 90% of decision-making is democratic

Mirror Data Stimulus 11



Team Support

- Wider support for the service involves positive feedback from stakeholders.
- Support from administrative team.
- Levels of support available include formal and informal support.
- Peer supervision and CPD log are good and provide strong team focus

Group Outcomes

At the end of the session participants were asked for any further comments on the outcomes of the session. The comments given below were the recorded comments of participants.

- The session has highlighted lots of thoughts and areas for consideration.
- The team needs to think how to take forward these.
- How to enable the team to have time to share perspectives and come to a shared understanding.
- It is helpful share to look at similarities and differences.
- Further work required on individual and team roles including role definition and boundary.

APPENDIX 7i. Thematic analysis of the professionals' reflections on activity triangle interview process

Theme	Data Extract 1	Data Extract 2	Data Extract 3	Data Extract 4	Data Extract 5	Data Extract 6	Data Extract 7
Opportunity to attend to detail	It has brought that out in a little more detail... Makes you think really hardwhen you sit down and really break it down even further,... its an enormous piece of work, really	I actually found it very useful unpicking it more.	So that is really helpful but actually unpicking it in a lot more detail, if only we could do that with every case,	Just breaking it down and thinking ooh what exactly, what is driving my work, what is making me talk to others? What are they getting from it and what am I getting from it?	you don't really get chance to look at the processes involved in the way we work . I've really valued that and enjoyed that.	when you write them down and break them up in the fashion you have done what you do is see them being compartmentalise, being part of a structure or even hierarchy of events which take place, yep, within those hierarchy you have connections	it is not often that you have the opportunity to look at the minutiae. It is a real luxury.
Opportunity to look at the whole picture	it was useful actually and to sit and look back at that whole big picture	If anything, you don't realise how much is involved, ...when you put it down on the paper it shows how huge it really is	. I like the chart,mind map art,	It is almost like looking from above down on the work, considering	It has helped me look at the things in a wider way because I've just, I think, with...being involved in that project, you're so involved with actual process of setting something up	which then sort of weave, which makes the inclusivity, that makes the whole thing hang together.	
Highlighting contradictions	The idea of drawing out the contradictions, that's really helpful indeed, some of the psychological stuff going on beneath, that I am hardly even aware of.	I feel there is a tension between my views and how the 'team' works. It has been helpful to actually talk about the tension.	The contradictions I thought that was quite useful for when you said them back to me, I suppose I am aware of them but to hear them said was particularly helpful	what's multi-agency about being in Tier 2 team?..... Because at times it is, and I suppose these are things that are about every multi-agency team, I don't know. We do some things	The view of the conflicts, balancing things and the whole team as well	It raised for me this contradiction for me in terms of the requirements of evaluation ...it's the dilemma between need and availability of	I don't think we are a rules based culture, except our referral very much is , we won't tolerate anything outside the way we work.

			to here things back	together, we do some joint things and there are other things that are quite separately done within each, each group, I think.		service.	
Promoting new learning insight	Certainly highlighting, perhaps the role, ..the further role that I could have in terms of evaluation of the group work.	From this I have learnt that sometimes when you are talking you forget things, I will and keep a note for myself, where my role is and what might be included at that point when I am talking	Only that I wish I had more time to attend [meetings], so I get a full knowledge, rather than little snippets, it would be nice to get the complete picture	I suppose even that is like a family, you know what the others do and you might be interested, but it doesn't mean to say you share the same interests or pursuits does it, but there is some sought of underlying togetherness, or something you hope	in terms of my learning. I need to put things more diplomatically and not to point the finger at one set of professionals	If that child came again as a re- referral, I'd probably....wouldn't necessarily get so involved, I'd probably take...take the view, right lets get these people who are already involved doing the work, ...it is about reassuring community people, people working in the community that they are probably doing the right thing but I think that might be a weaknesses of mine anyway, that I feel I've got to go in and mend it all	I have learnt quite a bit about my own world in the Primary Mental Health Team and also how Tier 2 team fits into CAMHS.
Reinforce and building on previous learning	I think, I think it is useful but the contradictions, for example, are ones which I'm quite familiar with.	we are all very well aware of issues that are there, because we are all very well aware of the work we do and how we do it.	It just highlights for me the importance of multi-agency communication and frustrations that can be there.	I think the contradictions are quite interesting, ...because...I although I am aware of them,... I didn't ...uhm.... and have	the tools, the rules, the constraints and all the sort of different players within that. I think I have always had that in my practice, I have	It made me feel, I do a really good job. There is a lot to working on the info line. This is where the bulk of our work comes through, our	it has actually allowed me to verbalise what was a thought, and that's the idea of the evolution of the

				learnt from them,.... I didn't look at, perhaps, so much of the significance of them.	always had that. It is good to put them down in a structure.	work comes via this line. So it's important. It is the hub	steering group into...something that.. It is the culture of Tier 2 team group that I want to affect and influence and develop. I think I have been able to verbalise that is really quite useful.
Opportunity to reflect	It's all extremely useful, it is always good to share the direct work you are doing	It has actually been really helpful as it has made me stop and think about it. What I am doing with this sort of training. I don't normally have time to do that. It has helped me think and reflect on the training .	I found it very, very useful and it's a very reflective process, in terms of what goes in to even in one aspect.	Also reflecting back on your thinking process, there is a lot of thought.	:It has helped me think about the criteria really, though I do not feel very optimistic about that	: It's been helpful to look at and to divide things into these areas, and so reflecting when we started off, and steering group is not a particularly fascinating area, and it's a bit sort of.... but there is an awful lot that I felt has come from it, in a sense I'd love a copy to go reflect on, think about	Makes you realise how complicated it is, actually, I mean I new it was complex
Opportunity to consider change	hope that it will make an impact long term I suppose,it was quite a useful process actually.	it shows how important academia and models and processes and can help practice and how these can assist	Definitely where it is going, and definitely this (pointing) the child in the	I think what we have got is the basis uhm.. uhm.. not a sort of manual, not even a recipe but an outline of some important	I am in a new position and therefore I am in good position to go back to things, y'know revisit things. I am in a good	I am going to take away the comment on the organisation of the programme, uhm..... Yes, and possibly as	To take a step back and look at the whole ... whole programme. How it would have

		me in my work as a operational manager to move things forward.	system, ...its that balance ... it's that balance between making sure that the child is part of it and at the centre of it but also making sure that you've got the information you need and you've got the parents on board before you can go in and do that.	features, yep, which are unique to Tier 2 team. Which we can now sort of quantify, which we can pin point, sorry, rather than quantify, which we can sort of pin point, and put down perhaps in a short paper even, couple of sides of A4. These have been some very important features as part of development and growth.	position to look at it again, when you are in post a little while it is harder to do that	well about the fact that it was a piece of collaborative working which resulted in a report which wasn't... we weren't consulted as such, throughout that process, yes at the end but at that point ... you see, I suppose when I think about the report, as it was written, I would have done it differently, we would all have done it differently ...	come across to the children as well? Y'know In a different way... How we would do it differently next time? How would I want to be involved with it? Would I want to be involved in something that was perhaps a little bit chaotic at times?
Challenge to subject identity and outcomes	the good parts as well and the positive aspects, the kind of effort the team has gone to and especially the team at Base X the kind of effort they have gone to help me fit in and that I am not fated on everything	That has been quite a learning experience for me, and the project management skills that I bring. I am keen that I am not seen just as a project manager. I do have a social work background and skills and am a successful practitioner.	That has been really useful - I've probably not used some of the skills I have got ... how to help people with learning.	I suppose one of the strengths rather than a contradiction because I sit within Tier 2 team as well as between, as I sit within CAMHS, then because I sit within a Tier 2 team and specialist CAMHS.	It has reinforced thatWe've never been good at, not defining our role, but informing others about that and actually how to help other people understand that a bit betterfor example, y'know consultation is one, we have a definition of what it does but really it is time to unpick it a little more.	I hope it does, because that highlights that we all, ... y'know... not that we are all similar in our work , but we have same understanding of the need of the service	

Evaluative comments on the process and tool used	<p>Very interesting</p> <p>I found it quite beneficial actually,</p> <p>I think it was brilliant actually.</p> <p>it's amazing, very good, it was very interesting</p>	<p>It was fascinating</p> <p>The tool that you've used? It was very interesting</p> <p>Fine, quite easy really!</p> <p>The actual, this process today? I've really enjoyed it and it been really interesting.</p>	<p>I found it a useful tool and it is helpful to be part of this process now actually.</p> <p>I found it really interesting, especially focussing the file management system, a very long, long and quite a laborious job</p>	<p>I found it very interesting, also this was the first training I had done with other professionals</p> <p>I would say. It is a valid and valuable tool really.</p>	<p>The way it gathers information, seems to be quite useful and so you can put things into categories at the outset.</p>	<p>Sometimes it's kind of nice to sit down to do something like that,</p>	<p>Looking at the titles, it is difficult to interpret the titles, I wish it was a little more accessible</p>
Researcher process and behaviour	<p>I'm sure when you're doing research you have to be critical and there has to be a critical element within it, it feels very comfortable, so I would be guessing there should be a critical element to it.</p> <p>I think the process</p>	<p>Very gentle, I don't mind being challenged, I didn't feel particularly challenged or uncomfortable. That's good.</p> <p>When you sort of feedback that to me, I'll sort of find that very very helpful,</p>	<p>the way you have done it, and the way you have obviously asked the questions and led me into the areas you're looking for, was very good.</p>	<p>You're sort of questioning has been quite helpful and feel better about that.</p> <p>Very useful ...very useful in terms of the questioning</p>	<p>It is almost easier to do it with someone like yourself, who is almost an outsider, because you have, then have an objective view haven't you.</p> <p>What you have also done very well is to sort of refocus, because what I have done in order to</p>	<p>You're very skilled about finding the tensions</p> <p>You start doing it and the fact that you probe and get more information.</p>	<p>The process was fine. Good. You were good at leading me through it</p> <p>What helped - being calm</p>

	hasn't been intrusive or a grilling. That's something to take back for yourself, hasn't been intrusive or a grilling. It's been a general conversation and dialogue.				explain things , you have asked a question I have explained and add to little bit from the side to give us a wider understanding. You have always brought back to the focus what we need to do		
Other ?	its observing what is actually happening , rather than what people say should be happening or the concept and it's .. it's what it looks like in reality .	Having discussion about to use activity theory	It would be a good tool to use for case supervision, very good!	Probably going to need more space in the future			

APPENDIX 7ii. Thematic grid displaying comments received within developmental work research

Theme	Data Extract 1	Data Extract 2	Data Extract 3	Data Extract 4	Data Extract 5	Data Extract 6	Data Extract 7
Opportunity for reflection	A great opportunity to be honest and reflective	Feedback and reflections on activities helpful	Excellent opportunity to share ideas thought and suggestions	Good as reflection tool			
Opportunity to work as a professional group	Opportunity to discuss with own discipline	Working in different groups with own agency	The group work was helpful	Group work useful	Opportunity to meet as discipline/team	Getting together as a team	Structure of day helpful moving from individuals, group and whole team
Opportunity to work with other disciplines	Opportunity to discuss with multi disciplinary colleagues	Working with colleagues from other team	Discussion and activities was helpful	Particularly regarding the multiagency approach	..and then later as a multidisciplinary team		
Use of model and mirror data	Initial context of research clear and helpful	Elaboration of the 'activity triangle' model and seeing its application to other professionals' views of team was helpful	The feedback on the strengths and areas of development was interesting and useful				
Highlighting contradictions	Small group discussion provided opportunity to focus on the contradictions.	To move forward with the contradictions highlighted so far to see if we can improve practices.	Highlighting contradictions.				

Application of activity theory to team development	To use the activity theory triangle in the future for self evaluation	To review this method on a regular basis	This kind of discussion does not happen on a day to day basis	Seeing that lots of our aims and objectives are being worked towards in the same frame of mind			
Supporting future development	To look at ways forward and to develop team for the future	All future sessions greatly welcomed	More sessions would be useful to look at what we need to take forward	Look at work such as successful pieces of work, and new ventures to meet changes in legislation	It will be useful to have a couple of additional sessions which would enable the team to develop further in terms of cohesiveness and awareness of each team's role and responsibilities	Hopefully looking forwards to improve these areas	Make plans and visions for a positive way forwards
Improvements in DWR session and learning for researcher	A little more time for warm up activity	More detail on the thematic analysis undertaken so far (i.e. data analysis steps)	I felt that a more positive approach would have been more in keeping with the style and work of tier 2 team	Not all learning outcomes were discussed and mentioned	Comment about the content being simplified inappropriate	I would have appreciated having an introduction which allowed team members to....	..share the area they chose to discuss with the researcher to set the scene and context of the discussion
Presence of all team colleagues	PMHW Stay for a whole day	PMHW were able to stay for whole day	All team members were able to attend or at least a representative number from each area	PMH team could have stayed all day	Can support staff came to these events as they are part of the team and its engine.		

Appendix 7iii. Thematic grid of e-mail responses to individual activity theory analyses in phase 1 research

Question	Yes	No	Comment
Fair, accurate record	25	0	None
Anything to be added	21	4	<ul style="list-style-type: none"> • Strategy sheets and SDQ were used with the family • Under DoL PMHW offers consultation to professionals at tier 1 & 2, seeks consultation at tier3 • See email comment on experience and rules - all assessment visits • (see email) • although a little condensed • very accurate • well represented and correct • very comprehensive
Further contradictions	5	20	<ul style="list-style-type: none"> • Perhaps to have explored the child perspective of change • Who is in charge of training? Who does it belong to is not clear. • Perhaps not all EPs see themselves as community orientated even if nearly all EPs have a community element to their work • Parents are the obvious omission (from community) they provide consent and receive information about

			the programme. Although SPARKs is a school based programme more participation could be sought through a from parent info/training session
Other comments learning	4	21	<ul style="list-style-type: none"> • [As a result] discussion re allocations meeting was held with managers to discuss overall process of allocation • It was a useful process, with outcomes that I will be able to take forward in a 'formulated' way. Many thanks. • The activity triangle is a great way to provide an overview and capture the complexities of social activity – the discussion provides a systematic structure for thinking and the record supports further reflection. • The discussion has highlighted some 'intervention drift' in practice particularly around EP role in follow-up and contribution to formal evaluation. The discussion

			<p>encouraged me to be more proactive in this area (addressing contradictions between the tools, object and DoL?) A worthwhile activity – I was glad I made time for this.</p>
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APPENDIX 8 - INDIVIDUAL FAMILY SUPPORT WORKER ACTIVITY TRIANGLES

Tools and/or artefacts: Conceptual: ECM Agenda, UN Convention Rights of the Child, Knowledge of Child Protection Process and Local safeguarding arrangements and Children act concepts of 'Good enough parenting' and the paramount importance of meeting 'children needs'. Understanding of behaviour management techniques, children's learning and development and the impact of learning disability. Understanding of mental health and limits of Strengths and Difficulties Questionnaires (SDQ).
Concrete: Observation of Parent – Child Interaction, Discussion with other relevant professionals, multi-agency meeting and liaison, Behaviour Management Advice and Strategy Sheet (adapted to be presented visually using Traffic Light Behaviour Chart). Use of Solution focused techniques. Joint home visit with other worker to introduce and facilitate transition to another service.

Flexibility required in professional judgement and the expected conventions of team?

Qualitative measures needed but quantitative expected?

Knowledge and skills in the team and those required for need?

Subject: Senior Family Support Worker (SFSW)
Experience: 17 years working with Children and Families, 9 years with Tier 2 team.
Training: NNEB, Counselling Skills, and BTEC Management
CPD: 2nd year of Social Work Training, attachment theory, anti-discriminatory practice, and disability issues

Rules:

Team members are expected to use pre and post SDQ to evaluate impact of involvement.
Tier 2 team offers time-limited intervention
Tier 2 Team members share resources
Tier 2 Team members are expected to facilitate communication between the network of professionals involved.
Collaborative co-working promotes knowledge and understanding within the team
Tier 2 team should offer consultation tier 1 professionals.

FSW trying to facilitate the communication network but some in the professional communities are reluctant to engage?

Object:
Supporting a parent with learning disability to appropriately respond to her 9 year old son with special needs and challenging behaviour

Outcomes: Hoped for: Empower parent in order to build her confidence as a parent, to set appropriate limits and ensure child's safety.
Actual: Parent responding more appropriately but in need of ongoing support.
Family Support Meeting held, when roles were agreed. Family sign-posted to Voluntary sector Family Welfare Care Worker (FWCW)

Community:

Child and Parent
SFSW (Subject)
Community Disability Nurse (CDN)
Family Welfare Care Worker (FWCW)
Headteacher and School Nurse
Adult and Childcare Duty Assessment worker,
Adult Psychiatrist (AP)
Other FSW Colleagues, EP and PMHW
Team Manager (Children Service Duty Team) (CSDT).

Division of Labour:

SFSW facilitates calling of multi-agency meeting and provides support, consultation to FWCW and signposts parent to this service and closed case.
Team Manager (CSDT) chaired meeting and was responsible for deciding whether case met social care criteria for service
All others present shared information on their view of the child's development and progress
CDN was responsible for long term support re mum's health and liaison with adult psychiatrist
FWCW provided ongoing FSW and Behaviour management advice to parent
EP, PMHW and FSWs contributed to case discussion and consultation to SFSW.

Tools and/or artefacts: Conceptual: Understanding of family development and make up and its influence on child development; understanding of parenting skills and their assessment; understanding of the influences of family environment on separation anxiety and of how to build the resilience and confidence of parents.
Concrete: Using previous experience as both parent and family support worker, to demonstrate empathy and understanding. Solution Focused techniques including problem free talk, building on the positives and resources of parent, Records of 1st Response including case record, use of scaling questions of confidence and triplicate record of actions for parent, tier 2 team staff and others involved.

Use of experience and knowledge of practice vs. theory and evidence base of approaches?

Ensuring the voice of the child as well as parent is heard?

Subject: Family Support Worker tier 2 team 5 years
Training: NNEB, Adult Teacher Training Qualification
Experience: 13years as a nanny and 3 years as a Nursery manager; Involvement in breakfast club and youth group; Personal experience of disability and caring role.
CPD: Behaviour Management and Parenting, infant and children's mental health, baby massage, stress and attachment, solution-focused approaches

Formal FSW role but informal family friendly needed? and process used

Object:
Providing a first response visit to parents of a 9 year old girl who was anxious, displaying challenging behaviour and refusing to attend school

Independent records made in multi-agency meeting but shared action agreed?

Outcomes: Hoped for: Early intervention within a week of request. To promote parents skills, to reduce anxiety and identify most appropriate agency to support.
Actual: Initial assessment of suitability of case. Signpost and referred to School Anxiety Support Team (SAST) Identify family support and parenting needs. Re-referred to Case Allocation Meeting (CAM) for further tier 2 team work

FSW as key worker and lead professional?

Rules:
All 1st response visits are allocated to FSW on a rota-basis. A 1st Response should happen within a week of request. All 1st response visits are at a neutral venue and within working hours.

All follow up assessment visits involve pairs of workers and follow the home visiting policy/protocol
Tier 2 team work is determined by the business plan and team objectives

Providing personalised package of care plus meeting standard requirements of the team?

Community:
Primary
FSW (Information and Advice)
FSW (1st Response)
Child and Parents
Secondary: Classteacher
SENCO
Behaviour Support Teacher (BST)
Assistant Educational Psychologist (AEP) (tier 2 team)
Case Allocation Meeting (CAM)

Matching skills of team with the need of child?

Division of Labour:
Parents – shared concerns and gave the history through narrative account.
FSW(1st R) – acted as key worker for family, made initial response and made records of the meeting. Subsequently acting as advocate for child and family needs at allocation meeting
FSW(IALS) - received referral, determined level of response needed and provided information and consultation to FSW(1st Response).
CAM – considered 1st Response Information and allocated case to FSW as lead agency
BST and FSW call multi-agency meeting to share/gather information, build relationships and ensure consistency of advice.
AEP – available for co-work

APPENDIX 8ii

Tools and/or artefacts: Conceptual: Drawing on the use of soft systems to create a rich picture, presentation and data analysis skills. Situational leadership, use of soft systems methodology and psychology of organisations; Use of a force field analysis to consider the pro's and cons of change; Leadership, Supervisory and Project Management Skills; Understanding and knowledge of social care services and approaches to task and project management; knowledge of community social care work and service culture; Concrete: Information and data about calls to Information and Advice Line; ; Project task schedule with clear structure, timeline and an expected outcome; Consultation activities with staff via whole service team meetings, professional meetings, steering and management group meetings and individual supervision; Group activity exercises to identify the positive and negative aspects of IALs. IT and paper systems for monitoring progress.

Subject: Team Manager (Family Support Worker) part of tier 2 team for 2 years. Manager of 10 FTE Family Support Worker within three community centre in city areas.
Experience: Social work assistant (2 years), Social Worker in Child Protection (6 years), Intensive Support (3 years), Youth Offending (3 years) and Fostering Team (1 year).
Training: Diploma in Social Work and Applied Social Science degree
CPD: Child protection and safeguarding training, therapeutic approaches CBT, social constructionism and assessment skills and in-house leadership and management programme

Supporting the delivery and consistency vs. development of Tier 2 team services?

Object: Responsibility for change management within the tier 2 team (August 06 – Nov 07) relating to the operation of the tier 2 team Information and Advice Line

Possible contradiction between the paper and IT records kept in IALs- dual processes?

Outcomes: Hoped For: Implement change but maintain the same quality and level of service despite reduce level of staffing.
To keep the advice line operating for 4 days a week and 4 hours a day.
Actual: IALs service working with one worker, use of answer-phone. Improved procedures in the operation of the Information and advice line

PMHW service availability and agency commitment to the service?

Rules:
Business Plan determines the work and priorities of the team
Tier 2 team IALs is a non-urgent service
New projects and changes in practice are piloted and the evidence of the impact is reviewed and evaluated.
Tier 2 team is designed to deliver 70% of its time to direct work in the community in face to face contact with children and families

Clarity of accountability, responsibility for decision making and collaborative management approach?

Community:
Principal EP
Other Senior Tier 2 team Colleagues including Senior EP (tier 2 team) and Senior PMHW
Service Manager (Social Care and Health).
Lead Clinician (PMHW)
FSW Professional Group
Wider Tier 2 Team members
Steering Group Members

Tension due to differences in pay and conditions of service of professional groups?

Division of Labour:
Team Manager (FSW) with responsibility to develop proposals and to implement change.
Steering Group performs decision-making duties
Senior tier 2 team colleagues provide support and a collegiate management structure
Senior EP acts as a sounding board for developments and proposals.
Senior PMHW acts as a critical friend and brings knowledge and experience of CAMHS phone-line.
Professional leaders provide supervision to own professional group

APPENDIX 8iii

Tools and/or artefacts: Conceptual: Knowledge of child protection procedures, the impact of emotional abuse, parenting, age appropriate development, play environments for children and behavioural strategies.
Concrete: Discussion with child, observation of child – parent interaction, practical help to mum to access support, solution focused approach, consultation with other professionals, use of the Quality Protects Framework for the assessment of need. Use of Magic 123 programme and sticker chart for behaviour. Active listening skills, information gathering and sharing.

The flexibility and discretion of the professional versus the requirements of team procedures and protocols?

Framework for assessment used versus the diagnostic approach used and held by others in the community about disorder?

Subject: Family Support Worker (tier 2 team) 5 years 18 years Experience as a Nursery Officer in a Family Centre and as an Early Years SENCO including liaison with other professionals, running parenting groups and stress management courses
Training includes NNEB,
CPD: Facilitator of parenting programme: Strengthening families: Strengthening communities, Solution Focused Approaches, Baby massage, Parent–child attachment theory.

Object:
Participation in a professional meeting about a 7 year old girl with an ADHD diagnosis, where there were concerns about her lateness at school, child protection and the diagnosis

Outcomes: Hoped for: Child is no longer late for school, mum will have a set of tools and be able to draw on her personal resources to manage her daughter's behaviour
Actual: Clear and direct advice given to mum, a record of concerns made and shared with an appropriate agency i.e. Social Care DAS Team

Indirect consultative work of the team and directive approach required in this case?

Rules:
Tier 2 team doesn't work with higher levels of need

Tier 2 team involvement involves an 8 session change programme

Tier 2 team requires a range of assessment tools to be used in initial assessment

Tier 2 team allows flexibility and professional judgement in the intervention approaches used

Community:
FSW (subject)
Child
Parents
Paediatrician
School staff Headteacher (HT)
SENCO, Classteacher (CT)
Primary Mental Health Worker (PMHW)
Family Support Worker (FSW) (Red Cross)
Duty Assessment Service (DAS)
Senior FSW, EP and PMHW

The support and involvement of team vs. accessing another service in CAMHS service?

Division of Labour:
School Staff- made referral
Parents – signed to agree to involvement
Paediatrician – made diagnosis
SFSW, EP and PMHW – decided case allocation
PMHW – to address health issues and liase with Paediatrician
FSW(Tier 2 team) and PMHW – undertook initial joint assessment visit
FSW (Red Cross)- provided advice and strategy from magic 123 programme
FSW (Tier 2 team) – gave advice to mum, liased with others, compiled assessment information.
DAS received information and used this to determine its level of response

Tools and/or artefacts: Conceptual: Understanding of learning by doing and supervision process. Concrete: Discussion with Supervisor to fill gaps in knowledge and about key Tier 2 team processes i.e. initial assessment, information and advice line and first response procedure. Opportunity to read through papers and procedures. An opportunity to shadow and observe other team members doing their role within and across disciplines. CYP Induction checklist to address basic understanding and needs. CWDC Schedule 'Induction to work in Children's Social Care' to self-monitor and evaluate induction learning and outcomes. Principles and values training, manual of induction procedures for both Children centre and Tier 2 team and two days departmental induction providing the bigger picture. Training in other corporate issues is planned. CBT training was coincidentally within induction period.

Elements of induction programme are prescribed but some flexibility needed to take account of the experience of new team members?

Informal social contact mainly with close team members only, and contact with other groups less frequent and more formal?

Subject: Family Support Worker (Tier 2 team 2-3 months)
Experience: Family Learning Project (2 yrs) includes work with parents, as a key worker in a Crèche
Training: Early Child Studies Degree including child development and work in schools, NVQ 3 in Childcare.
CPD: tier 2 team Induction and CBT training

Object:
Induction of FSW into Tier 2 team through training, supervision and planned activities

Induction period is long (24 wks), involves indirect and passive learning but learning by doing and observing preferred method?

Outcomes: Hoped for: Improved knowledge of team procedures, process and practice. Increased confidence and understanding of the role and core Tier 2 team competencies and skills
Actual: Combination of corporate induction and team induction activity including shadowing activity and training in key competencies

FSW are 100% within Tier 2 team but other professionals not?

Three separate induction processes used for one service and role?

Rules:
Team members have a planned induction.

You have to attend corporate induction.

FSW workers are expected to work with and support parents and through them with children

Tier 2 team work involves collaboration with other professionals

Collaboration promoted between agencies but opportunities for this limited by time and availability of profession?

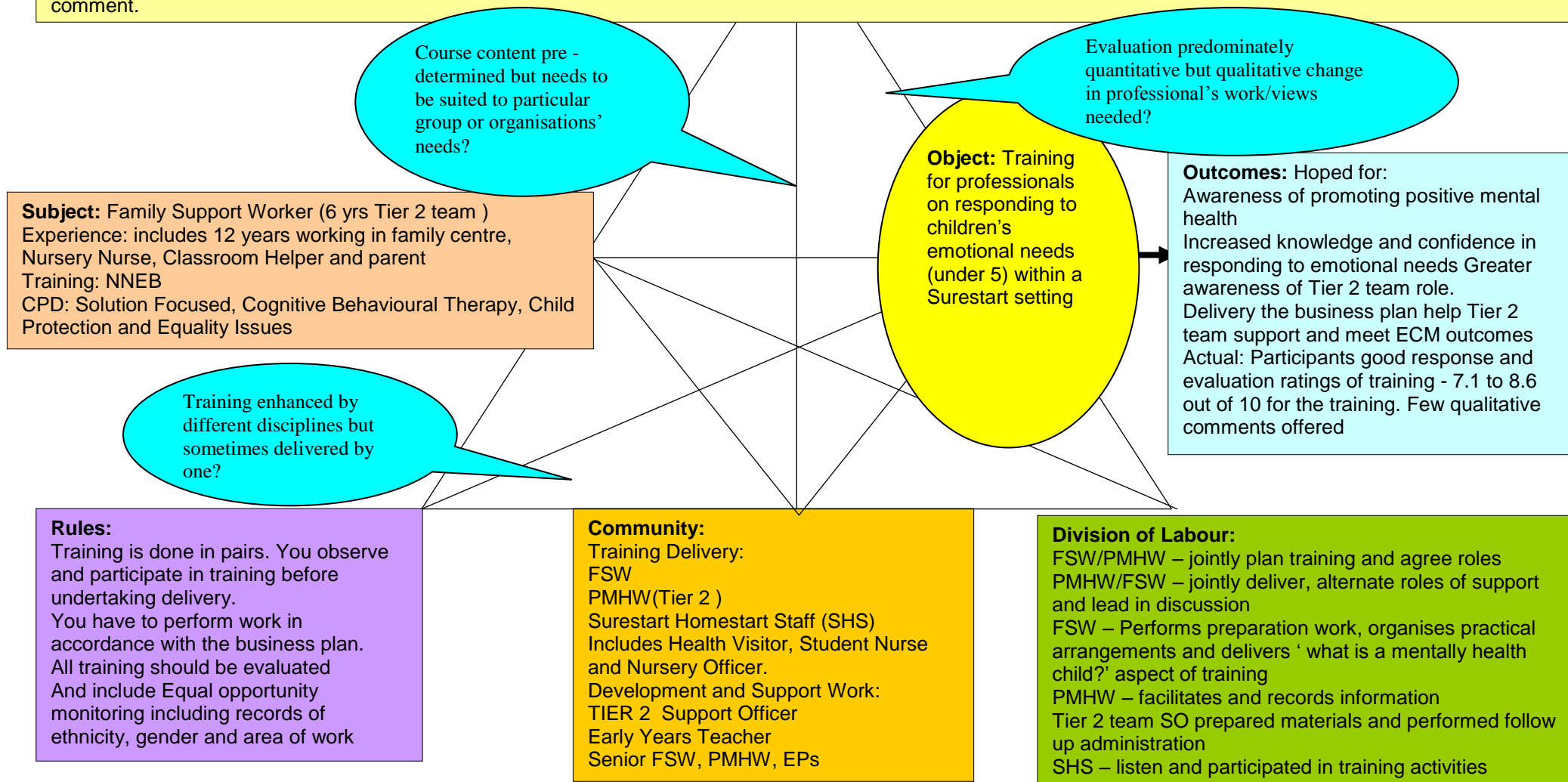
Community:

FSW
SFSW
Paediatric Nurse (PN)
Team Manager(FSW)
Team Manager (Surestart)
PMHW
SEP (Tier 2 team)
Tier 2 team Support Officer (SO)
Workforce Development Team (WDT) Training Team

Division of Labour:

FSW – participated in Induction activity and training and made some of own arrangements and was responsible for time/diary management
SFSW – provided initial induction, support and supervision for the activities undertaken
Team Manager (FSW) – oversaw and planned the induction process
Tier 2 Team members provided observation and shadowing opportunities
Tier 2 team SO - provided practical support and Info'
Workforce Development Trainers – developed and delivered corporate training programme.
Other professionals participated in training e.g. Paediatric Nurse

Tools and/or artefacts: Conceptual: Bright Futures (1999) concept of mental health; Drawing on own practical and professional experience and understanding of what supports parent-child attachment and knowledge of experiential exercises, activities and learning.
Concrete: Group facilitation and discussion drawing on a range of professional views and experiences; solution focused questioning to facilitate the discussion. Information booklet on meeting emotional needs of under fives including a directory of contacts and information about services to support mental health needs of the under 5s and their parents. Structured evaluation questionnaire used to obtain participants immediate evaluation of the training involves use of rating scale and comment.



Tools and/or artefacts: Conceptual: Understanding and knowledge of child development and disability issues; understanding of factors that impact on self-esteem and anxiety. Knowledge of 'good enough' and appropriate parenting and Department of Health guidance on mental health promotion; Solution focused practice adapted to be developmentally appropriate including the use of scaling; Informal discussion and relationship building with parents. Formal assessment using SDQ and formative discussion and planning with child and mum. Tier 2 team good practice and activity guides for parents.

Long term involvement needed but short term required?

Roles expected of FSW in Tier 2 team protocols and professional judgement about what is needed ?

Indirect support encouraged but direct work often needed?

Subject: Family Support Worker (2yrs)
Experience includes Teacher (12yrs) in FE, Curriculum Leader and trained NVQ assessor/examiner.
Training: PGCE, NNEB, and BTEC in Education and Childcare.
Professional Development includes interest in welfare of children, early intervention and parenting.

Brief Assessment and Involvement of Health Visitor and required liaison role in Tier 2 Team?

Rules:
Team involvement requires written parental consent
Requests for involvement must go to the case allocation meeting in the first instance.
Tier 2 team does short term interventions (up to 8 visits).
The work of the team supports early intervention and staff are expected to liaise with Tier 1 professionals e.g. Health Visitors

Object:
To work with a family of 5 year old boy to address the violent behaviour he shows toward school peers and parents

Outcomes:

Developed For: Improved confidence and competence of parents in managing the behaviour. Improved relationship with brother. Improved parenting

Actual: Parenting much improved
Boy now able to cross the road safely (previously being unaware of dangers)
Relationships in school and with peers much improved but child and family with unmet need and referred to another service i.e. CCAT.

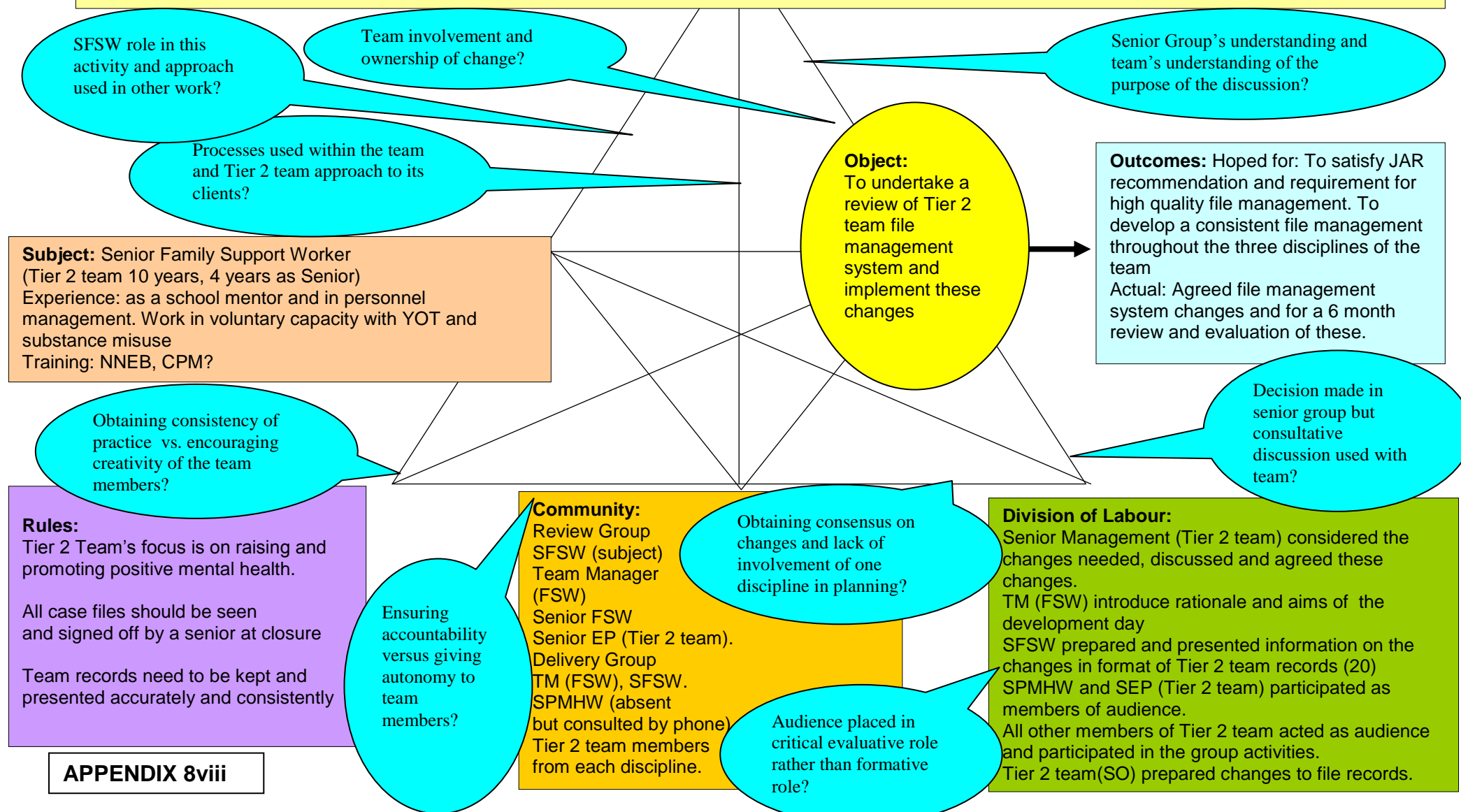
Community:
Child, Father and Mother
Maternal Uncle (Mother's brother)
Family Support Worker
GP and Health Visitor (HV)
Community Care Assessment Team
Adult Social Care Disability Team (Duty Assessment Team)
School Staff
Senior Tier 2 team Staff

FSW role in meeting the needs of Parent and Child?

Division of Labour:

School – publicised the service and provided information to parents
Parents – Self refer to service and share concerns
Maternal Brother – offered respite care to Health Visitor - undertook initial screening of child's and parent's needs
Senior Tier 2 team staff – consider referral and allocate the case to appropriate agency
FSW – provided informal and practical support to parents and referred on to another service or helped parent to access these services.

Tools and/or artefacts: Concrete: Adapted file records and management system, collaborative discussion in group as Seniors, didactic presentation to full tier 2 team using OHT outlining changes proposed. Followed by whole group discussion and consideration of 20 record forms.
Conceptual: Drawing on knowledge of Joint Area Review Outcomes, Social Care Procedures and underlying Child Protection and Safeguarding procedures and reasons for accurate record keeping and file management is important.



APPENDIX 8viii

Tools and/or artefacts: Conceptual: Understanding of age appropriate development and milestones, behaviour management techniques, understanding the causes of attention seeking behaviour and possible strategies; Experience and knowledge of other professional work, processes and procedures; Background understanding of ECM agenda and safeguarding procedures. Concrete: Solution focused script, phone-line protocols and scripts and record forms including call log, initial inquiry form, first response form and, where appropriate referral forms; Use of the 'to do' file, screening of the case allocation referrals to check information is correct. Computer, fax, phone and photocopier and access to the Internet.

Worker duty to child protection and the nature of the confidentiality given to parents?

City and County referral procedures vary i.e. parental vs. professional?

Dual processes used both paper and IT based systems - some duplicated information? and effort?

Having a script versus personalising response to need?

Subject: Family Support Worker 1 year (Tier 2 team)
Experience: Nursery Officer (13 years) in a social service family centre including parenting work; Classroom Assistant, Telephonist and Parent.
Training: NNEB trained including child development, play and environmental stimulation etc
CPD: Child Protection, Parenting, Solution Focused and Cognitive Behavioural Therapy, CAF and multi-agency working

Line is open 10 until 2pm but needs 24/7 answerphone?

Object:
Working on the Tier 2 team
Information and advice line providing consultation, support and advice to parent

Outcomes: Hoped For:
Parent informed about the service or provided with information/contact of a more appropriate service.
First response or a referral agreed.
Parent provided with reassurance and basic advice re strategies.
Actual: Agreed 1st Response, completed initial inquiry, identified FSW on rota, allocated case, booked room, (returned phone-call?) sent letter to parent as confirmation of appointment

Rules:
Workers on line to should follow the set script and IALS procedures.
Workers switch answer-phone on/off at start and end of session and completes tasks in 'to do' file. Workers should obtain the postcode from the caller. Workers should advise parents who report involvement of CAMHS and Social care services, or live outside city boundary, or are age 11 (Y6) and above, that they cannot have service.
If need described is severe and outside Tier 2 team criteria parent should be advised to seek more appropriate support elsewhere.
1st Day responses are made by FSWs where appropriate on a strict rota basis.
All work should follow the business plan

Working alone or as part of the team? The process of support for difficult issues e.g. distressing calls or language limitations?

Individual service line vs. Comprehensive CAMHS approach?

Empowerment of the parent vs. helping them to access a service?

Community:
Parent (and Child age 5)
FSW (IALS)
FSW (1st Response Rota)
Senior FSW (SFSW)
Community Venue Manager and reception/administration
Support Officer (SO) (Tier 2 team)
CAMHS (Phone-line)

Division of Labour:
Parent makes call.
FSW (IALS) receives call, gets and gives information and agrees next steps; Consults SFSW and other service including CAMHS phone line as necessary and gives feedback on outcome/decision to parent.
Allocates case to next FSW on 1st Response Rota; Sets the 1st Response appointment and books room.
SFSW offers phone supervision and advice FSW (IALS) sends information to SO (Tier 2 team) to forward to allocated FSW
CAMHS advice line offers consultation to FSW IALS

APPENDIX 8ix

Tools and/or artefacts: Concrete: Course uses video, supported by a participant pack and use of worksheets/exercises. It involves delivery of theoretical underpinnings of solution-focused approaches and background to the approach. Drawing on the work of DeShazer and Berg. Case studies and practical applications of work are used to demonstrate how the principles of SFBT are applied to work with children and families. The solution-focused approaches used include problem free talk, exception finding, the think break and scaling. Each aspect of the approach is presented and then practised in pairs or small groups using scenario exercises. Both Tier 2 team and Staff Development (SD) evaluations are used; Tier 2 team uses scaling and written feedback. SD use phone interview and oral feedback.

Solution focused approach and the problem orientated work of some in the audience i.e. those engaged in child protection?

Methods used in evaluation and the purpose of the tools used by Tier 2 team and SD teams?

Subject: Senior Family Support Worker (Tier 2 team) 9 years with 3 years as FSW
Experience: includes work as Tutor and Assessor of Childcare courses (NVQ and BTEC) Crèche supervisor for a community college, Nursery nurse in a special school, work as nurse in maternity and residential care settings.
Training: State Enrolled Nurse (SEN), NNEB, Registered Assessor, Facilitator of strengthening families and strengthening communities parenting programme.

Object:
Involvement in the development and delivery of solution focused training to groups of children's service professionals

Outcomes: Hoped for: Practitioners go away with interest and knowledge of SFBT Professionals with additional skills to apply in their work with children and families. Encourage experimentation in the use of positive approaches and extend thinking. Actual: Follow up session provides a review of participant's success and problems in applying the approach. Attendance rates at follow up are good and very positive experiences are usually reported and recorded in evaluation of the course

A difference in presenter's understanding of the process and content of SFBT?

How trainers are determined and the opportunity and skill of team members?

Rules:
Provision of solution focused training is part of the Tier 2 team business plan
All Tier 2 team members are expected to know about and use Solution Focused Approaches
Experience in training is developed by Tier 2 Team members observing, supporting and then leading it.
Training should have agreed aims and learning outcomes and be evaluated by SDT.

Community:
SFSW (Tier 2 team) Subject Member of Staff Development Team (MSDT)
Other SFSW
SEP (Tier 2 team)
EPs
PMHW
FSWs

Time constraints and the availability of other team members to deliver training?

Division of Labour:
SFSW leads SFBT training both in and outside team. SFSW/MSDT have joint planning meeting
MSDT does theory input to training
SFSW worker does practice-based input
SFSW, SEP (Tier 2 team) and SPMHW act as small steering group and decide on SFBT trainers
All other team members (EP, PMHW, FSW) can be drawn in to deliver training depending on need and setting involved.

APPENDIX 8x

Tools and/or artefacts: Conceptual: Knowledge of child development, 'good enough' parenting, sibling rivalry and understanding of child protection procedure. Knowledge of cultural issues and understanding of how this would impact on family perception of mental health. Knowledge of the assessment framework and understanding of systems theory. Concrete: The use of listening and relationship building skills. Strategies sheet and triplicate carbon copy booklet used to feed back. Child, parent and teacher Strength and difficulties Questionnaire (SDQ) were available but not used on this case as it was felt inappropriate and solution focused scaling questions used. A follow up session.

Tension between the support role, and child protection role of Tier 2 team FSWs?

Tension between the thresholds held by Tier 2 team and those of other services?

Subject: Family Support Worker (8 years Tier 2 team)
Relevant Experience: Nursery Officer (10 years) within a Family Centre; Crèche worker in a college and summer scheme; and work within retail business.
Training: NVQ Level 3 Childcare and Education
Professional Development: includes solution focused therapy, cognitive behavioural therapy and Strengthening Families, Strengthening Communities Parenting Programme.
Currently undertaking social work degree

The complexity and severity of child and family needs and the expected length of Tier 2 team involvement?

Object:
To provide support for a 're-referred' parents to help them in understanding and managing the behaviour of their 9 year old son with learning and behavioural difficulties.

Outcomes: Hoped For: Improvement in parent's understanding of their child's needs.
Improvement in both parent's management of behaviour including structured routines and positive attention.
Actual: Child given ADHD diagnosis and referred to specialist CAMHS
Closed case and parent referred on to Family Action Service (FAS)
No significant changes in parenting observed.

Rules:
Involvement of specialist CAMHS means work Tier 2 team should cease.
Tier 2 team work is time limited
Child must be seen as part of Tier 2 team direct work to check to rule out any child protection concerns.
All work c needs to be conducted within service policies on record keeping, child protection and health and safety.
Assessment Follow up at 3mths

Agenda and model held by school staff versus agenda and model of Tier 2 team worker and their purpose, objective and role in this case?

Community:
Child – boy 9 years old
Parents - Mum and Dad
FSW (Parenting Programme) and Previous Caseworker))
FSW (Allocated Worker)
EP
Teacher (BST)
School Mentor (SM)
Class teacher (CT)
SENCO
Specialist CAMHS
Family Action Service (FAS)

School objectivity and assessment and the assessment of external agencies such as Tier 2 team?

Division of Labour:
FSW (PP) suggested re-referral of parent
FSWs (PP and AW) made initial joint assessment visit to introduce new allocated worker as well as undertaking an updated assessment.
FSW (AW) then followed up work with five home visits and two multi-agency meeting involving EP, BST and School Reps.
SENCO chaired the meetings. Parents attended at the end of the meeting
EP undertook assessment separately and referred to specialist CAMHS
FAS – received and accepted referral at Tier 2 team closure

APPENDIX 9 - INDIVIDUAL PRIMARY MENTAL HEALTH WORKERS ACTIVITY TRIANGLES

Tools and/or artefacts: Concrete: DVD based on Attachment in Practice (Svenberg?), PowerPoint presentation of infant attachment theory, individual and group discussion, experiential activities and active listening skills (reflecting and reframing etc), Tier 2 team booklet on mental health of children including local directory of services, EY Service Evaluation tool. Definition of mental health, and risk and resilience taken from Bright Futures (1999) Mental Health Foundation and Think Family (2008) Initiative and Scottish Heads Up – infant mental health programme.

Conceptual: Attachment theory, concepts of mental health, risk and resilience and understanding of the influence of individual, family and environment factors using models from family therapy and systems theory. Other theoretical frameworks that informed approach included principles of solution-focused approach, behaviour management and link between adult–child Mental Health (Fogarty?)

Tension between the diversity of audience needs and the predetermined nature of programme?

Subject: Primary Mental Health Worker (Tier 2 team)
In Tier 2 team for 9 years since inception
PMHW Time split 3 ways Tier 2 team (tier 2), Specialist CAMHS (tier 3) and Primary Care (tier 1)
Experience: Social Worker in Child Protection and Crisis team and social worker in a residential unit.
Training: Diploma and MA in Social Work, Diploma in Child Mental Health
CPD: Systems theory and Family Therapy, CAF

Object:
½ day training courses on child mental health for early years care providers

Outcomes: Hoped For: Better understanding of child mental health
Building professional confidence in own knowledge and skills
Understanding what promotes positive mental health.
Better understanding own and other roles.
Actual: Highly regarded training with positive quantitative and qualitative evaluations and some anecdotal evidence of improved practice in support of child MH outcomes.

PMHW special expertise vs. enabling others to fulfil aspects of the role - What to give away safely?

Rules:

TIER 2 Team is here to promote a positive model of mental health and to collaborate and work with other professionals at tier 1.

Training in EYs needs to be professionally presented and meet EYs quality standards.

PMHW and other workers are autonomous professionals with skills and competencies.

Building the capacity and resources of other professionals will ultimately save time and support earlier intervention

Community:
Development:
PMHW
Senior FSW,
EP (Tier 2 team)
Early Years SENCO
Delivery
EP, PMHW
and EY SENCO
25 participants

Time available for this work versus demand from other aspects of role i.e. casework?

PMHW main link between tier 1,2 and 3 in health vs. creating links and better understanding across whole team?

Division of Labour:

EP (Tier 2 team) initiated idea of extending training to early Years settings and led development.
Early Years SENCO had responsibility for ensuring training and materials was of a suitable standard.
Area SENCO introduced course
PMHW involved in planning and developing input on attachment and mental health services.
FSW contributed to delivery and brought an understanding of the practice of the 'customer'.
Tier 2 Team members alternated contributions during delivery

Tools and/or artefacts: Concrete: Information and Advice Line sheet, request for support sheet, sheet detailing the list of cases to be discussed with space for agreed actions and allocated agency (where appropriate). Past files when appropriate and discussion and debate about suitability of the case and what is an appropriate case for PMHW. Conceptual tools: include ideas and understanding of what is a straightforward 'mental health' issue including understanding of principal symptoms of conditions such as self harming. Understanding of what is the Primary Mental Health Worker role.

PMHW understanding of role and others' understanding of it?

Knowledge of other Tier 2 team professional roles and decision-making in a particular case?

Allocated worker's understanding of decision and need, and information shared from CA meeting?

Tension in having two separate professional and administrative processes?

Subject: Primary Mental Health Worker (PMHW) (Tier 2 team 4 years),
Experience: PMHW (LAC) within Specialist CAMHS, Social Worker in Therapeutic and Child Care Teams (3yrs) and Residential Social worker (4yrs)
Training: Social Work CQSW, Child Psychotherapy, CPD: Attachment theory, counselling(diploma), CBT, SFBT, Child Protection, parenting and Infant Observation and mental health

Object: PMHW contribution to Tier 2 team case allocation meeting and follow up process when a PMHW case

Outcomes: Hoped for: Child is supported by appropriate agency and discipline. Appropriate course of action is determined.
Case is sign-posted to another agency if needed:
Actual: Case allocated to agency, outcome communicated to parent(?) and child placed on agency waiting list. Cases for PMHW go to next case referral meeting for PMHW service for further discussion (?)

Rules:
Cases discussed at case allocation meeting must have referral form with all the necessary information provided.
A referral must be signed by a parent as indication of consent.
Participation in case allocation is rotated between team members.
Each discipline has to be represented in the discussion.
Meeting should be a collaborative process in which consensus is reached.
Disagreements would be referred to Senior's Group?

Rotating membership of CAM and consistency of decision making?

Community:
Case Allocation Meeting (CAM):
PMHW
EP
SFSW
Tier 2 team Support Officer
PMH Service Meeting
2 SPMHW city and county
PMHW administrator
Other: Parent and IALs Worker

Time available from each discipline, waiting time and case need?

Division of Labour:
Tier 2 team (SO) prepares agenda and case papers
IALs worker checks the information required is available and requests this where needed.
PMHW/EP/SFSW represent own agency, consider cases and allocate to agency as appropriate. Chair/note taker agreed jointly – note of agreed allocation made but reasons for decision not?
PMHW contributes knowledge of mental health and CAMHS service criteria, waiting list and priorities. EPs and FSW represent their respective agency criteria for involvement and service availability.
PMHW carries allocated cases to CAMHS PMHW service. PMH service administrator processes referrals for PMH Meeting. Senior PMHWs meet, consider and allocate cases to PMHWs waitlist.

Tools and/or artefacts: Conceptual: Thresholds and criteria to decide the level of mental need and access to a particular tier of service Tier 1/2/3. Knowledge of services available at tier 1,2,3 or 4. Knowledge of assessment frameworks to gather evidence of mental health need versus those that are more behavioural and socially determined. Knowledge of learning disability, and its potential impact on mental health.

Concrete Tools: Care plans and protocols including set standards and measurement of response times. Assessment tools to support mental health formulation including use of known symptoms for certain conditions and checklists. Tier 2 team referral guidelines, referral forms and baseline questionnaire. Parent referral (city) and professional referral (county) information (?)

Competing workload pressures versus need to offer equality of access to service from each tier?

Tier 2 team age limit of 11yrs and PMHW and CAMHS Tier 3 go up to age 18?

Subject: Senior Primary Mental Health Worker (Tier 2 team 5years).
Experience: includes Specialist CAMHS Worker for Learning Disability outpatient work for 10 years. Manager of home for adults with learning disability (3 years), Community Nurse for Learning Disability and Inpatient Disability Ward Nurse.
Training: State Enrolled Nurse and State Registered Nurse.
CPD: Management training, experience of multi-disciplinary work and audit of CAMHS trends. Experience of Play Therapy, Family Therapy and Solution Focussed Therapy and experience of CAMHS services for children with learning disability

Object: Operation of the Single Point of Access to PMHW service and its link with Tier 2 team referral process

Outcomes: Hoped for: Consistency of response and decision making. Equality of access to service Screening of referrals and a timely and appropriate level of response matched to need. Match the skills and resources of team to child and family needs
Actual: Approximately 14% referrals are currently not appropriate
Consistency in core group decisions. PMHW (Tier 2 team) act as a conduit to referral to specialist CAMHS and subsequent PMHW involvement

Rules:
Each case needs to be assessed for potential indicators of risk and severity and complexity of Mental Health Need. Nominated lead agency has responsibility for records and processing referral and information
Involvement of specialist CAMHS leads to closure of Tier 2 team case. Access to specialist CAMHS is defined by criteria that are clinician determined. Those with risk factors would get an early response

Tension between the time available and the criteria used to access PMHW in Tier 2 team?

Community:
Tier 2 team allocation meeting
Senior PMHW
Senior FSW
Senior Practitioner EP.
Primary Mental Health Service Meeting
Senior PMHW (City and County)
Consultant Psychiatrist
Wider CAMHS team
CPN, OT, and Clin. Psych?
Referrers: GPs, SWs, EPs are approved referrers

Understanding of each agency role and criteria and PMHW acting as main link?

Consistency of decision making and rotating members of group?

One PMHW service, two teams and 3 tiers?

Division of Labour:
Referrers (Parents for Tier 2 team) complete referral form or professionals provide letter of referral to PMHWs service
Tier 2 team meeting chair and note taker rotated, brief notes made of outcome and agency allocated.
PMHWs meeting
SPMHW chairs (rotated between county/city)
Administrator takes minutes and notes decisions
Psychiatrist offers medical perspective and opinion (Which Psychiatrist attends varies?)
PMHW consult with school nurse, health visitor, connexions worker and seeks further clarification from parent or professional referrer if needed.

Tools and/or artefacts: Conceptual: Approaches drawing on behaviourist principles, attachment theory and historical development of the child and their environment. Use of medical and family history. Understanding of the diagnostic criteria for mental health disorders such as ADHD. Concrete tools: include initial assessment pro-forma, observation in school of teacher-child interaction and at home of parent-child interaction. Teacher and parent Strength and Difficulties Questionnaire (SDQ) used as a measure, other scaling questions to support evaluation. Case supervision and support from CAMHS Occupational therapist and line manager supervision to aid formulation of need.

Use of a psychiatric diagnosis and the empowering preventive work within Tier 2 team?

Medical model of base agency team and the psychosocial nature of the work within Tier 2 team?

Subject: Community Psychiatric Nurse (Tier 2 team 2 months) seconded to the Primary Mental Health Work Service for 3 months
Experience: 7 years as a Psychiatric Nurse of a tier 4 inpatient facility treating a range of diagnosed conditions. Previously seconded to Specialist CAMHS setting for 3 months.
Training: Nurse with specialisation in mental health. Currently studying a Postgraduate Certificate in Primary Mental Health Work.
CPD: Law degree, shadowing and work placement as part of primary health work course modules include child development, stigma, family systems and therapy etc

Object:
To undertake an initial assessment of a 5-year old boy with behaviour and anger control issues supported by a colleague.

Outcomes: Hoped for: Improved understanding of the behaviour of the child beyond a diagnosis
Improved understanding of the family dynamics and mum's competencies in managing behaviour and creating an appropriate home environment.

Actual: Normalised the child's behaviour, ruled out ADHD by observation and discussion and reached a professional consensus about the child's needs.

Tension between professional autonomy and accountability?

Rules:
Child Protection is paramount to the work of professionals

Initial Assessment should follow agreed protocol

Professional records should be kept detailing involvement, actions and outcomes

Ensuring consistency of practice vs. allowing room for creativity and diversity in practice?

Community:
Tier 2 team Case Allocation Panel
Community Psychiatric Nurse (CPN)
Senior PMHW
Occupational Therapist (OT) (Specialist CAMHS)
Other Tier 2 team professionals
5 year old boy, 8 year old sibling, mum and partner
Class teacher
Supply teacher.
GP

Support provided by single agency but multi-agency team available?

Division of Labour:
SPMHW led the initial assessment, delegated role to CPN to follow up with the child, family and school and provided case supervision as appropriate.
CPN supported assessment, consulted with OT and SPMHW and undertook school observation and discussion with classteacher, OT provided case consultation to CPN(PMHW) regarding school observation
Mum and partner provide information on child. School provided information on behaviour in class and school.
GP received information on outcome and closure

APPENDIX 10 INDIVIDUAL EDUCATIONAL PSYCHOLOGIST'S ACTIVITY TRIANGLES

Tools and/or artefacts: Conceptual Tools: Understanding of behaviour theory including the principles of reinforcement and what leads to attention seeking. Knowledge of approaches to behaviour management such as those suggested by Bill Rogers. Knowledge of schools and school systems and solution-focused brief therapy approaches. Understanding of the impact of bereavement on adult behaviour toward children. Concrete Tools: Active listening and use of counselling skills such as challenging and confronting carer with their own behaviour and its potential consequences to create opportunity for change. Initial assessment visit form, SDQ, scaling questions, carbonised pad to record outcomes and provide complements. The use of peer consultation within joint Tier 2 team working partnership.

Tension between time available from EP and providing early assessment and intervention?

Subject: Senior Practitioner Educational Psychologist (Tier 2 team 5 years)
0.5 time with Tier 2 team and 0.5 with CPS.
Experience: Educational Psychologist (13 years), Teacher for 21 years across primary, secondary and in a specialist teaching service for literacy support.
Training: Masters in Educational Psychology, PGCE and Psychology Degree
CPD: A range within EP role including behaviour management, SfBT and problem solving approach.

Object:
Supporting the main carer with the management of her 6-year-old granddaughter's behaviour at home.

Performing a supportive role but needing to challenge and confront client about their own behaviour?

Outcomes: Hoped for: Improvements that meet the clients own goals for change and their reasons for requesting support.
Actual: Positive evaluation and improvement reported by grandmother such that she didn't feel she needed further support

Evaluation used from one perspective and not school or child in this case?

Rules:
Initial visits and assessment should occur within a short time period after referral.
Parental consent should be obtained to contact other agencies involved.
Pre- measures need to be taken on initial visit using SDQ and scaling of confidence.
Tier 2 team involvement involves a maximum of 8 sessions.
Cases should be followed after a 3-month period.

Community:
Case Allocation Panel involving EP, FSW and PMHW.
SEP (Tier 2 team)
Child
Grandmother plus partner
EP (Tier 2 team) Lead Agency
FSW Support Agency
School SENCO
Senior Teacher (BST)

Division of Labour:
Case Allocation Panel allocates case to relevant discipline.
SEP (Tier 2 team) gives case to appropriate EP
EP (Tier 2 team) performs nominated lead agency role.
FSW performs support role
EP/FSW undertake consultation prior to involvement to plan visit and then did joint assessment home visit.
Grandma provides information on her concerns and sets goals
EP leads initial assessment and took on the challenge role and work with the adult.
FSW took support role and provided positive feedback to family and worked with child.
EP liased with BST/SENCO re school behaviour.

Tools and/or artefacts: Concrete Tools: Promotional activities include departmental market stall days to promote and share information about the team's work and Tier 2 team promotional leaflets and materials. Evaluation tools used are both quantitative and qualitative including use of survey and questionnaire, use of SDQ as pre and post intervention measure as well as solution focused scaling from parents/child as appropriate. Other questionnaires used occasionally include LAWSEQ and B/G esteem. Parent support group is used occasionally for consultation to obtain a consumer perspective on service provision and developments (?). Full team and professional group discussions are used to gather information from the frontline and the professional perspective on need and provision. Common themes are then identified by senior staff before setting priorities in the plan. Conceptual Tools: Understanding of small group and whole group work and team management skills are used to support decision-making. A PATH framework is used to involve team in identifying vision. Knowledge and analysis of the national direction and priorities using DoH/DCSF guidance on ECM/NSF as a backdrop to current practice and future priorities.

Using implicit assumptions about team involvement
Vs having explicit processes and procedures for
planning and consultation?

Review processes used and obtaining wider
CAMHS professional perspective?

Subject: Senior Educational Psychologist (Tier 2 team 5 yrs). Roles include line management and professional supervision of psychologists and contributing to the strategic management of the service. 20% time used for participation in wider Psychology Service management. Experience: includes work as a High School teacher and as an EP (15yrs) since 1988 initially as main grade and then specialisms in ASD, Bilingualism and Early years. Training includes Masters Degree in Educational Psychology and teacher training. CPD includes amongst other things Sfbt, Art Therapy and CBT. Relevant experience includes community based project management, participation in LA work groups and team development activities, involvement in CAMHS commissioning group, joint steering group CAMHS, Be Healthy Theme group and parenting strategy sub-group.

The priorities of partner
teams and differences in
the commitment of each
to tier 2 team multi-
agency planning and
delivery?

Object:
Development of
the Tier 2 team
Business Plan
to underpin
the team's
activity and
work.

Outcomes: Hoped For: The development of the Tier 2 team business plan based on a review of existing work and evaluation of outcomes and impact. The team, service user and Tier 2 team and CAMHS and Tier 2 team steering group perspective are obtained in setting service plan and priorities. Actual: identify any unmet needs through feedback from clients and team. The parameters of the work to be undertaken by the team are agreed including what the team does and does not do and priorities and objectives are established. The team is successful in meeting the psychological and emotional needs of children and families it supports and this is supported by evaluative evidence.

In trying to promote and deliver
both indirect consultative service
and direct work with children?

Rules:

Children's needs and unmet needs are of paramount importance to the team. Team members should put needs of children and families needs first. Service clients are defined by age up to 11 year and level of need. Funding is limited so the team's work has to be cost effective. The team must demonstrate its effectiveness through effective evaluation. The team should be consulted in the business planning process. Strategic Managers and Steering Group are responsible for deciding on and finalising the plan. Team members need to understand the extent and limit of their role within the development and implementation of the plan

Community:

Senior EP (Tier 2 team) (Subject)
Principal Educational Psychologist (PEP)
Tier 2 team Steering Group (including PEP,
SPMHW, TM (FSW), Voluntary sector
representatives.
Joint Steering Group (CAMHS)
XXXXXXshire Children and Young
People's Partnership.
CAMHS Commissioning Group
Be Healthy Theme Group
Parenting Strategy
Group
Tier 2 Team.

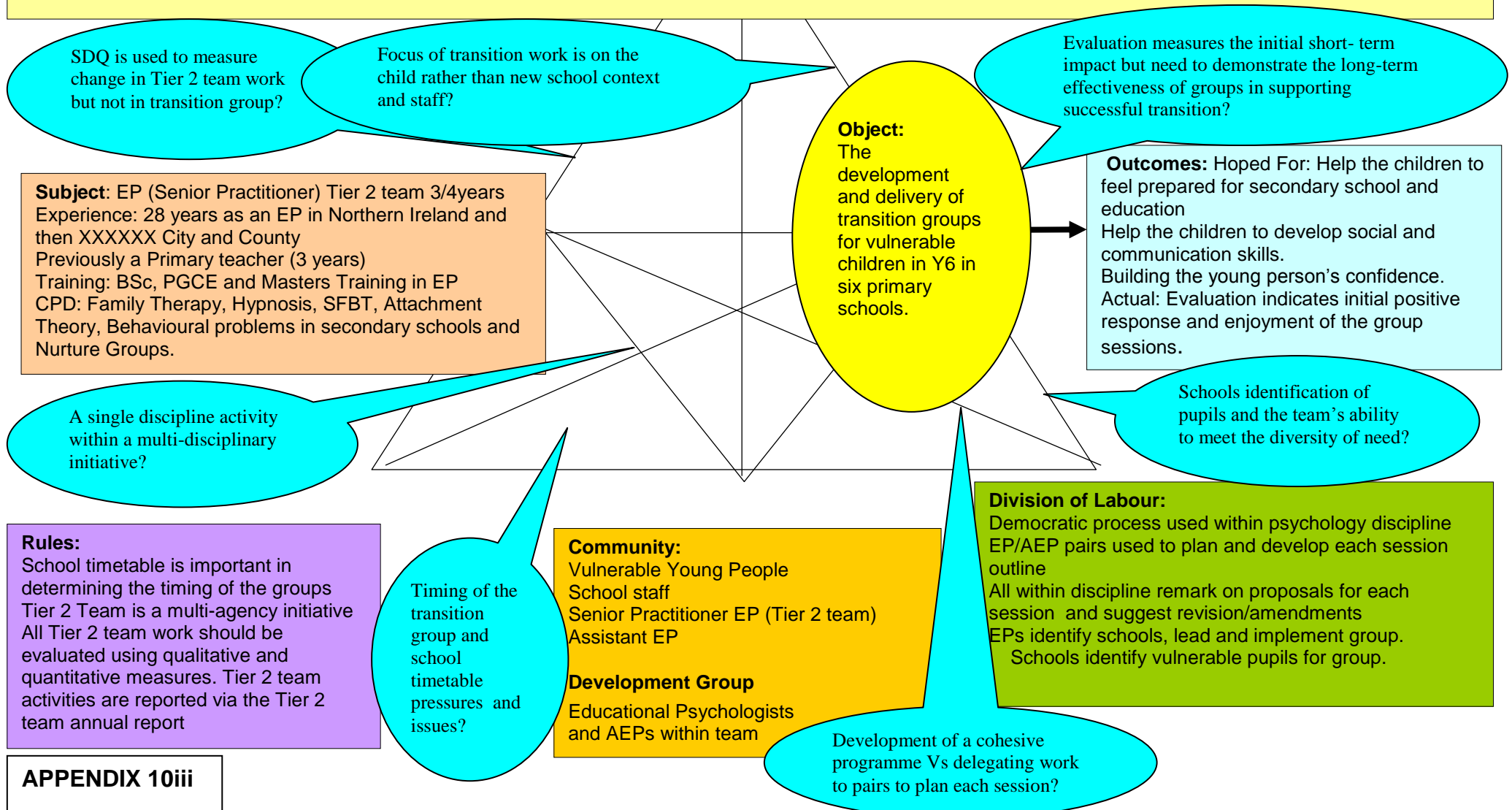
Service designed to support
parents but how to include
their perspective fully in
service planning?

Division of Labour:

Joint Steering Group agrees remit and parameters of the team. Senior EP (Tier 2 team) draws up plan within these parameters and presents to the steering group for comment, amendment and agreement. The Business plan is then shared with team for comment. Principal EP oversees the budget including receipt of grant funding and expenditure to support the plan. Tier 2 team Steering group establishes the objectives and priorities of the team within the plan. Tier 2 Team then implements plan and priorities including targets for direct work 70%, Training 10%, Consultation 10% and IALs (?).

Tools and/or artefacts: Conceptual Tools: Programme is a 5 session programme which draws on concepts from SPARKS pro-social skills programmes, solution focused and cognitive behavioural principles and involves use of individual and group activities which are practical and fun. Evaluation tools used include the use of scaling.

Concrete Tools: Tier 2 team Booklet on Transition developed from a range of sources includes icebreakers, introducing self and meeting new people, getting to know a new culture, confidence building and saying goodbyes. The programme includes consideration of practical aspects of going to secondary school and preparing for this.



Tools and/or artefacts: Concrete Tools: Meeting uses agenda, chair/minute taker and minutes as record of meeting. Democratic processes used to support decision-making. Conceptual Tools include Knowledge and awareness of group theory, dynamics and processes and supported by clear communication and dialogue. Drawing on problem solving model and approach, Checkland's soft system methodology, self-organised learning and the management of organisational change (Drawing on Senge, Dance of Change). Meeting draws on a solution orientated approaches and uses awareness of the importance language and discourse with and between agencies.

Attempting to support democratic processes at the same time as holding executive power?

Professional responsibility and role for professional supervision Vs management support and/or challenge?

Support for professional innovation Vs managing any professional (turf wars?) disagreement between agencies?

Subject: Principal Educational Psychologist (PEP) and Member of the Tier 2 team Steering Group
Experience: Previously SEP within XXX City for 2 years, a Senior Practitioner EP for Tier 2 team for 4 yrs and SEP for another authority for 4 yrs with BEST team. Previously a teacher for 9 yrs
Training: PGCE, Psychology degree, Masters in Educational Psychology (Nottingham) and
CPD: Doctorate in Educational Psychology

Agency worker e.g. (PMHW) acts as main link to own agency (health) but does this build understanding and collaboration in Comprehensive CAMHS?

Object: Participation in the discussion, information exchange and decision-making in the Tier 2 team steering group and linking with other strategy groups and

Outcomes: Hoped for: Steering group effectively manages Tier 2 Team activities, monitors budget and impact through outcome measures and collaborative processes.
Actual: Tier 2 Team work by work parameters are agreed, set and monitored by steering group.
Tier 2 team provides a model of multi-disciplinary practice, co-ordinates engagement and activity of the team and creates links within Comprehensive CAMHS.

Involvement/commitment of each agency to strategic planning and the contribution they make to delivery?

Attendance and level of engagement in steering group vs. commitment to initiative?

Rules:
Service has to operate within the budget and grants are available. The team has to demonstrate its effectiveness
Meeting operates to agenda with standing and non-standard items
Each agency contribution is of equal value and importance
Tier 2 team is a Tier 2 service that should work in and link to Comprehensive CAMHS.

Participation of Specialist (CAMHS) in Tier 2 team (Clin.Dir) in planning, decision making and delivering Comprehensive CAMHS?

Community: Steering Group members
CAMHS (City/County) commissioning group and manager
School and Community Health Team (SCHT) now TaMHs?
SEP (Tier 2 team)
Senior PMHW
Senior SW manager
Team Manager (Family Support)
Team Manager (Behaviour Support)
Policy Officer Social Care
Clinical Director (Tier 3 CAMHS)

Division of Labour:
Chair and minutes rotated between members of steering group
Members of each agency can raise agenda items and meeting attempts to provide equality of agency input. PEP attends as Head of Psychology Service budget holder and line manager
SEP (Tier 2 team) provides operational and strategic leadership and management
SPMHW provides clinical perspective and link with specialist CAMHS
All members contribute agency perspective and consider inter-agency ethical dilemmas.
Clinical Director (CAMHS) no longer attends.

Tools and/or artefacts: Conceptual: Understanding of Rogerian Theory and humanistic psychology, cognitive behavioural principles in anger management using concepts such as self-regulation. Concrete Tools: included letter sent to parents explaining aims and objectives of project using slightly different terminology to describe project (one didn't use term Domestic Violence (DV)). Training materials covering an introduction to DV, and covering we choose to be kind, we all have feelings and help is in your hands. Drawing on work from SPARKS (Special Pro-social Assertive Resilient Kids) programme, use of Persona Dolls, teaching skills and experience of class and group management. Rotating group work used with children moving to different facilitator for each part of the training.

Knowledge of school organisations, class and group management versus the tools used to negotiate entry and organise groups?

Possible ethical issue about information shared with parents and the consent given was it properly informed?

Possible Contradiction?

Knowledge, confidence and competence of team members vs. role taken in training?

Link to SEAL?

Subject: Assistant Educational Psychologist (Tier 2 team 14 months):
Experience: Formerly a teacher within special schools Inc SLD/Autism and previous work as a residential support worker for LAC/children who had Autism/challenging behaviour. Also Teaching assistant for LAC in mainstream school.
Training PGCE, Applied Psychology including input on Development Psychology by former EP

Object:
Development and delivery of a half day pilot workshop for year 6 pupils on Domestic Violence (DV)

Outcomes: Hoped for: Training materials which looked at DV and its impact on children. The materials and training needed to be suitable for Y6 pupils and aimed to raise their self-awareness and to support early intervention.
Actual: Two ½ day workshops in two schools with follow up evaluation session. A completed draft report highlighting positive impact and feedback received from project workers, school staff and children.

Training offered versus knowledge of school context?

Rules:

Projects are time and funding limited.
Projects need to fit with participants other timetable, priorities and needs.
Projects undertaken need to be evaluated and outcomes reported to managers and commissioners
New initiatives rely on funding for continuation.
Parents should give consent to project and research work.

Community: Tier 2 Team
Assistant EP (Subject)
Primary Mental Health Worker
Family Support Worker
DVIRP Team Children and Young people's manager and therapeutic worker (DVRIP CYPM)
School Staff and children in two primary schools
Tier 2 team Steering Group including SEP (Tier 2 team)

Team collaboration in development and delivery but not at report writing stage?

Division of Labour:

SEP (Tier 2 team) nominated AEP to participate. AEP was responsible for developing certain aspects of materials i.e. 'we all have feelings' section and in facilitating groups in workshop.
DVIRP CYPM negotiated entry to one school and provided a draft letter for schools and led development of 'perpetrator-victim', 'power – control' element of workshop delivery, and wrote final evaluation report for steering group
PMHW negotiated entry into one school, developed scripts for persona dolls and participated in delivery of training.
All other groups contributed to delivery of workshop group. Tier 2 team Steering commissioned the project and received the report for consideration.

Tools and/or artefacts: Conceptual tools: Knowledge of consultation and sampling from multi-perspectives using behavioural and solution focused paradigms. Understanding of how modelling of appropriate strategies (drawing from social learning theory) and consultation (using a symbolic interactions and social constructionist approach) can support psychological understanding and facilitate change. Concrete tools include: Home visit using Information from IALs referral, initial assessment using solution focused questions, active listening, pre and post Strength and Difficulties Questionnaire (SDQ) and confidence scaling. Use of Video to record and review appropriate child-adult interaction (Video Interactive Guidance?). Use of Tier 2 team resources and advice sheets to support work with parents and child.

Subject: Senior Practitioner Educational Psychologist (Tier 2 team) 1 day a week (0.2), 4 days a week (0.8) working as Patch EP, previously worked for CBI for 0.5. Experience: includes 1 ½ years as an EP in Another City Authority and 4 years as an EP with XXXXXX City and 3 years as a primary teacher. Training: includes Undergraduate psychology degree, Primary PGCE, Masters in Educational Psychology. Studying for the Doctorate in Educational Psychology. CPD: Solution Focused Brief Therapy and for example, making team meetings work. Other experience including work in early years, family and behaviour work as an EP

Role of EP in assessment of children's needs vs. EP performing parent support role?

Parents understanding and expectation of the EP role vs. EPs own understanding and expectation?

Object:
A joint home visit, as an exceptional arrangement, and use of video guidance of behaviour at home

Outcomes: Hoped For: Parents feel happier about child's behaviour and that they had gained something practical in their management of the behaviour including improved strategies, knowledge and skills etc Parents feel confident to choose a strategy to manage child's behaviour appropriately. Actual: SDQ indicated no measurable change but) parents eager to try strategies. Child re-referred to service.

Undertaking a full and thorough EP assessment and intervention vs. Tier 2 team's short time-limited involvement?

EP role in Tier 2 team vs. performing generic EP role in schools?

Rules:
Tier 2 team involvement should be an 8- session short-term change programme
Involvement should be followed by a three-month review.
Cases should be allocated to appropriate agency and caseworker based on client need
Evaluation should use a pre and post SDQ.

Parent's first language and understanding of EP purposes in this case?

Community:
EP (Tier 2 team) (Subject)
Family Support Worker
Parents (Mum and Dad)
Child (Male Year 2)
Sibling (Female Year 6)
School SENCO
School link EP
Speech and Lang' Therapist

EPs are the professional of choice for school related problems vs. building the skills capacity and knowledge of other groups?

Division of Labour:
EP performed lead professional role involving assessment, active empathetic listening and building relationship and trust with family.
FSW provided support role in initial assessment and provided specialist second language knowledge and skills.
FSW modelled interacting and managing child's behaviour in video
SENCO provided information on the service to parents supported referral and outlined difficulties in school. Parents signed form, shared concerns and sought additional support for child.

APPENDIX 10vi

Tools and/or artefacts: Concrete Tools: The SPARKS programme manual outlining 10 sessions giving an overview of each session detailing the objectives and expected outcomes. Sessions follow a routine structure involving Introduction, group rules, recap on previous weeks learning and practice followed by new focus. Activities include the use role-play, puppetry, puzzles, games and individual and co-operative group activities. Conceptual Tools: The programme employs cognitive behavioural approaches, draw on positive psychology, social learning theory and solution focused. Programme is evaluated by informal debriefing after groups and formally using the pre-post Strengths and Difficulties Questionnaire (SDQ).

Prescribed nature of programme Vs flexibility required by facilitator?

Qualitative evaluation used but mechanism for formal feedback and evaluation of impact to be developed?

Variation in needs of the pupil group versus the prescribed nature of the programme?

The role of the AEP in planning and evaluating Vs EP's role and responsibility for overall effectiveness and delivery?

Subject: Educational Psychologist (Tier 2 team) for 14 months with responsibility for SPARKS and transition group programme.
Experience: 3 years as an EP with XXXXXX City, Assistant EP within Family Service, XXXXXXshire and as a Secondary Teacher for 5 years as a French teacher.
Training: Masters in Education Psychology, Bachelor Degree in Psychology/French, PGCE and Diploma in Psychology.
CPD includes Solution Focused Brief Therapy, Cognitive Behavioural Therapy Training, parent training, group work and developing emotional wellbeing in children.

Object:

Planning and delivery of Special, Pro- social, Assertive Resilient Kids (SPARKs) programme.

Outcomes: Hoped for: Improvements in the self -confidence and social competence of children.
Schools with the ability to introduce and implement the programme independently. The programme aims to improve self -confidence and esteem, develop assertive behaviour, self- management of behaviour and friendship skills.
Actual: the majority of schools have a nominated training partner and have implemented the programme at least once. Evaluations indicate positive impact on children in the short term

Rules: Facilitators have to be trained in the SPARKS programme.
It is expected that the facilitators will follow the prescribed structure of the programme.
When SPARKS group work is offered it is expected that there will be a trained school partner who can jointly deliver the training.
The groups are offered at a time in the school year and time of day to suit the school context.

The way schools are invited to nominate partners and ensuring they have the confidence and competence to perform the role?

Community:

EP (Tier 2 team) Subject
Children and Young People in Year 2
Year 2 Classteacher
SENCO and Headteacher
Assistant EP (AEP)
EP (School Patch)

Obtaining appropriate pupil nominations and the responsibility held for selection of pupils?

Division of Labour:

Patch EPs promote availability of SPARKs programme during planning meetings.
AEP involved in the recruitment of school and providing information. AEP are also involved in offering practical support and planning for group work in targeted schools
School Staff identify a potential pool of children who may benefit from the training
EP/AEP and School Partner deliver SPARKs programme to a selected group of children
AEPs undertake evaluation and follow up.

Tools and/or artefacts: Conceptual Tools: Person-centred approaches, Solution-focused methods, models of consultation including process consultation, concepts of risk and resilience concepts found in Rutter et al (1979) and psycho-social concepts of mentally healthy children and environments (and myths). Understanding and knowledge of SEAL, systems theory and understanding of concept of hero innovator/expert versus process facilitator, who supports and challenges. Course make links to National Service Framework for the Mental Health of Children and Young People and Every Child Matters (ECM) Green Paper, Mental Health Foundation Bright Futures Paper. Concrete Tools: Use of group work and experiential learning activities using adult learning models. Risk and resilience 'strips' exercise, case studies/scenarios on risk and resilience, a booklet on Mental Health with information on what promotes MH and service contacts details.

Models of mental health used in training and person-centred and psychosocial approach preferred?

Subject: Senior Practitioner EP
Part-time(0.6) Tier 2 team (4 years).
Professional Training includes Psychology Degree, PGCE, and Masters in Educational Psychology
Experience: as an EP (7 years), an Assistant Psychologist (Psychiatric Rehabilitation), Primary School Teacher and Teacher of English.
CPD includes, for example, Solution Focused, Person Centred Approaches and Mental Health Training amongst other things

EP time allocation and Tier 2 Team member allocation availability, and time use?

Psychosocial models held by EP vs. medical model used by some health and other professionals?

Object:
Development and delivery of a multi-agency training on mental health awareness for frontline CAMHS staff (Tier 1)

Outcomes: Hoped for: Tier 1 workers have greater awareness and responsibility for child mental health. Understanding and awareness of mental health as a positive concept. Understandings of own role and responsibilities in regard to mental health and are able to discharge these.
Actual: Positive evaluations received and those who offer negative evaluations is often due to challenge to their previous construction of mental health

Rules:
EPs work to a predetermined time allocation system.
In MH training there is an expectation that the Tier 2 Team will present and audience listen, participate and learn (!).
Models of mental health used in Tier 2 team are determined and driven by statutory and non-statutory guidance. Tier 2 Team works within disability, equality and diversity legislation. EPs are expected to act as 'education' professionals in tier 2 team

Some in the Community view EPs as 'education' focused but EPs see selves as community orientated?

Community:
Development Group:
Training Co-ordinator
County and City EPs
County and City PMHW
Psychiatrist
Delivery Group:
EP and PMHW
Supported by Administrator, Managed by Senior EP (Tier 2 team) and PEP

Different perception of EP role held by self and other professions?

Independent and separate preparation and delivery but a team initiative?

Division of Labour:
Development:
Training Co-ordinator – Chairs the Group
EPs - contribute an EP perspective on mental health issues.
Psychiatrist and PMHW contribute their health perspective on mental health.
EPs lead and present on risk and resilience.
PMHW - lead on referral pathways to CAMHS.
Psychiatrist leads on mental health disorders and treatment.
Delivery: Precise roles can be open to negotiation but sections usually delivered separately.

APPENDIX 11 INDIVIDUAL SUPPORT STAFF ACTIVITY TRIANGLES

Tools and/or artefacts: Conceptual: Knowledge of budget setting, monitoring and auditing processes. Experience of council finance and procurement procedures. Concrete Tools: Information systems including excel spreadsheet and formula, finance management system including budget setting and monitoring involving monthly return via an intranet pro-forma, payroll and invoicing procedures. Overseeing operation of Tier 2 team Budget and two other budgets (Psychology Service and Targeted Mental Health?) and two grants (mental health grant (family support service) and vulnerable children grant (funds 0.5 EP in team)).

Not having full information from members of the community can lead to difficulty operating the budget procedures correctly?

Inconsistencies in the budget planning cycles vs. project academic and financial year?

Subject: Service Office Manager (6½ years) responsibility for the oversight of Tier 2 team budget operation and line management of staff.
Experience: As a recruitment consultant, insurance consultant, bank cashier and administration manager and of XXXXXX City finance procedures.
Training: Human resource management, recruitment and personnel, internal audit, budgets and payroll and IT systems.
CPD: Institute of Leadership and Management (ILM)

Object:
The Operational management and monitoring of the Tier 2 team budget.

Outcomes: Hoped for: Tier 2 team projects achieve goals supported by the funding available.
There are sufficient resources to support the fulfilment of the Tier 2 team Business Plan
The budget is balanced and not over or under spent.
Actual: Budget is usually balanced and additional monies for projects identified. Occasionally Recruitment difficulties can mean that budget is under spent

Rules:
There is a named budget holder and signatory accountable for income and expenditure within the Tier 2 team budget.
LA officers should follow local government finance rules and procurement procedures.
Work has to be undertaken within statutory requirement and comply with contract and tender law and data protection act.
Project grants have agreed parameters within which they can be spent and used.

SO manager operating and monitoring budget but not able to access and authorise expenditure?

Community:
Service Office Manager (SOM)
Deputy Office and IT Manager
Tier 2 team Support Officer (SO)
Principal Educational Psychologist
Senior EP (Tier 2 team)
Team Manager (TM (FSW)
Tier 2 team Steering Group
City Finance Team
and Accountants

One team but two or three budgets streams creates ambiguity?

SO used to attend Tier 2 team steering group but not now due to time constraints leaving gap in knowledge and communication?

Division of Labour:
LA accountants set budget and guidelines.
Steering Group agrees budget and set priorities.
PEP acts as budget holder and signatory.
Service Office Manager oversees the day to day operation of the budget and ensures a balanced budget. SOM with deputy monitor and manage the budget
Tier 2 team SO processes the basic incoming and outgoing invoices associated with ordering of resources and supplies.
Senior EP (Tier 2 team) and TM (FSW) available for budget queries and concerns.

APPENDIX 11i

Tools and/or artefacts: Conceptual tools: Knowledge of Tier 2 team processes and activity including the information and advice and case allocation process. Understanding of teamwork, the wider network of services and the administrative procedures of the team and work of the different Tier 2 team bases. Knowledge of resources, publicity and finance ordering. Concrete tools: Computer, typing, telephone and filing skills. Tier 2 team Support Officer procedures file and diary/file management systems. Standard letters and reporting frameworks. Use of computer systems including an adapted Excel spreadsheet as database, use of e-mail communication and electronic file management. Meetings with Tier 2 team Managers as when required for any concerns and queries.

Professional groups have different procedures in response to allocation rather than one process for all of the team?

Subject: Tier 2 team Support Officer (for 3yrs)
Experience: Extensive secretarial work with psychology, education and legal settings.
Training: Secretarial skills and IT packages
Creative thinking course

Tier 2 team has Team Procedures but three different professional group conventions?

Rules:
Tier 2 team and other staff are expected to use standard forms for referral, assessment and closure of cases.

Each case should have a file and an allocated lead professional within two weeks.

Key decisions are fed back to staff and referrers using standard procedures and letters.

Tier 2 team SO time and work with and on behalf of Tier 2 team and other teams?

Community:
Support Officer (Tier 2 team)
Senior EP/Manager Tier 2 team
Team Manager (FSW)
Service Office Manager
IT Technician and Manager
Information and Advice Line Operators
Case Allocation Meeting Members (SFSW, EP and PMHW)
Psychology Service Staff

Object:
Manage, maintain and operate the Tier 2 team database in order to record of Tier 2 Team's work and activity

Some separate paper and electronic systems?

Outcomes: Hoped for and Actual:
Monitor the team's activity with accurate record of case and other work.
To update and co-ordinate information
Evaluation and monitoring the team's work.
Providing reports of the team's activity as required by managers.

Tier 2 team (SO) at Centre and Hub of the team but outside certain key meetings e.g. team meeting leading to gap in communication?

Division of Labour:
Information and Advice Line operator receives new referral and checks for required information
Support Officer – checks database to see if case is already known, logs new information on database, scans referrals, creates list of new referrals, collates referral forms for case allocation meeting and receives decision of the meeting and creates files as appropriate.
Lead worker takes referral, passes to agency and then back to Support Officer
Case Allocation Meeting considers papers and notes decision and agency allocation

APPENDIX 11ii

APPENDIX 12 - PRIMARY MENTAL HEALTH WORKER THEMATIC GRIDS

Appendix 12i: Subjects and linked data extracts taken from Socio-Cultural Activity Theory Interviews with Primary Mental Health Workers:

Theme	Subject 1	Subject 2	Subject 3	Subject 4	Totals
Subject	SPMHW	PMHW	PMHW	Temp PMHW	4 PMHWs
Time in current role	6 years	9 years	4 years	3 months	19years 3mths
Other roles	MHW/Nurse	Social Work	PMHW/SW	MH Nursing	MH/Nursing/SW
Time in other roles	15 years	5 years	9 years	7 years	36 years approx
Training and qualification	Nursing	Social Work	Social Work	Nursing	Nursing/SW
Specialisms	Learning Dis	Child Ment H.	Psychotherapy	Tier 4 Mental Health	LD/therapy/Ment H
Total Time	21 years	14 years	13 years	7years 3months	55 years 3months

Appendix 12ii: Object theme and linked data extracts taken from Socio-Cultural Activity Theory Interviews with Primary Mental Health Workers

Subject	SPMHW	PMHW	PMHW	Temp PMHW
Object Meeting the mental health needs of children and young people in family and community settings?	The operation of the Single Point of Access to Primary Mental Health Worker (PMHW) Service and its link with the tier 2 team referral process.	The PMHW contribution to Tier 2 team case allocation meeting and follow up process when a PMHW case is allocated.	A half-day training on child mental health for early years care providers.	To undertake an initial assessment of a 5-year-old boy with behaviour and anger control issues supported by a colleague.

Appendix 12iii: Analysis of the Primary Mental Health Workers Community:

Theme	Internal	External	Total
Health	7 (PMHW)	10	17
Education	4 (EP)	3	7
Social care	4 (SFSW)	1	5
Total	15	14	29

Appendix 12iv: Thematic Grid for Division of Labour with linked data taken from Socio-Cultural Activity Theory Triangle Interviews with Primary Mental Health Workers:

Theme	Data Item 1	Data item 2	Data item 3	Data item 4	Data Item 5	Data item 6	Data Item 7	Data item 8
Independent or collaborative multiagency work in casework and training	CPN [PMHW] supported assessment, consulted with OT and SPMHW and then undertook school observation and discussion with classteacher.	PMHW consult with school nurse, health visitor, connexions worker and seeks further clarification from parent or professional referrer if needed.	PMHW involved in planning and developing input on attachment and mental health services.	PMHW carries allocated cases to CAMHS.	Tier 2 Team members alternated contributions during delivery [of training].	EP (TIER 2) initiated idea of extending training to Early Years settings and led development. Early Years	Area SENCO introduced course	FSW contributed to delivery and brought an understanding of the practice of the 'customer'.
Contributions to decision making discipline agency	PMHW/EP/SFSW represent own agency, consider cases and allocate to agency as appropriate.	PMHW contributes knowledge of mental health and CAMHS service criteria, waiting list and priorities.	Psychiatrist offers medical perspective and opinion (Which Psychiatrist attends varies?)	EPs and FSW represent their respective agency criteria for involvement and service availability.	Tier 2 Team meeting chair and note taker rotated, brief notes made of outcome and agency allocated.	Chair/note taker agreed jointly – note of agreed allocation made but reasons for decision not?	PMHW service. Senior PMHWs meet, consider and allocate cases to PMHWs waitlist	SPMHW chairs PMHWs meeting (rotated between county/city)
Professional supervision and support	SPMHW led the initial assessment, delegated role to CPN [PMHW] to follow up with the child, family and school and provided case supervision as appropriate.	OT provided case consultation to CPN(PMHW) regarding school observation	IALs worker checks the information required is available and requests this where needed	Tier 2 Team (SO) prepares agenda and case papers	Administrator takes minutes and notes decisions	PMH service administrator processes referrals for PMH Meeting	. SENCO had responsibility for ensuring training and materials was of a suitable standard.	
Referral and provision of information	Referrers (Parents for Tier 2 Team or professionals for PMHWs) complete referral form or provide letter of referral to PMHWs service	Mum and partner provide information on child.	School provided information on behaviour in class and school.	GP received information on outcome and closure				

Appendix 12v: Thematic Analysis of Rules and linked data extracts taken from Socio-Cultural Activity Theory Triangle Interviews with Individual Primary Mental Health Workers.

Theme	Data item 1	Data Item 2	Data Item 3	Data item 4
Protocols, procedures and recording keeping	Cases discussed at case allocation meeting must have referral form with all the necessary information provided.	A referral should be signed by a parent as indication of consent.	Nominated lead agency has responsibility for records and processing referral and information	Initial assessment should follow agreed protocol. Professional records should be kept detailing involvement, actions and outcomes.
Risk assessment	Each case needs to be assessed for potential indicators of risk and severity and complexity of Mental Health Need.	Those with risk factors would get an early response.	Child Protection is paramount to the work of professionals	
Collaboration and consensus	Tier 2 Team is here to promote a positive model of mental health and to collaborate and work with other professionals at tier 1.	The meeting should be a collaborative process in which consensus is reached. Disagreements would be referred to Senior's Group?	Participation in case allocation is rotated between team members. Each discipline has to be represented in the discussion.	Building the capacity and resources of other professionals will ultimately save time and support earlier intervention
Criteria that define and limit practice	Involvement of specialist CAMHS leads to closure of Tier 2 case.	Access to specialist CAMHS is defined by criteria that are clinician determined.	Training in EYs needs to be professionally presented and meet EYs quality standards.	

Appendix 12vi: Thematic Analysis of Tools and Artefacts and linked data extracts taken from Socio-Cultural Activity Theory Interviews with Primary Mental Health Workers:

Theme	Data item 1	Data Item 2	Data Item 3	Data Item 4	Data item 5	Data item 6
Knowledge of mental health, its assessment and treatment	Conceptual: Knowledge of assessment frameworks to gather evidence of mental health need versus those that are more behavioural and socially determined.	Definitions of mental health, and risk and resilience taken from Bright Futures (1999) Mental Health Foundation and Think Family (2008) Initiative and Scottish Heads Up – infant mental health programme.	Conceptual tools include ideas and understanding of what is a straightforward ‘mental health’ issue	Conceptual: Understanding of the diagnostic criteria for mental health disorders such as ADHD.	Assessment tools to support mental health formulation including use of known symptoms for certain conditions and checklists.	Tier 2 Team booklet on mental health of children including local directory of services, EY Use of medical and family history.
Awareness of risk and resilience factors	Knowledge of learning disability and its potential impact on mental health.	concepts of mental health, risk and resilience	Understanding of principal symptoms of conditions such as self-harming.	understanding of the influence of individual, family and environment factors	And [Knowledge of] link between adult and child Mental Health (Fogarty?)	Observation in school of teacher-child interaction and at home of parent-child interaction.
Knowledge of services across CAMHS tiers	Thresholds and criteria to decide the level of mental need and access to a particular tier of service Tier 1/2/3. Knowledge of services available at tier 1,2,3 or 4.	Tier 2 Team booklet on mental health of children including local directory of services,				
Knowledge of PMHW role	Discussion and debate about suitability of the case and what is an appropriate case for PMHW	Understanding of what is the Primary Mental Health Worker role.				

Case management, referral information, monitoring and evaluation	Concrete Tools: Care plans and protocols including set standards and measurement of response times.	Information and Advice Line sheet, request for support sheet, sheet detailing the list of cases to be discussed with space for agreed actions and allocated agency (where appropriate). Past files available where appropriate and	Teacher and parent Strength and Difficulties Questionnaire (SDQ) used as a measure, other scaling questions to support evaluation.	Tier 2 Team referral guidelines, referral forms and baseline questionnaire. Parent referral (city) and professional referral (county) information (?)	Concrete tools: include initial assessment pro-forma,	Service Evaluation tool
Theoretical driven and informed practice	Approaches drawing on behaviourist principles, attachment theory and historical development of the child and their environment.	Using models from family therapy and systems theory	Attachment theory and other theoretical frameworks that informed approach included principles of solution focused approach, behaviour management	PowerPoint presentation of infant attachment theory,	DVD based on Attachment in Practice (Svenberg?),	
Case supervision and support	Case supervision and support from CAMHS Occupational therapist and line manager supervision to aid formulation of need.					
Specialist knowledge	Learning disability?					

Appendix 12vii: Thematic Analysis of Outcomes and linked data extracts taken from Socio-Cultural Activity Theory Interviews with Primary Mental Health Workers:

Theme	Data Item 1	Data Item 2	Data item 3	Data item 4
Developing awareness and understanding of child mental health needs	Hoped for: Improved understanding of the behaviour of the child, beyond a diagnosis.	Actual: Normalised the child's behaviour, ruled out ADHD by observation and discussion.	Hoped For: Better understanding of child mental health.	Understanding of what promotes positive mental health.
Building the capacity i.e. the confidence and competence of parents and professionals	Improved understanding of the family dynamics and mum's competencies in managing behaviour and creating an appropriate home environment.	Building professional confidence in own knowledge and skills	Better understanding own [professional] and other roles.	
Matching service offered to child and family need	Hoped for: Screening of referrals and a timely and appropriate level of response matched to need. Match the skills and resources of team to child and family needs	Actual: Approximately 14% referrals are currently not appropriate	PMHW (Tier 2 Team) act as a conduit to referral to specialist CAMHS and subsequent PMHW involvement	Hoped for: Child is supported by appropriate agency and discipline. Case is sign-posted to another agency if needed.
Evidence of outcome and evaluation	Actual: Case allocated to agency, Cases for PMH work goes to next case referral meeting for PMHW service and further discussion	Outcome communicated to parent and child placed on agency waiting list.	Actual: Highly regarded training with positive quantitative and qualitative evaluations	Some anecdotal evidence of improved practice in support of child MH outcomes.
Consensus and consistency in decision making	Consistency of response and decision making. Equality of access to service	Consistency in core group decisions.	Appropriate course of action is determined.	and reached a professional consensus about the child's needs.

Appendix 12viii: Thematic Analysis of Contradictions with linked data taken from Socio-Cultural Activity Theory Interviews with Primary Mental Health Workers:

Themes	Data Item 1	Data item 2	Data Item 3	Data item 4	Data item 5	Contradiction
Knowledge of own and other roles	Understanding of each agency role and criteria and PMHW acting as main link?	PMHW special expertise vs. enabling others to fulfil aspects of the role - What to give away safely?	PMHW as main link between tier 1,2 and 3 in health vs. creating links and better understanding across whole team?	PMHW understanding of role and others' understanding of it?	Knowledge of other Tier 2 Team professional roles and decision-making in a particular case?	Tools–Community
Time constraints to practice	Competing workload pressures versus need to offer equality of access to service from each tier?	Tension between the time available and the criteria used to access PMHW in Tier 2 Team?	Time available for this work versus demand from other aspects of role i.e. casework?	Time available from each discipline, waiting time and case need?		Rules –Division of Labour
Consistency in decision making	Consistency of decision making and rotating members of the group?	Allocated worker's understanding of decision and need, and information shared from CA meeting?	Rotating membership of CAM and consistency of decision making?	Ensuring consistency of practice vs. allowing room for creativity and diversity in practice?	Tension between professional autonomy and accountability?	Tools-Rules
Paradigms and cultures of agency and teams	Use of a psychiatric diagnosis and the empowering preventive work within Tier 2 Team?	Medical model of base agency team and the psychosocial nature of the work within Tier 2 team?	Tension in having two separate professional and administrative processes?	Tension between the diversity of audience needs and the predetermined nature of programme?		Tools – Community
Bridge and link between tiers	Understanding of each agency role and criteria and PMHW acting as main link?	PMHW main link between tier 1,2 and 3 in health vs. creating links and better understanding of whole team?	Support provided by single agency but multiagency team available?	One PMHW service, two teams and 3 tiers?		Community– Division of Labour
Professional boundaries and criteria	Tier 2 team age limit of 11yrs and PMHW service and CAMHS Tier 3 go up to age 18?	Tension between the time available and the criteria used to access PMHW in Tier 2 team?				Rules and Community

APPENDIX 13 EDUCATIONAL PSYCHOLOGY THEMATIC GRIDS

Appendix 13i: Thematic Analysis of subjects and linked data extracts taken from Individual Socio-Cultural Activity Theory Triangle Interviews with Educational Psychology Professional Group

Theme	Subject 1	Subject 2	Subject 3	Subject 4	Subject 5	Subject 6	Subject 7	Subject 8	Total
Subjects	PEP	SEP (1.0)	EP (0.6)	EP(0.5)	EP (0.2)	EP(0.4)	EP(0.4)	AEP(1.0)	8 (3.1Tier 2 team
Time in Role	1 year	5 years	4 years	5 years	4 years	4 years	1yr 4mths	1yr 4mths	25 years 8mths
Other Roles	SEP, SPEP, Teacher	EP(SP), EP, Teacher	EP, AEP Teacher	EP, Teacher	EP, Teacher	EP, Teacher	AEP, EP Teacher	Teacher TA	Teacher, AEP, EP, SEP
Time in other roles	19 years approx	25 years	10 years	34 years	5 years	31 years	8 years	5 years approx	137 years approx
Training and qualif'n	PGCE, BSc, MSc, DApp	PGCE, Psych BSc MSc	PGCE, Psych BSc MSc	PGCE, Psych BSc MSc	PGCE, Psych BSc MSc	PGCE, Psych BSc MSc	PGCE, Dip Psych BSc MSc	PGCE BSc Psych	Teaching Qualif. Bachelor and Master Degree in Psych
Specialisms	BEST, Tier 2	ASD, EY, Bilingualism	SfBT, Mental health	SfBT, Behaviour	SfBT	SfBT, Family Fam'Therapy, Hypnosis	SfBT, CBT, Group work	SLD Autism	SfBT, CBT and a Range of other Psychologies
Total Time	20 years	30 years	14 years	39 years	9 years	35 years	9years 4mths	6yrs 4mths	162 years approx

Appendix 13ii: Objects taken from Socio-Cultural Activity Theory Triangle Interviews with Individual Educational Psychologists:

Subject	PEP	SEP	EP(SP)	EP(SP)	EP(SP)	EP(SP)	EP(SP)	AEP
Object Theme The psychological wellbeing in children and young people in family and community settings?	Participation in discussion, information exchange and decision-making in the Tier 2 team steering group and linking with other strategy groups and initiatives.	Development of the Tier 2 team Business Plan to underpin the team's activity and work.	Development and delivery of a multiagency training on mental health awareness for frontline CAMHS staff (Tier 1)	Supporting the main carer with the management of her 6-year-old granddaughter's behaviour at home.	A joint home visit, as an exceptional arrangement, and use of video guidance of child behaviour in interaction with parents at home	Planning and delivery of Special, Pro- social, Assertive Resilient Kids (SPARKs) programme.	Development and delivery of transition groups for vulnerable children in Y6 in six primary schools.	Development and delivery of a half day pilot workshop for year 6 pupils on Domestic Violence (DV)

Appendix 13iii: Thematic Analysis of the Community and linked data extracts taken from Individual Socio-Cultural Activity Theory Triangle Interviews with those from Educational Psychology Professional Discipline:

Theme	Internal	External	Total
Education	12	17	29
Health	6	8	14
Social care	7	2	9
Total	25	27	52

Appendix 13iv: Thematic Analysis of the Division of Labour and linked data taken from Socio-Cultural Activity Theory Triangle Interviews with those from the Educational Psychology Professional Group:

Theme	Data Item 1	Data item 2	Data Item 3	Data Item 4	Data item 5	Data item 6	Data item 7	Data item 8
Strategic management	SEP (Tier 2 team) provides operational and strategic leadership and management	PEP attends as Head of Psychology Service budget holder and line manager	Principal EP oversees the budget including receipt of grant funding and expenditure to support the plan.	Joint Steering Group agrees remit and parameters of the team.	Tier 2 team Steering group establishes the objectives and priorities of the team within the plan.	Chair and minutes rotated between members of steering group	CAMHS Training and Development: Co-ordinator – Chairs the Group	Senior EP (Tier 2 team) draws up plan within these parameters and presents to the steering group for comment, amendment and agreement.
Operational management	SEP (Tier 2 team) provides operational and strategic leadership and management	Tier 2 team then implements plan and priorities						
Service delivery, target setting and monitoring and evaluation	Tier 2 team then implements plan and priorities including targets for direct work 70%, training 10%, Consultation 10% and IALs?	AEPs undertake evaluation and follow up.						
Offering professional perspective.	EPs - contribute an EP perspective on mental health issues.	Psychiatrist and PMHW contribute their health perspective on mental health.	All members contribute agency perspective and consider inter-agency ethical dilemmas.	SPMHW provides clinical perspective and link with specialist CAMHS.				

Allocation of work	Case Allocation Panel – allocates case to relevant discipline.	SEP (Tier 2 team) allocates case to appropriate EP	SEP (Tier 2 team) nominated AEP to participate.					
Lead or support professional	EPs lead and present on risk and resilience.	EP/FSW undertake consultation prior to involvement to plan visit and then did joint assessment home visit.	EP (Tier 2 team) performs nominated lead agency role.	FSW performs support role	FSW took support role and provided positive feedback to family and worked with child.	EP leads initial assessment and took on the challenge role and work with the adult.	PMHW - lead on referral pathways to CAMHS.	Psychiatrist leads on mental health disorders and their treatment.
Single or multiagency initiative	Democratic process used within psychology discipline	All within discipline remark on proposals for each session and suggest revision/amendments	EP/AEP pairs used to plan and develop each session outline	Precise roles can be open to negotiation but sections usually delivered separately.	The Business plan is then shared with team for comment.	Members of each agency can raise agenda items and meeting attempts to provide equality of agency input.		
Main link to schools and education professionals	EP liaised with BST/SENCO re school behaviour.	EPs identify schools, led and implemented groups.	Patch EPs promote availability of SPARKs programme during planning meetings.	AEP involved in the recruitment of school and providing information.	AEP are also involved in offering practical support and planning for group work in targeted schools	DVIRP CYPM negotiated entry to one school and provided a draft letter for schools and led development of ‘perpetrator-victim’, ‘power – control’ element of workshop delivery, and wrote final evaluation report and attended steering group.	PMHW negotiated entry into other school, developed scripts for dolls and participated in delivery.	

Work at the level of the child or adult	Grandma provides information on her concerns and sets goals	SENCO provided information on the service to parents supported referral and outlined difficulties in school.	and School Partner deliver SPARKs programme to a selected group of children	Parents signed form, shared concerns and sought additional support for child	School Staff identify a potential pool of children who may benefit from the training EP/AEP	EP performed lead professional role involving assessment, active empathetic listening and building relationship and trust with family.	FSW provided support role in initial assessment and provided specialist second language knowledge and skills.	FSW modelled interacting and managing child's behaviour in video Schools identify vulnerable pupils for group
Development and delivery of training	AEP was responsible for developing certain aspect of materials i.e. 'we all have feelings' section of training and in facilitating groups in workshop.							

Appendix 13v: Thematic Analysis of Rules and linked data extracts taken from Socio-Cultural Activity Theory Triangle Interviews with Individuals from Educational Psychology Professional Group.

Theme	Data item 1	Data Item 2	Data Item 3	Data item 4	Data item 5	Data item 6	Data Item 7
Budget and funding determinants	Projects are time and funding limited.	New initiatives rely on funding for continuation.	Service has to operate within the budget and grants that are available.	Funding is limited so the team's work has to be cost effective.			
Legislative and statutory determinants	Models of mental health used in Tier 2 team are determined and driven by statutory and non-statutory guidance.	Tier 2 team works within disability, equality and diversity legislation.					
Demonstrate evidence of impact through evaluation	Evaluation should use a pre and post SDQ.	Pre- measures need to be taken on initial visit using SDQ and scaling of confidence.	All Tier 2 team work should be evaluated using qualitative and quantitative measures.	The team has to demonstrate its effectiveness	The team must demonstrate its effectiveness through effective evaluation.	Projects undertaken need to be evaluated and outcomes reported to managers and commissioners	
Equality and collaboration within and between agencies expected	Each agency contribution is of equal value and importance	Tier 2 team is a multiagency initiative	Tier 2 team is a Tier 2 service that should work in and link to comprehensive CAMHS	The team should be consulted in the business planning process.	When SPARKS group work is offered it is expected that there will be a trained school partner who can jointly deliver the training.		

Responsibility for decision making	Strategic Managers and Steering Group are responsible for deciding on and finalising the plan.	Team members need to understand the extent and limit of their role within the development and implementation of the plan	Meeting operates to agenda with standing and non-standard items.	Tier 2 team activities are reported via the Tier 2 team annual report			
Engage parent's and addresses children's needs	Children's needs and unmet needs are of paramount importance to the team.	Team members should put needs of children and families needs first.	Cases should be allocated to appropriate agency and caseworker based on client need		Parental consent should be obtained to contact other agencies involved	Parents should give consent to project and research work.	
Time and service boundaries	Tier 2 team involvement should be an 8-session short-term change programme Involvement should be followed by a 3 month review.	Tier 2 team involvement involves a maximum of 8 sessions. Cases should be followed after a 3-month period.	Initial visits and assessment should occur within a short time period after referral	Service clients are defined by age up to 11 year and level of need.	It is expected that the facilitators will follow the prescribed structure of the programme.	Facilitators have to be trained in the SPARKS programme.	
Context and other agency determinants	School timetable is important in determining the timing of the groups	Projects need to fit with participants other timetable, priorities and needs.	EPs work to a predetermined time allocation system.	In MH training there is an expectation that the Tier 2 team will present and audience listen, participate and learn (!).	The groups are offered at a time in the school year and time of day to suit the school context.	EPs time is allocated to different aspects of their other work.	EPs should receive professional supervision from a suitably qualified and experienced EP.

Appendix 13vi: Thematic Analysis of Outcomes and linked data extracts taken from Individual Socio-Cultural Activity Theory Triangle Interviews with those within the Educational Psychology Professional Group

Themes	Data Item 1	Data Item 2	Data item 3	Data item 4	Data item 5	Data item 6	Data item 7
Development of children's social skills, social competence and confidence	Hoped for: Improvements in the self - confidence and social competence of children.	The programme aims to improve self -confidence and esteem, develop assertive behaviour, self-management of behaviour and friendship skills [of children].	The team is successful in meeting the psychological and emotional needs of children and families it supports and this is supported by evaluative evidence	Hoped For: Help the children to feel prepared for secondary school and education	Help the children to develop social and communication skills.	Building the young person's confidence	Hoped for: Training materials which looked at DV and its impact on children. The materials and training suitable for Y6 pupils and aimed to raise their self-awareness and to support early intervention.
Improvement in parents or significant others skills, confidence and competence	Hoped for: Improvements that meet the clients own goals for change and their reasons for requesting support.	Actual: identify any unmet needs through feedback from clients and team.	Hoped For: Parents feel happier about child's behaviour and	that they[parents] had gained something practical in their management of the behaviour including improved strategies, knowledge and skills etc	Parents feel confident to choose a strategy to manage child's behaviour appropriately.	Actual: SDQ indicated no measurable change but) parents eager to try strategies. Child re-referred to service	
Improvement in professional awareness, understanding confidence and practice	[Professionals] Understanding of their own role and responsibilities in regard to mental health and are able to discharge these.	Actual: the majority of schools have a nominated training partner and have implemented the prog at least once.	Schools with the ability to introduce and implement the programme independently.	Tier 1 workers have greater awareness and responsibility for child mental health	Hoped for: Understanding and awareness of mental health as a positive concept.	.	

Collaborative management and clear policy	Hoped For: The development of the Tier 2 team business plan based on a review of existing work and evaluation of outcomes and impact.	The team, service user and Tier 2 team and CAMHS and Tier 2 team steering group perspective are obtained in setting service plan and priorities.	Parameters of the work to be undertaken by the team are agreed including what the team does and does not do and priorities and objectives are established.				
Link created to other CAMHS tiers	Tier 2 team provides a model of multidisciplinary practice, co-ordinates engagement and activity of the team and creates links within Comp' CAMHS.						
Evaluation and evidence of impact	A completed draft report highlighting positive impact and feedback received from project workers, school staff and children	Actual: Positive evaluations received and those who offer negative evaluations, this is often due to challenge to their previous construction of mental health	Evaluations indicate positive impact on children in the short term	Actual: Positive evaluation and improvement reported by grandmother such that she didn't feel she needed further support	Hoped for: Steering group effectively manages Tier 2 team activities, monitors budget and impact through outcome measures and collaborative processes.	Actual: Define Tier 2 team work and ensure work parameters are agreed, set and monitored by steering group.	Actual: Two ½ day workshops in two schools with follow up evaluation session.

Appendix 13vii: Thematic Analysis of Tools and Artefacts and linked data extracts taken from Socio-Cultural Activity Theory Triangle Interviews with Individuals from within Educational Psychology Group:

Theme	Data item 1	Data Item 2	Data Item 3	Data Item 4	Data item 5	Data item 6	Data item 7	Data item 8	Data item 9
Knowledge and application of behavioural and cognitive behavioural approaches	Conceptual Tools: Understanding of behaviour theory including the principles of reinforcement and what leads to attention seeking.	Knowledge of approaches to behaviour management such as those suggested by Bill Rogers.	Challenging and confronting carer with observations of their behaviour and its potential consequences to create opportunity for change.	Cognitive behavioural principles in anger management using concepts such as self-regulation.	Conceptual tools: Knowledge of consultation and sampling from multiple-perspectives using behavioural and solution focused paradigms.	Understanding of how modelling of appropriate strategies (drawing from social learning theory)	The programme employs cognitive behavioural approaches, draws on positive psychology, social learning theory and solution focused.	Cognitive behavioural principles and involves use of individual and group activities which are practical and fun.	
Knowledge of humanistic and person centred approaches	Draws on positive psychology and solution focused.	Concrete tools include: using active listening,	Conceptual: Understanding of Rogerian Theory and humanistic psychology, , use of Persona Dolls,	Democratic processes used to support decision-making.	Conceptual Tools: Person-centred approaches, Solution-focused methods	Experiential learning activities using adult learning models.	Active listening and use of counselling skills	Other questionnaires used occasionally include LAWSEQ and B/G esteem.	
Knowledge of personal and social constructionist	Uses awareness of the importance language and discourse with and between agencies.	(using a symbolic interactions and social constructionist approach)	self-organised learning	Using slightly different terminology to describe project (one didn't use term Domestic Violence (DV)).					
Knowledge of systems theory and organisational change	Common themes are then identified by senior staff before setting priorities in plan.	And team management skills are used to support decision-making.	Tools A PATH framework is used to involve team in identifying vision.	Knowledge of schools and school systems	Drawing on problem solving model and approach	Checkland's soft system methodology,	Management of organisational change (Drawing on Senge, Dance of Change).	The programme includes consideration of practical aspects of going to secondary school and preparing for this.	

Understanding and application of models of consultation	The use of peer consultation within joint Tier 2 team working partnership.	models of consultation including process consultation,	, Systems theory and understanding of concept of hero innovator/expert versus process facilitator, who supports and challenges.	Conceptual tools: Knowledge of consultation and sampling from multiple perspectives using behavioural and solution focused paradigms.	How consultation can support psychological understanding and facilitate change.				
Understanding of group theory, processes and group work	Parent support group is used occasionally for consultation to obtain a consumer perspective on service provision and developments	(?). Full team and professional group discussions are used to gather information from the frontline and the professional perspective on need and provision.	Understanding of small group and whole group work	Conceptual Tools include Knowledge and awareness of group theory, dynamics and processes and supported by clear communication and dialogue.	Use of group work and experiential learning activities Individual and co-operative group activities.	The SPARKS programme manual outlining 10 sessions giving an overview of each session detailing the objectives and expected outcomes.	Sessions follow a routine structure involving Introduction, group rules, recap on previous weeks learning and practice followed by new focus. Activities include the use of role-play, puppetry, puzzles, games	Drawing on work from SPARKS (Special Pro-social Assertive Resilient Kids) programme. The Programme is a 5 session programme which draws on concepts from SPARKS pro-social skills programmes,	Teaching skills and experience of class and group management. Rotating group work used with children moving to different facilitator for each part of the training.
Awareness and understanding of concepts and tools within mental health	Knowledge and analysis of the national direction and priorities using DoH/DCSF guidance on ECM/NSF as a backdrop to current practice and future priorities.	Understanding of the impact of bereavement on adult behaviour toward children.	Concepts of risk and resilience concepts found in Rutter et al (1979) and psycho-social concepts of mentally healthy children and environments (and myths). Understanding and knowledge of SEAL	Course makes links to National Service Framework for the Mental Health of Children and Young People and Every Child Matters (ECM) Green Paper, Mental Health Foundation Bright Futures Paper.	Concrete Tools: Risk and resilience 'strips' exercise, case studies/scenarios on risk and resilience, a booklet on Mental Health with information on what promotes MH and service contacts details.	Training materials covering an introduction to DV, and covering we choose to be kind, we all have feelings and help is in your hands.	Tools: Promotional activities include departmental market stall days to promote and share information about the team's work and Tier 2 team promotional leaflets and materials.		

Understanding and application of solution focused frameworks and approaches	Solution focused scaling from parents/child as appropriate.	And solution-focused approaches.	Scaling questions with carbonised pad to record outcomes and provide complements.	Meeting draws on a solution orientated approaches and	Conceptual tools: Knowledge of consultation and sampling from multiple-perspectives using behavioural and solution focused paradigms.	Draw on positive psychology, social learning theory and solution focused.	solution focused questions, pre and post Strength and Difficulties Questionnaire (SDQ) and confidence scaling.	Solution focused principles and involves use of individual and group activities which are practical and fun.	Evaluation tools used include the use of scaling.
Use of team assessment, evaluation protocols and resources	Concrete Evaluation tools used are both quantitative and qualitative including use of survey and questionnaire, use of SDQ as pre and post intervention measure	Initial assessment visit form, SDQ,	Concrete Tools: Meeting uses agenda, chair/minute taker and minutes as record of meeting.	Use of Tier 2 team resources and advice sheets to support work with parents and child.	Programme is evaluated by informal debriefing after groups and formally using the pre-post Strengths and Difficulties Questionnaire (SDQ).	Home visit using Information from Telephone IALs referral, initial assessment	Use of Video to record and review appropriate child-adult interaction (Video Interactive Guidance?).	Concrete Tools: Tier 2 team Booklet on Transition developed from a range of sources includes icebreakers, introducing self and meeting new people, getting to know a new culture, confidence building and saying goodbyes.	Concrete Tools: included letter sent to parents explaining aims and objectives of project

Appendix 13viii: Thematic analysis of Contradictions and linked data from individual sociocultural activity theory triangle interviews with those from the Educational Psychology discipline:

Themes	Data item 1	Data item 2	Data item 3	Data item 4	Data item 5	Data item 6	Data item 7	Contradiction
EPs as the key link to schools rather than community	EPs are the professional of choice for school related problems vs. building the skills, capacity and knowledge of other groups?	Some in the community view EPs as 'education' focused but EPs see themselves as community orientated?	EP role in Tier 2 team vs. performing generic EP role in schools?	Training offered versus knowledge of school context?	Agency worker e.g. (EP) acts as main link to own agency (education) but does this build understanding and collaboration in comprehensive CAMHS?			Community and Division of labour
Responding to child needs versus adult and organisational needs	Performing a supportive role but needing to challenge and confront client [Parent] about their own behaviour?	Role of EP in assessment of children's needs vs. EP performing parent support role?	Variation in needs of the pupil group versus the prescribed nature of the programme?	Focus of transition work is on the child rather than new school context and staff?	Rotating group work used with children moving to different facilitator for each part of the training vs. understanding child story and needs?			Tools - Outcomes
Time allocation and responsiveness to need	Tension between time available from EP and providing early assessment and intervention?	Undertaking a full and thorough EP assessment and intervention vs. Tier 2 team's short time-limited involvement?	EP time allocation and Tier 2 team member allocation availability, and time use?					Rules- Outcomes

EP understanding of their own role versus other's understanding of it	Parents understanding and expectation of the EP role vs. EPs own understanding and expectation?	Different perception of EP role held by self and other professions?	Knowledge, confidence and competence of team members vs. role taken in training?	PEP Professional responsibility and role for professional supervisor vs. management support and/or challenge?				Tools-Community
EPs indirect collaborative approach vs. direct leadership and challenge role	Using implicit assumptions about team involvement Vs having explicit processes and procedures for planning and consultation?	The role of the AEP in planning and evaluating Vs EP's role and responsibility for overall effectiveness and delivery?	Attempting to support democratic processes at the same time as holding executive power?	In trying to promote and deliver both indirect consultative service and direct work with children?	The way schools are invited to nominate partners and ensuring they have the confidence and competence to perform the role?	Obtaining appropriate pupil nominations and the responsibility held for selection of pupils?	Schools identification of pupils and the team's ability to meet the diversity of need? Development of a cohesive programme vs. delegating work to pairs to plan each session?	Rules-Tools
MH paradigm of EP discipline vs. MH paradigms held within comprehensive CAMHS	Models of mental health used in training and person-centred and psychosocial approach preferred?	Psychosocial models held by EP vs. medical model used by some health and other professionals?	Support for professional innovation vs. managing any professional (turf wars?) disagreement between agencies?					Tools - Community

Single agency work vs. multi-agency initiative	A single discipline activity within a multi-disciplinary initiative?	Independent and separate preparation and delivery but a team initiative?	Team collaboration in development and delivery but not at report writing stage?	Attendance and level of engagement in steering group vs. commitment to initiative?	Participation of specialist (CAMHS) in Tier 2 team vs. planning, decision-making and delivering comprehensive CAMHS?	Involvement and commitment of each agency to strategic planning and the contribution they make to delivery?	The priorities of partner teams and differences in commitment of each to Tier 2 team multi-agency planning and delivery?	Division of Labour-Community
Demonstrating impact vs. type of evaluation undertaken	Evaluation used from one perspective and not school or child in this case?	Qualitative evaluation used but mechanism for formal feedback and evaluation of impact is to be developed?	Evaluation measures the initial short-term impact but need to demonstrate the long-term effectiveness of groups in supporting successful transition?	SDQ is used to measure change in Tier 2 team work but not in transition group?				Tools-Outcomes
Obtaining commitment and engaging with others	Service designed to support parents but how to include their perspective fully in informing service planning?	Parent's first language and understanding of EP purposes in this case?	Prescribed nature of programme vs. flexibility required by facilitator?	Timing of the transition group and school timetable pressures and issues?	Possible ethical issue about information shared with parents and the consent given - was it properly informed?	Service designed to support parents but how to include their perspective fully in informing service planning?	Review processes used and obtaining the wider CAMHS professional perspectives?	Tools – community

APPENDIX 14 THEMATIC GRIDS FOR FAMILY SUPPORT WORKER GROUP

Appendix 14i: Thematic Analysis of subjects and linked data extracts taken from Individual Socio-Cultural Activity Theory Triangle Interviews with Family Support Worker Professional Group

Theme	Subject 1	Subject 2	Subject 3	Subject 4	Subject 5	Subject 6	Subject 7	Subject 8	Subject 9	Subject 10	Subject 11	Total
Subjects	TM (FSW)	SFSW	SFSW	SFSW	FSW	FSW	FSW	FSW	FSW	FSW	FSW	11
Time in Role	2 years	9 years	10 years	9years	5 years	8 years	5 years	1 year	3mths	6 years	2 years	57yrs 3mths
Other Roles	Social Worker Social Work Ass't	Nursery Officer and FSW	Mentor Personnel Manager	Tutor, Assessor Nursery Nurse	Nursery Officer	Nursery Officer	Nanny and Nursery Manager	Nursery Officer Classr'm Assistant	Family Learning Project Worker	Nursery Nurse	Teacher NVQ Assessor	Nursery Nurse or Officer
Time in other roles	15 years	17 years	6 years	20 years +	18 years	10 years	16 years	13 years	2 years	12 years	12 years	141 years
Training and	SW, Bsc SS	NNEB	NNEB,	NNEB, Nurse	NNEB	NVQ 3 Childcare	NNEB	NNEB	NVQ 3 Deg Ch St	NNEB	PGCE, NNEB BTEC	NNEB, BTEC NVQ 3
Specialisms	SW, Foster Adoption	SW Training	Personnel YOT	NVQ Ass Parenting	Facilitator Parenting	Parenting SW Train	Parenting Behaviour	Parenting Ch Protect	Childhood Studies	Ch Protect	Parenting	Parenting SW Training
Total Time	17 years	26 years	16 years	29 years	23 years	18 years	21 years	14 years	2yrs 3m	18 years	14 years	198yrs 3mth

Appendix 14ii: Objects taken from Socio-Cultural Activity Theory Triangle Interviews with Individual Family Support Workers:

1	2	3	4	5	6	7	8	9	10	11
TM(FSW)	SFSW	SFSW	SFSW	FSW	FSW	FSW	FSW	FSW	FSW	FSW
Responsibility for change management within the Tier 2 team (August 06 – Nov 07) relating to the operation of Information and Advice lines	To undertake a review of Tier 2 team file management system and implement these changes	Involvement in the development and delivery of solution focused training to groups of children's service professionals	Supporting a parent with learning disability to appropriately respond to her 9 year old son with special needs and challenging behaviour	Induction of FSW into Tier 2 team through training, supervision and planned activities	Providing first response to parents of 9 year old girl who was anxious, displaying challenging behaviour refusing to attend school	Training for professionals on responding to children's emotional needs (under 5) within a Surestart setting	Participation in a professional meeting about a 7 year old girl with an ADHD diagnosis, where there were concerns about her lateness at school, child protection and the diagnosis	To work with a family of a 5 year old boy to address the violent behaviour he shows towards school peers and parents	To provide support for a 're-referred' parents to help them in understanding and managing the behaviour of their 9 year old son with learning and behavioural difficulties.	Working on the Tier 2 team Information and advice line, providing consultation , support and advice to a parent

Appendix 14iii: Thematic Analysis of the Community and linked data extracts taken from Individual Socio-Cultural Activity Theory Triangle Interviews with those from Family Support Worker Professional Discipline:

Theme	Internal	External	Total
Education	8	13	21
Health	8	10	18
Social care	25	9	34
Other	3	7	10
Total	44	39	83

Appendix 14iv: Thematic Analysis of the Division of Labour and linked data extracts taken from Sociocultural Activity Theory Triangle Interviews with Family Support Workers:

Theme	Data Item 1	Data item 2	Data Item 3	Data Item 4	Data item 5	Data Item 6	Data item 7	Data Item 8	Data Item 9	Data Item 10
Referral and information source (parents, schools, tier 2 team professionals)	School Staff-made referral Parents – signed to agree to involvement	Parents – shared concerns and gave the history through narrative account.	Parent makes call.	FSW (PP) suggested re-referral of parent to Parents attended at the end of the meeting.	FWCW provided ongoing FSW and Behaviour management advice to parent	Paediatrician – made diagnosis.	School – publicised the service and provided information to parents	Parents – Self refer to service Maternal Brother – offered respite care	Health Visitor undertook initial screening of child's needs	FSW (IALS) receives call, gets and gives information and agrees next steps.
Allocate case and other work (SFSW/ case allocation meeting)	SFSW, EP and PMHW – decided case allocation	EP, PMHW and FSWs contributed to case discussion and consultation to SFSW	SFSW do the above and represent the service in Senior's meeting and case allocation meetings	Senior Tier 2 team staff – consider referral and allocate the case to appropriate agency	SFSW, SEP (Tier 2 team) and SPMHW act as small steering group and decide on SFBT trainers	All other team members (EP, PMHW, FSW) can be drawn in to deliver training depending on need and setting involved.	FSW/PMHW – jointly plan training and agree roles	Subsequently acting as advocate for child and family needs at allocation meeting	Allocates case to next FSW on 1st Response Rota; Sets the 1 st	CAM – considered 1 st Response Information and allocated case to FSW as lead agency.
Provide supervision and consultation and management support (TM, SFSW and SPMHW)	SFSW – provided initial induction, support and supervision for the activities undertaken	SFSW Provides line management and professional supervision to FSW.	TM (FSW) Provides professional supervision to SFSWs.	SFSW provides support, consultation to FWCW	Senior PMHW acts as a critical friend and brings knowledge and experience of CAMHS phone-line.	case discussion and consultation to SFSW	Senior EP acts as a sounding board for development and proposals. Professional leaders provide supervision to own professional group			
Provide initial response, assessment and support (FSW)	FSWs (PP and AW) made initial joint assessment visit	FSW(Tier 2 team) and PMHW – undertook initial joint assessment visit	FSW (IALS) - received referral, determined level of response needed and provided information and consultation to FSW (1 st Response).	FSW (Tier 2 team) – gave advice to mum, liased with others, compiled assessment information	FSW (1 st R) – acted as key worker for family, made initial response and made records of the meeting.	Consults SFSW and other service including CAMHS phone-line as necessary and gives feedback on outcome decision to parent.	FSW (AW) then followed up work with five home visits			

Received referral and used information in determining action (FSW/ Other agencies)	DAS received information and used to determine its level of response	FAS – received and accepted referral at Tier 2 team closure	Team Manager (CSDT) chaired meeting and was responsible for deciding whether case met social care criteria for service	FSW signposts parent to this [another] service and closed case.						
Participate in multi-disciplinary and joint work (Other tier 2 team and agency staff)	Tier 2 team members provided observation and shadowing opportunities	TM (FSW) Links and Liases with SPMHW and SEP (Tier 2 team). Line managed by PEP?	FSW introduced new allocated worker as well as undertaking an updated assessment.	SFSW facilitates calling of multi-agency meeting	All others present shared information on their view of the child's development and progress	SFSW leads SFBT training both in and outside team.	BST and FSW call multi-agency meeting to share and gather information, build relationships and ensure consistency of advice. AEP – available for co-work	SFSW/MSDT have joint planning meeting. MSDT does theory input to training SFSW worker does practice-based input	PMHW/FSW – jointly deliver, alternate roles of support and lead in discussion	Two multi-agency meetings involving EP, BST and School Reps. SENCO chaired the meetings.
Provide leadership and management (TM/SFSW)	Team Manager (FSW) – oversaw and planned the induction process	Team Manager (FSW) with responsibility to develop proposals and to implement change.	Steering Group performs decision-making duties	Senior Tier 2 team colleagues provide support and a collegiate management structure	TM (FSW) leads the team, contributes to operational, project, change and strategic management through steering and Management group.	Senior Management (Tier 2 team) considered the changes needed, discussed and agreed these changes.	TM (FSW) introduce rationale and aims of the development day	SFSW prepared and presented information on the changes in format of Tier 2 team records (20)	SPMHW and SEP (Tier 2 team) participated as members of audience.	All other members of Tier 2 team acted as audience and participated in group activities.
Provides administrative support (SO Tier 2 team)	Tier 2 team SO - provided practical support and Info' records.	Tier 2 team (SO) prepared changes to file records.	Tier 2 team SO prepared materials and performed follow up administration.							

Other?	Workforce Development Trainers – developed and delivered corporate training programme.	Other professionals participated in training e.g. Paediatric Nurse	CDN was responsible for long term support re mum's health and liaison with adult psychiatrist	EP undertook assessment separately and referred to specialist CAMHS	PMHW – to address health issues and liase with Paediatricia n	FSW (Red Cross)- provided advice and strategy from magic 123 programme	PMHW – facilitates and records information SHS – listen and participated in training	FSW – participated in induction activity and training and made some of own arrangements and was responsible for time/diary management		
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Appendix 14v: Thematic Analysis of Rules and linked data extracts taken from Socio-Cultural Activity Theory Triangle Interviews with Individuals from Family Support Worker Group.

Theme	Data item 1	Data item 2	Data item 3	Data item 4	Data item 5	Data item 6	Data item 7	Data item 8	Data item 9
Short-term time -limited involvement	Tier 2 team work is time limited	Tier 2 team involvement involves an 8 session change programme	Tier 2 team offers time-limited intervention	Assessment Follow up at 3mths	Tier 2 team does short term interventions (up to 8 visits) and the work of the team is to support early intervention .	Tier 2 team should provide time limited involvement, support and intervention	Tier 2 team IALs is a non-urgent service	Tier 2 team is a non-urgent support there to promote mental health, to support early intervention and prevent mental health and behavioural needs.	
Effectiveness of involvement is evaluated	Training should have agreed aims and learning outcomes and be evaluated by SDT.	All training should be evaluated And include Equal opportunity monitoring including records of ethnicity, gender and area of work	Team members are expected to use pre and post SDQ to evaluate impact of involvement.	New projects and changes in practice are piloted and the evidence of the impact is reviewed and evaluated					
Collaboration and co-operation is expected	Tier 2 team work involves collaboration with other professionals	Tier 2 team members are expected to facilitate communication between the network of professionals involved.	Collaborative co-working promotes knowledge and understanding within the team	Tier 2 Team members share resources	Experience in training is developed by Tier 2 team members observing, supporting and then leading it.	Training is done in pairs. You observe and participate in training before undertaking delivery.	1 st Day responses are made by FSWs where appropriate on a strict rota basis.	All 1 st response visits are allocated to FSW on a rota-basis.	
Work is determined by the team business plan	Business plan determines the work and priorities of the team	Provision of solution focused training is part of the Tier 2 team business plan	All work should follow the business plan	You have to perform work in accordance with the business plan.	Tier 2 team work is determined by the business plan and team objectives				

Provide a direct service to clients	FSW workers are expected to work with and support parents and through them with children	Tier 2 team is designed to deliver 70% of its time to direct work in the community in face to face contact with children and families.	Children need to be seen as part of Tier 2 team involvement.	Child must be seen as part of Tier 2 team direct work to check to rule out any child protection concerns.	The safeguarding of children is a paramount responsibility of all professionals.				
Follow team protocol and procedures	All work needs to be conducted within service policies on record keeping, child protection and health and safety.	Tier 2 team requires a range of assessment tools to be used in initial assessment	All follow up assessment visits involve pairs of workers and follow the home visiting policy/protocol	A 1 st Response should happen within a week of request.	All case files should be seen and signed off by a senior at closure	Tier 2 team allows flexibility and professional judgement in the intervention approaches used	All 1 st response visits are at a neutral venue and within working hours.	Requests for involvement must go to the case allocation meeting in the first instance	Team involvement requires written parental consent Team records need to be kept and presented accurately and consistently
Have core competencies	Team members have a planned induction.	All Tier 2 team members are expected to know about and use Solution Focused Approaches							
Limits and boundaries to service	Involvement of specialist CAMHS means work Tier 2 team should cease.	Tier 2 team doesn't work with higher levels of need	Workers should advise parents who report involvement of CAMHS and Social care services, or live outside city boundary, or are age 11 (Y6) and above, that they cannot have service.	If need described is severe and outside Tier 2 team criteria parent should be advised to seek more appropriate support elsewhere	.				
Other?	Tier 2 team should offer consultation to tier 1 professionals.	TIER 2 team's focus is on raising and promoting positive mental health.	You have to attend corporate induction.						

Appendix 14vi: Thematic Analysis of Outcomes and linked data taken from Individual Sociocultural Activity Theory Triangle Interviews with those within the Family Support Worker Group

Theme	Data item 1	Data item 2	Data item 3	Data item 4	Data item 5	Data item 6	Data item 7	Data item 8	Data item 9
Quality and consistency of service	Hoped For: Implement change but maintain the same quality and level of service despite reduce level of staffing.	Hoped for: Improved knowledge of team procedure, process and practice.	Increased confidence and understanding of the role and core Tier 2 team competencies and skills	Delivery the business plan help TIER 2 team support and meet ECM outcomes	Hoped for: To satisfy JAR recommendation and requirement for high quality file management.	To develop a consistent file management throughout the three disciplines of the team	Actual: Combination of corporate induction and team induction activity including shadowing activity and training in key competencies	Improved procedures in the operation of the Information and advice line.	Agreed file management system changes and for a 6 month review and evaluation of these
Level and accessibility of service	To keep the advice line operating for 4 days a week and 4 hours a day.	Actual: IALs service working with one worker, use of answer-phone.	FSW on Rota, allocated case, booked room, returned phone-call sent letter to parent as confirming appointment						
Information on, and signposting to services	Actual: a record of concerns made and shared with an appropriate agency i.e. Social Care DAS Team	Family sign-posted to Voluntary sector Family Welfare Care Worker (FWCW)	Actual: Child given ADHD diagnosis and referred to specialist CAMHS	Identify most appropriate agency to support.	Signpost and referred to School Anxiety Support Team (SAST)	Re-referred to Case Allocation Meeting (CAM) for further Tier 2 team work	Closed case and parent referred on to Family Action Service (FAS)	Hoped For: Parent informed about the service or provided with information and contact of a more appropriate service.	Greater awareness of TIER 2 team role
Supporting parents and professionals in meeting children's needs	Hoped For: Improved confidence and competence of parents in managing the behaviour.	Hoped for: Child is no longer late for school, mum will have a set of tools and be able to draw on her personal resources to manage her daughter's behaviour	Parent provided with reassurance and basic advice re strategies.	Hoped for: Empower parent in order to build her confidence as a parent, to set appropriate limits and ensure child's safety.	Actual: Parent responding more appropriately but in need of ongoing support. Family Support Meeting held, when roles were agreed.	Hoped for: Awareness of promoting positive mental health Increased knowledge and confidence in responding to emotional needs	Professionals with additional skills to apply in their work with children and families. Encourage experimentation in the use of positive approaches and extend thinking.	Actual: Follow up session provides a review of participant's success and problems in applying the approach.	Clear and direct advice given to mum,

Clear evaluated outcomes from involvement	Actual: Participants good response and evaluation ratings of training - 7.1 to 8.6 out of 10 for the training. Few qualitative comments offered	Attendance rates at follow up are good and very positive experiences are usually reported and recorded in evaluation of the course							
Early assessment, intervention and support	First response or a referral agreed.	Actual: Agreed 1 st Response, completed initial inquiry, identified	Hoped for: Early intervention within a week of request.	Actual: Initial assessment of suitability of case.					
Improvements in parent(s) – child interaction	Hoped For: Improvement in parent's understanding of their child's needs.	To promote parents skills, to reduce anxiety and	Actual: Parenting much improved	Improved relationship with brother. Improved parenting	Improvement in both parent's management of behaviour including structured routines and positive attention.	Boy now able to cross the road safely (previously being unaware of dangers).			
Unmet needs	Actual: Parent responding more appropriately but in need of ongoing support. Family Support Meeting held, when roles were agreed.	No significant changes in parenting observed.	Relationships in school and with peers much improved but child and family still with unmet needs.						

Appendix 14vii Thematic Analysis of Tools and Artefacts and linked data extracts taken from Sociocultural Activity Theory Triangle Interviews with Individuals from within Family Support Work Group:

Theme	Data item 1	Data item 2	Data item 3	Data item 4	Data item 5	Data item 6	Data item 7	Data item 8	Data item 9	Data item 10
Knowledge and experience of child development, disability and care	Knowledge of age appropriate development, play environments for children.	Understanding of age appropriate development and milestones,	Understanding and knowledge of child development and disability issues.	The paramount importance of meeting 'children needs'	Knowledge of child development milestones, appropriate environments to promote play and child development.	Children's learning and development and the impact of learning disability.				
Knowledge of Parenting and 'what's good enough' to support family functioning	Knowledge of parenting,	Understanding of family development and make up and its influence on child development;	Drawing on own practical and professional experience and understanding of what supports parent-child attachment	Knowledge of 'good enough' and appropriate parenting;	Knowledge of parenting.	Understanding of parenting skills and their assessment;	Observation of Parent – Child Interaction,	Knowledge of child development, 'good enough' parenting, sibling rivalry	Discussion with child, observation of child – parent interaction,	concepts of 'Good enough parenting'
The application and use of solution focused approaches	Solution focused questioning to facilitate the discussion.	Solution focused practice, adapted to be developmentally appropriate including the use of scaling;	It involves delivery of theoretical underpinnings of solution-focused approaches and background to the approach.	Drawing on the work of DeShazer and Berg. Case studies and practical applications of work are used to demonstrate how the principles of SFBT are applied to work with children and families.	The solution-focused approaches used include problem free talk, exception finding, the think break and scaling.	Training in solution focused approaches	Use of scaling questions of confidence And a Solution focused approach	Solution focused script, And Use of Solution focused techniques.	Solution Focused techniques including problem free talk, building on the positives and resources of parent,	Solution focused scaling questions used. A follow up session.

Knowledge and application of behaviour management strategies	and behavioural strategies	behaviour management techniques, understanding the causes of attention seeking behaviour and possible strategies;	CBT training was coincidentally within induction period.	Use of Magic 123 programme and sticker chart for behaviour.	Behaviour Management Advice and Strategy Sheet (adapted to be presented visually using Traffic Light Behaviour Chart).	Understanding of behaviour management techniques				
Awareness and use of child mental health policy and practice	DoH guidance on mental health promotion;	Information booklet on meeting emotional needs of under fives including a directory of contacts and information about services to support mental health needs of the under 5s and their parents.	Understanding of factors that impact on self-esteem and anxiety.	: Bright Futures (1999) concept of mental health;	Understanding of the influences of family environment on separation anxiety and of how to build the resilience and confidence of parents.	Contributing to mental health awareness training.	Understanding of mental health and limits of Strengths and Difficulties Questionnaires (SDQ).	Knowledge of cultural issues and understanding of how this would impact on family perception of mental health.	Child, parent and teacher Strength and Difficulties Questionnaire (SDQ) were available but not used on this case as it was felt inappropriate.	
Provision of practical and emotional support for parents	Using a combination of hands on direct support and work and indirect empowerment of parents and other professionals at tier 1/2.	Informal discussion and relationship building with parents.	Using previous experience as both parent and family support worker, to demonstrate empathy and understanding.	The use of listening and relationship building skills.	Practical help to mum to access support,	Active listening skills, information gathering and sharing.				

Knowledge of child protection and social care	Knowledge of child protection procedures, the impact of emotional abuse,	Knowledge of child protection and safeguarding procedures.	Background understanding of ECM agenda and safeguarding procedures	Drawing on knowledge of Joint Area Review Outcomes, Social Care Procedures and underlying Child Protection and Safeguarding procedures	Understanding and knowledge of social care services	The use of direct work involving assessment based Quality Protects Children in Need framework and CAF	Knowledge of community social care work and service culture;	Understanding of child protection procedure.	Knowledge of the assessment framework, use of the Quality Protects Framework for the assessment of need.	ECM Agenda, UN Convention Rights of the Child, Knowledge of Child Protection Process and Local safeguarding arrangements and Children act
Use of team protocols, assessment and evaluation procedures and resources	Both Tier 2 team and Staff Development (SD) evaluations are used; Tier 2 team uses scaling and written feedback. SD use phone interview and oral feedback	Structured evaluation questionnaire used to obtain participants immediate evaluation of the training involves use of rating scale and comment.	Tier 2 team Good practice and activity guides for parents.	Lead or support for initial assessment visits and short term intervention programme over 8 sessions.	Formal assessment methods using SDQ and formative discussion and planning with child and mum.	Telephone IALs rota, first response rota and visits, Information and Advice Line	Phone-line protocols and scripts and record forms including call log, initial inquiry form, first response form and, where appropriate referral forms	Use of the 'to do' file, screening of the case allocation referrals to check information is correct.	Knowledge of key Tier 2 team processes i.e. initial assessment, information and advice line and first response procedure. Opportunity to read through papers and procedures	Joint home visit with other worker to introduce and facilitate transition to another service.
Use of file and record keeping	The use of effective case management, record keeping and file management.	Triplicate record of actions for parent, Tier 2 team staff and others involved.	Records of 1 st Response including case record	Reasons for accurate record keeping and file management is important	Adapted file records and management system,	Triplicate carbon copy booklet used to feed back.	Information and data about calls			

Group facilitation and consultation	Team, Case Allocation and professional group meetings	Group facilitation and discussion drawing on a range of professional views and experiences	Each aspect of the approach is presented and then practised in pairs or small groups using scenario exercises.	Knowledge of experiential exercises, activities and learning.	Group activity exercises to identify the positive and negative aspects of IALs. IT and paper systems for monitoring progress.	Discussion with other relevant professionals, multi-agency meeting and liaison,	consultation with other professionals			
Tools to support, supervise and manage change	The use of informal support, line manager supervision, induction and professional development activities.	Principles and values training, manual of induction procedures for both Children centre and Tier 2 team and two days departmental induction providing the bigger picture. Training in other corporate issues is planned.	Consultation activities with staff via whole service team meetings, professional meetings, steering and management group meetings, and individual supervision.	Project task schedule with clear structure, timeline and an expected outcome.	CWDC Schedule 'Induction to work in Children's Social Care' to self-monitor and evaluate induction learning and outcomes.	: Drawing on the use of soft systems to create a rich picture, presentation and data analysis skills.	Supervisory and Project Management Skills and approaches to task and project management and leadership.	Use of a force field analysis to consider the pro's and cons of change.	Situational leadership, use of soft systems methodology and psychology of organisations and understanding of systems theory.	Understanding of learning by doing and supervision process. Discussion with Supervisor to fill gaps in. An opportunity to shadow and observe other team members doing their role, within and across disciplines. CYP Induction checklist to address basic understanding and needs.
Other? Knowledge of other services	Concrete: Computer, fax, phone and photocopier and access to the Internet.	Experience and knowledge of other professional work, processes and procedures.	Course uses video, supported by a participant pack and use of worksheets and exercises.							

Appendix 14vii: Thematic Analysis of Contradictions and linked data extracts taken from Individual Sociocultural Activity Theory Triangle Interviews with those from Family Support Worker Professional Discipline:

Themes	Data item 1	Data item 2	Data item 3	Data item 4	Data item 5	Data item 6	Data item 7	Data item 8	Data item 9	Data 10	Contradiction
Professional flexibility vs. consistency of service	Course content pre - determined but needs to be suited to particular group or organisations' needs?	Flexibility required in professional judgement and the expected conventions of team?	The flexibility and discretion of the professional versus the requirements of team procedures and protocols?	Elements of induction programme are prescribed but some flexibility is needed to take account of the experience of new team members?	Roles expected of FSW in Tier 2 team protocols and professional judgement about what is needed?	Providing a personalised package of care plus meeting standard requirements of the team?	Supporting the delivery and consistency vs. development of Tier 2 team services?	Ensuring accountability versus giving autonomy to team members?	Obtaining consistency of practice vs. encouraging creativity of the team members? Having a script versus personalising response to need?	Balancing the short-term nature of Tier 2 team work with the complex needs of clients of some children and families?	Rules- Tools
Constraints to work created by time/work of other disciplines	Tension between the thresholds held by Tier 2 team and those of other services?	Agenda and model held by school staff versus agenda and model of Tier 2 team worker and their purpose, objective and role in this case?	Framework for assessment used versus the diagnostic approach used and held by others in the community?	Collaboration promoted between agencies but opportunities for this limited by time and availability of profession?	FSW are 100% within Tier 2 team but other professionals not?	Informal social contact mainly with close team members only, contact with other groups less frequent and more formal?	Time constraints and availability of other team members to deliver training?	Brief assessment and involvement of Health Visitor and required liaison role in tier 2 team?	PMHW service availability and agency commitment to the service?	Being the main Tier 2 service and work with Tier 2 team agencies?	Community- Division of Labour
Differences in understanding and co-operation and collaboration within and between services	School objectivity and assessment and the assessment of external agencies? such as Tier 2 team	FSW trying to facilitate the communication network but some in the professional communities are reluctant to engage?	How trainers are determined and the opportunity and skill of team members?	A difference in presenter's understanding of the process and content of SFBT?	Independent records made in multi-agency meeting but shared action agreed?	Audience placed in critical evaluative role rather than formative role?	Individual profession service within a multi-agency approach?	Team involvement and ownership of change?	Working alone or as part of the team and the process of support for difficult issues e.g. distressing calls or language limitations?	Providing a service and linking with other services in Comp CAMHS?	Tools – Community

Meeting the needs of parent and child	FSW role in meeting the needs of parent and child?	Ensuring the voice of the child as well as parent is heard?	Knowledge and skills in the team and those required for need?	Matching skills of team with the need of child?							Tools– Outcomes
Formal child protection role and informal support role	Tension between the support role, and child protection role of Tier 2 team FSWs?	Formal FSW role but informal family friendly needed?	Worker duty to child protection and the nature of the confidentiality given to parents?	Balancing child protection responsibility with delivering a support to parents?							Tools– Outcomes
Time and other limits to support offered vs. meeting the child and family need	The complexity and severity of child and family needs and the expected length of Tier 2 team involvement?	Long term involvement needed but short term required?	Line is open 10 'til 2pm but needs 24/7 answerphone?	City and County referral procedures vary i.e. parental vs. professional?	Time constraints and availability of other team members to deliver training?						Rules- Outcomes-
Providing both indirect 'enabling' support and direct practical 'hands on' support	Indirect consultative work of the team and directive approach required in this case?	Indirect support encouraged but direct work often needed?	Empowerment of the parent vs. helping them access a service?	Balancing offering hands on practical support with indirect empowerment of clients?							Tools- Outcomes-
Models of other services and those of the team	Solution focused approach and the problem-orientated work of some in the audience i.e. those engaged in child protection?	FSW as key worker and/or lead professional?	Tension due to differences in pay and conditions of service of professional groups?	Training enhanced by different disciplines but sometimes delivered by one?	SFSW role in this activity and approach used in other work?	Senior group's understanding and team's understanding of the purpose of the team discussion?	Induction period is long(24 wk) involves indirect and passive learning but learning by doing and observing preferred method?				Tools – Community

Level of access, involvement in team collaboration	Senior Group's understanding and team's understanding of the purpose of the team discussion?	Clarity of accountability /responsibility for decision making and collaborative management approach?	Obtaining consensus on changes and lack of involvement of one discipline in planning?	Processes used within the team and Tier 2 team approach to its Clients?	Decision made in Senior group but consultative discussion used with team?						Tools- Community
Single or duplicated procedures	Three separate induction processes used for one service and role?	Possible contradiction between the paper and IT records kept in IALs- dual processes?	Dual processes used both paper and IT based systems - some duplicated information and effort?								Tools – Division of labour
Links with other agencies?	The support and involvement of team vs. accessing another service in CAMHS service?										Tools- Community
Evaluation and evidence of impact?	Evaluation predominately quantitative but qualitative change in professional's work/views needed?	Qualitative measures needed but quantitative expected?	Methods used in evaluation and the purpose of the tools used by Tier 2 team and SD teams?	Use of experience and knowledge of practice vs. theory and evidence base of approaches?							Tools – Outcomes

Appendix 15:
Table showing
the object theme
and linked type
and number of
individual
objects identified
by the team
members.

[illegible]

